NEW HEALTH PROFESSIONS AND GRADUATE MEDICAL EDUCATION RECOMMENDATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

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NEW HEALTH PROFESSIONS AND GRADUATE MEDICAL EDUCATION RECOMMENDATIONS

TUESDAY, APRIL 16, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 9, 1996
No. HL-16

CONTACT: (202) 225-3943

Thomas Announces Hearing On New Health Professions and Graduate Medical Education Recommendations

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on recommendations on the future national needs in the areas of health professions training and the financing of graduate medical education. **The hearing will take place on Tuesday, April 16, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include representatives of the Institute of Medicine's Committee on U.S. Physician Supply and the Pew Health Professions Commission. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Currently, the United States has over 300 major teaching hospitals where most graduate medical education of physicians takes place as well as the training of many other health professionals. These institutions generally provide the full range of medical services, but are particularly noted for the contribution they make in health care training, research, and tertiary care services. Certain institutions are also critical to communities for the provision of primary care to areas and people not readily served by other health care providers.

The evolving health care market is having a major effect on the viability of teaching hospitals as we know them today, the financing of graduate medical education, and most importantly, the national needs regarding health professionals. Medicare assumes a major role in the financing of graduate medical education and the unique missions of teaching hospitals.

The Medicare program recognizes the costs of graduate medical education in teaching hospitals and the higher costs of providing services in those institutions. Medicare recognizes the costs of graduate medical education under two mechanisms: direct graduate medical education payments and an indirect medical education adjustment. The direct cost of approved graduate medical education programs include salaries of residents and faculty, and other education costs for residents, nurses, and allied health professionals trained in provider-operated programs and are paid on the basis of a formula that reflects each hospital's per resident costs. The indirect medical education adjustment is designed to pay hospitals for the costs resulting from such factors as the extra demands placed on the hospital staff as a result of the teaching activity, greater severity of patient illness, or additional tests and procedures that may be ordered by residents.

Issues relating to health professions and teaching hospitals are of critical importance to the Medicare program and its beneficiaries. The Institute of Medicine Committee on the U.S. Physician Supply and the Pew Health Professions Commission have both recently made recommendations concerning the structure and financing of health professions training and the overall national health professions needs.

(MORE)

In announcing the hearing, Chairman Thomas stated: "The recommendations of these two groups are extremely significant and timely. The hearing provides an important opportunity to begin a dialogue in the Health Subcommittee on the future of health professions training and graduate medical education financing in this country."

FOCUS OF THE HEARING:

The hearing will focus on the recommendations of the Institute of Medicine's Committee on the U.S. Physician Supply and the Pew Health Professions Commission on the future national needs in the areas of health professions training and the financing of graduate medical education, particularly as they effect the Medicare program and its beneficiaries.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, April 30, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

(FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. The Subcommittee will come to order. Would our witnesses, Governor Lamm and Dr. Detmer, please approach?

Last year, the Health Subcommittee conducted hearings on graduate medical education and Medicare payments to teaching hospitals. It was clear from the discussions that the future of physician training and the other activities of teaching hospitals have broad implications for health care far beyond the Medicare Program.

The hearings demonstrated conclusively that the manner in which the Medicare Program and the Federal Government could contribute to the funding of physician training and other costs of teaching hospitals needed to be redesigned.

As a result, the Ways and Means Committee developed provisions for both the Medicare Preservation Act of 1995 and the Balanced Budget Act of 1995, which reformed funding for graduate medical education in teaching hospitals. In those measures, the reforms passed by the Congress provided for a new financing structure of graduate medical education and teaching hospitals and mandated further study of the many details necessary for successful implementation of these new payment policies over the long term. Unfortunately, the President chose to veto these much-needed reforms.

The Ways and Means Committee, however, remains committed to the efforts we began last year. Therefore, the Health Subcommittee will address the study portions of last year's bills in order to gain guidance on the details of implementing new payment policy for graduate medical education and teaching hospitals.

We begin today with a hearing to receive the recommendations of two noted private sector groups—the Pew Health Professions Commission and Governor Lamm, and the Committee on the U.S. Physician Supply of the Institute of Medicine and Dr. Detmer. We look forward to the insights of these two study groups which address the same issues we focused on in our recent legislation, that is, the future of teaching hospitals in the competitive health care marketplace, the extent the Federal Government should subsidize graduate medical education and training, and the payment policy for teaching hospitals.

Both reports concentrate appropriately on the issues regarding the number of physicians this country is now producing, as well as the difficult problem of extreme growth in the number of international medical graduates training in U.S. teaching hospitals.

This hearing marks a new round in the examination of graduate medical education and teaching hospital payment policy which will continue with further hearings and discussions in this Subcommittee. The goal obviously is to refine the conclusions that we reached initially.

I welcome our distinguished witnesses to this hearing and want to express the appreciation of the Subcommittee for their good work and their willingness to share their views with us.

I now yield to the gentleman from California, the Ranking Member, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. Thank you for holding this hearing on these two reports.

I think everyone agrees that there is an oversupply of physicians, and I think there is some agreement that we need more primary care physicians and fewer specialists, and it is important to understand how Medicare can help encourage—if it should—what may already be happening in the marketplace.

At the same time, I am somewhat confused as to whether we are dealing with physician oversupply as a means to save money or whether we are trying to get more primary care physicians in total. We have problems of oversupply, yet millions of Americans are poorly served. Rural communities and inner cities go begging for doctors. Minorities are underrepresented in the Nation's medical schools. So the problem is many faceted.

Both Republican and Democrat budgets propose major changes in graduate medical education, and these GME budgets cannot be looked at, I do not think, in isolation. The major teaching hospitals are also the leaders in medical research, caring for the uninsured, and their margins are about half of what the average hospital's is—about 2.1 as opposed to 4.3 for average hospitals.

So I hope today's witnesses can respond to the overall impact of trying to cut 30 percent out of, say, disproportionate share payments, or a 2-percent reduction in hospital updates; massive cuts in Medicaid; State support for Medicaid, which is waning. What will all of these cumulative cuts mean for the future of medical education and medical research?

The Institute of Medicine recommendations would end the use of foreign medical graduates, a specific recommendation. But there is really fuzzy, vague advice about helping hospitals in rural communities dependent upon these graduates in attracting American-trained doctors. I'd like to hear, if we are going to shut the door on the supply, what replacement program we might have to serve the poor rural and inner-city residents.

So there are many issues this morning that I think will be interesting, and I look forward to the witnesses' statements, Mr. Chairman.

Mr. THOMAS. Thank you very much, and obviously, any written statement that either of the witnesses has will be made a part of the record, and you may inform us as you see fit of the findings.

I would just concur with my colleague from California that what has been proposed is of course interesting; what was not proposed is probably more interesting to us, witness all of the above list that the gentleman from California iterated.

Governor Lamm, we will begin with you.

STATEMENT OF HON. RICHARD D. LAMM, CHAIRMAN, PEW HEALTH PROFESSIONS COMMISSION

Mr. LAMM. Mr. Chairman, Members of the Committee, thank you. I am going to just summarize my testimony; I think that is the way we both enjoy it most.

Our Committee found that Adam Smith has arrived in the health care system in a very big way, and this is causing dramatic and traumatic changes in the staffing patterns of health care delivery systems.

Second is that markets, as we all know, are rather ruthless reorganizers. We are moving from a cottage industry to a set of inte-

grated delivery systems and this is a major, major change. This is equivalent to some of the changes that hit dentistry when fluoride was discovered or the defense industry in Southern California in the wake of military base closures. In other words, we found that there is a decade of change every 6 months in the whole area of delivery of health care.

Third, the halcyon days of blank check medicine are definitely over. Every payor, whether business or States under their Medicaid or even Medicare, is really asking about value, staffing patterns, and the reasons for paying subsidies. In other words, there is a whirlwind of change out there.

Fourth, these changes are definitely affecting the size of the infrastructure. I spent some time in Europe, looking at the European health care systems. Everybody takes a great deal of interest in the size of the infrastructure, the number of doctors we train, the number of hospitals we have, the number of hospital beds and MRI machines. All of that infrastructure has a great deal to do with the cost of health care because it has to be amortized, and other countries take great care not to try to overbuild their infrastructure. Some of them, by the way, train way too many doctors.

The fifth point I would like to make is that the utilization of physicians in these new systems is substantially different than the historic way we have been doing it in fee-for-service medicine. It is very dramatic. It is not that we find that these systems value specialists any less; it is that they utilize them much more efficiently and effectively. So that what you are finding is that, where you used to have a very high specialist staffing ratio all of a sudden integrated delivery systems are coming and delivering those services with far fewer physicians.

The sixth point is that while the market is out working on more effective utilization of physicians, you essentially have the production end being driven, or at least 40 percent of it being driven, by the Federal Government and taxpayers' money. So you have sort of Adam Smith operating over here, and you have the government over here, continuing to produce or help to produce more physicians than the market is signaling us very strongly that it is utilizing.

The seventh point I would make is that public money ought to buy public goods. Our commission asked itself why should there be Federal money in medical education. Well, there should be to the extent that it purchases public goods. But when you are purchasing and pushing an oversupply that the market is signaling is an oversupply, we think that is a mistake.

My recommendations are in my testimony, or I could quickly summarize them, depending upon what you would like. Oh, I see—I have time left.

Our recommendations, then, Members of the Committee, would be to reduce the number of graduate medical training positions to 110 percent of U.S. medical graduates, which would of course have the net effect of reducing the number of international medical graduates.

Second, we would like to redirect some of the graduate medical training money so that by the year 2000, 50 percent of the medical students would be trained in primary care disciplines.

Third, 25 percent of medical residents' clinical experience should take place in community-based settings.

Fourth, we very much urge a public-private all-payer pool, so that it is not only the Federal Government that makes such a major contribution to medical education, but that all users contribute. Finally, we recommend enlarging the National Health Service Corps to take care of those very real problems that Congressman Stark mentioned.

Mr. Chairman, thank you.

[The prepared statement follows:]

STATEMENT OF RICHARD D. LAMM
CHAIRMAN
PEW HEALTH PROFESSIONS COMMISSION

Mr. Chairman, members of the Sub-Committee, I am Richard Lamm. For the past three years I have served as chairman of the Pew Health Professions Commission. This eight year effort funded by the Pew Charitable Trusts of Philadelphia, Pennsylvania, is an effort to assist the health professions of the nation in better understanding the changes that are occurring in the health care system and to develop responses to these changes that alter the way we educate, train and regulate the next generation of health care workers.

This past November, the Commission released its third report "Critical Challenges: Revitalizing the Health Professions for the 21st Century". The report contains over 50 recommendations for action across all of the major health professions and at all levels of government and institutional life. Today I would like to focus my remarks on the recommendations we made for medicine. Though not without controversy, these recommendations have served to frame much of the current debate over the future of medicine and our academic health centers. Let me review our assumptions and the recommendations that derive from them.

Assumptions

The health care system that has grown up over the past five decades has served some of the needs of the nation very well. However, that system now consumes 15% of our productive effort and is in the process of being redirected by powerful market forces. In its growth, the system has over built the health care infrastructure in such a way that we may have as many as 60% too many hospital beds and 50% too many hospitals. In terms of health care personnel, we will soon recognize that the oversupply of doctors may be as great as 100,000 to 150,000; all of them in specialty areas. As we now have a market driven reform as opposed to the policy proposals developed in 1993 and 1994, we will see the transformation take place faster and more completely than if it were held captive by political forces. Because of this we will see rapid rationalization of physician utilization across the country.

Conclusions

Even without such bold reordering of health care, we have produced too many physicians. With such changes the oversupply is and will be dislocating.

This oversupply has been brought about by two forces. First and most important, a phenomenal growth in the number of medical residency positions in the United States has yielded a dramatic increase in the number of international medical graduates who come to the U.S for residency training, 80% of whom stay on in this country to practice medicine. Today, there are 1.4 first year medical residency positions for every 1 U.S. medical graduate. Second, the number of entering US medical school positions has doubled from 7,000 in 1970 to 15,000 today.

The reasons for action to reduce the oversupply of physicians are varied. Leaving the market to correct itself is not appropriate in this case, because the market is skewed by the over 6 billion dollar subsidy that the federal government provides through Medicare funding for graduate medical education. Medicare GME funding accounts for 40 percent of all funding for graduate medical education in the United States. Because this subsidy is so powerful we must act to at least neutralize it or use it as an instrument for positive policy action. Second, we must act for the sake of the young people entering the medical profession. They cannot look forward to a rewarding career if the profession is mired in such a morass as this oversupply is producing . Third, the oversupply will serve to weaken the profession. While change in physician behavior is necessary for significant reform, no one on the Commission wishes to fatally weaken this important profession. Finally, Medicare GME reform is good public policy. Why should we subsidize the production of unneeded doctors anymore than we should subsidize unneeded soy beans, military bases or corporations? It makes no sense.

Recommendations

Our recommendations are pretty straight forward. They are detailed in the report of the Commission that we have made available to members and staff. Let me summarize the recommendations that have implications for direct federal action. I will begin with those that are likely to fall under the jurisdiction of this sub-committee:

A. Reduce the number of graduate medical training positions to approximately the number of U.S. medical school graduates plus 10%. For 1996 this would mean the base of 17,500 MD and DO graduates should support 19,000 to 20,000 entry level graduate training positions. *This could be accomplished by changing the laws surrounding the financing of GME through the Health Care Finance Administration.*

B. Redirect graduate medical training programs (6, 951 programs as of 1991) so that by the year 2000 a minimum of 50% of medical residents are in the primary care areas of family medicine, general internal medicine, and general pediatrics. *Specialty residency programs should be funded at a significantly reduced rate. This rate should vary from specialty to specialty, reflecting the relative oversupply in each specialty. The Congress should then ensure that residency review committees for specialties are not subject to FTC sanctions for restraint of trade when evaluating residency programs. The residency review committees would then be in a position to make their own decisions as to whether to keep funding at the same level for all existing programs or reduce the number of programs using quality as the criterion for determining which programs should close.*

C. Move training of physicians at the undergraduate and graduate levels into community, ambulatory and managed care based settings for a minimum of 25% of clinical experience. *Such a requirement could be written into the HCFA guidelines for Medicare GME as is currently done in New York State for Medicaid GME.*

D. Create a public-private payment pool for funding health professions education that is tied to all health insurance premiums and is designed to achieve policy goals serving the public's health. *Effective public action could lead to a fair and informed mechanisms for funding graduate health professions programs.*

E. Enlarge the National Health Service Corps to attract graduate physicians into service roles currently being met by the excessive number of medical residents. *This is necessary to assist academic centers, teaching hospitals, and other organizations that serve the underserved in meeting these needs with reduced numbers of residents.*

In addition two other policy issues need attention, but fall outside of the purview of this sub-committee.

First, we need to insure that the immigration laws that apply to other professions are equally enforced for the medical professions. It makes little sense of the US to subsidize the training of physicians from other countries and encourage them to stay on in practice in this country, when this nation has an excess number of physicians. International physicians participating in the exchange visitor program should return to their home countries following training, if that program is to achieve its goal of improving medical care in developing countries.

Second, state legislatures and boards of trustees of private and public universities must reconsider whether or not the current sizes of entering classes at their medical schools are desirable. There is little that Congress can or should do to address this issue, but we believe your policies must be developed with this reality in mind.

Mr. THOMAS. Thank you very much, Governor.
Mr. Detmer.

STATEMENT OF DON E. DETMER, M.D., COCHAIR, COMMITTEE ON THE U.S. PHYSICIAN SUPPLY, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES

Dr. DETMER. Good morning, Mr. Chairman and Members of the Committee. I thank you for this opportunity to present the Institute of Medicine's study on physician supply and requirements in the United States.

I will in fact read these comments because I want to carefully reflect the IOM's report, but will be happy to respond to questions in the discussion, and I am really here representing myself and Dr. Neal Vanselow, as cochairs of the group. The full list of the committee is in the testimony.

The committee had a diversity of views and disciplines, including medicine, economics, law, health policy, and health services research.

As the 21st century draws near, the size and composition of the physician work force troubles both health professionals as well as policymakers, and with the collapse of efforts between 1992 and 1994 to enact comprehensive health reform, much of this restructuring is taking place, as was mentioned, in the private sector—changes, with as yet unforeseen consequences, with real concerns, as has already been mentioned, for access to care and quality of care.

In early 1995, the Institute of Medicine appointed an expert committee to carry out a short but substantive review of existing data about the U.S. physician supply to identify positive and negative implications of the possible mismatch between supply and requirements in coming years and to lay out possible options for addressing any perceived problems.

Three principles guided the committee's deliberations. First, the Nation should separate national work force policy for graduate medical education from the service delivery needs of selected parts of the health care system.

Second, long-term physician work force policy should be driven by aggregate requirements nationally, and meeting those requirements should be cued more to the output of U.S. allopathic and osteopathic schools than it is today.

And third, opportunities in the United States for careers in the health arts such as medicine should be reserved first for graduates of U.S. schools.

Most studies on the adequacy of the physician work force for the past 15 years have concluded that the United States already has or will soon have an oversupply of physicians generally characterized as a large surplus of mostly non-primary care specialists and either a shortage or relative balance in the supply of primary care physicians.

These figures can be interpreted in the light of a landmark report in 1981 on the adequacy of the U.S. physician work force from the Graduate Medical Education National Advisory Committee, GMENAC. GMENAC concluded that the Nation could expect to have a surplus of physicians that would grow from 70,000 physi-

cians in 1990 to 145,000 by the year 2000. Clearly, by the midnineties, the Nation was well on its way to surpassing the GMENAC predictions.

Graduate medical education plays a significant role in U.S. physician supply because following graduation from medical school, doctors in graduate training—interns, residents and fellows—provide considerable patient care and because GME is the necessary pathway to a medical career. More than 99,000 physicians were in graduate training in 1992, and it is over 100,000 at this point, and the numbers have increased steadily at about 4 percent per year.

The number of U.S. medical graduates in GME training has remained stable, however, since the early eighties; but between 1988 and 1993, the number of international medical graduates in residency or fellowship training dramatically increased by 80 percent, from 12,433 to 22,706.

As many as 75 percent of foreign international medical graduates who take their residency training in the United States will remain in, or shortly return to, this country to practice. In short, the issue of the long-term match between the supply of physicians in this country and the expected requirements for physician services cannot be addressed without consideration of the role of GME and the role of international medical graduates within GME.

On the relationship of physician supply to key elements of the health care system, the temptation to argue that an ever-increasing physician oversupply will have a beneficial impact on cost, access, or quality should be resisted. Based on our review of the data, such an assertion does not stand up to scrutiny. Our Nation's record in addressing these issues, even with a dramatically increased supply of physicians, is far from adequate.

For example, an abundance of physicians has not so far and by itself will not solve the problem of maldistribution by geographic area or specialty. Only targeted programs will.

Having far more physicians than are needed to meet the Nation's requirements is a waste of the Federal resources currently spent on physician graduate education, and it may also be a poor personal investment for prospective medical students.

The current use of public financial support for very large numbers of IMG trainees lowers opportunities for young, able Americans, the daughters and sons of our taxpayers, to enter the medical profession, particularly underrepresented minorities and women, and some might argue that it also deprives the citizens of other nations of their own talented youth.

So the recommendation, very briefly, was to freeze the current output of U.S. class sizes and students, to revamp graduate medical education to essentially break the connection between training and service needs, to have the total number of medical residency first-year training slots much closer to the current number of U.S. medical school output, and to take care of the care needs of those hospitals particularly in the Nation's inner cities that could be particularly hurt by these policy changes. These hospitals supply a substantial amount of very important care for poor and disadvantaged populations. Finally, data collection and information dissemination is needed so that prospective students know the prospects for a medical career and so U.S. policymakers and the profession

can better track these issues in the future with all of the changes underway.

Thank you.

[The prepared statement and attachment follow:]

The Nation's Physician Workforce:
Options for Balancing Supply and Requirements

Statement by
Don E. Detmer, MD[1] and **Neal A. Vanselow, MD**[2]
Co-Chairmen, Committee on the U.S. Physician Supply
Institute of Medicine, National Academy of Sciences
April 16, 1996

Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to present the results of an Institute of Medicine study of physician supply and requirements in the United States. Our statement today represents the views of the Institute of Medicine (IOM) and the Institute's Committee on the U.S. Physician Supply, which we co-chaired. The committee comprised a diversity of views and disciplines, including medicine, economics, law, health policy, and health services research. A list of the members of the committee is attached to this statement.

As you are aware, the Institute of Medicine is not a governmental agency, but rather is an independent, non-profit organization, chartered in 1970 by the National Academy of Sciences to examine policy matters pertaining to the health of the public.

As the twenty-first century draws near, the size and composition of the physician workforce trouble both health professionals and policymakers, particularly because of the radical, rapid, and unpredictable transformation of the health care delivery system. With the collapse of efforts between 1992 and 1994 to enact comprehensive health care reform, much of this restructuring is taking place through changes in the private sector, with-as yet-unforeseen consequences, but with real concern for access to care and the quality of care.

In early 1995, the IOM appointed an expert committee to carry out a short but substantive review of existing data about the U.S. physician supply, to identify positive and negative implications of the possible mismatch between supply and requirements in coming years, and to lay out possible options for addressing any perceived problems. Three principles guided the committee's deliberations.

- First, the nation should separate national workforce policy for graduate medical education from the service delivery needs of selected parts of the health care system.
- Second, long-term physician workforce policy should be driven by aggregate requirements nationally, and meeting those requirements should be cued more to the output of U.S. allopathic and osteopathic schools than it is today.
- Third, opportunities in the United States for careers in the healing arts, such as medicine, should be reserved first for graduates of U.S. schools.

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[1]Professor of Health Policy and of Surgery, and Senior Vice President, University of Virginia
[2]Professor of Medicine, Tulane University

Summary of Findings and Conclusions

Most studies of the adequacy of the physician workforce for the past 15 years have concluded that **the United States already has or will soon have an oversupply** of physicians, generally characterized as a large surplus of mostly nonprimary care specialists and either a shortage or relative balance in the supply of primary care physicians.

In 1970, the United States had approximately 300,000 active physicians (both allopathic and osteopathic), or a ratio of about 150 physicians per 100,000 population; in 1992, the respective figures were nearly 630,000 and 245.0, which represented an increase in the physician-to-population ratio of about 62 percent.

One important number involves active physicians in patient care (excluding those in training). In 1970, the figure was 222,657, with a physician-population ratio of 109.2 per 100,000; two decades later, the number was 461,405, giving a ratio of 180.1 physicians per 100,000 population in that year (an increase in the ratio of about 65 percent).

These figures can be interpreted in light of a landmark report in 1981 on the adequacy of the U.S. physician workforce from the Graduate Medical Education National Advisory Committee (GMENAC). GMENAC concluded that the nation could expect to have a surplus of physicians would grow from 70,000 physicians in 1990 to 145,000 by the year 2000. Clearly, by the mid-1990s, the nation was well on its way to surpassing the GMENAC predictions.

- Graduate medical education (GME) plays a significant role in U.S. physician supply because, following graduation from medical school, doctors in *graduate* training (interns, residents, and fellows) provide considerable patient care and because GME is the necessary pathway to a medical career. More than 99,000 physicians were in graduate training in 1992. Since 1988-89, the numbers have increased steadily at about 4 percent per year.

The number of U.S. medical graduates (USMGs) in GME training has remained stable since the early 1980s, but between 1988 and 1993, the number of IMGs in residency or fellowship training dramatically increased by 80 percent (from 12,433 to 22,706). As many as 75 percent of the FNIMGs who take their residency training in the United States will remain in, or shortly return to, this country to practice. In short, the issue of the long-term match between the supply of physicians in this country and the expected requirements for physician services cannot be addressed without consideration of the role of GME and the role of IMGs within GME.

Relationship of Physician Supply to Key Elements of the Health Care System

- The temptation to argue that an ever-increasing physician oversupply will have a beneficial impact on costs, access, or quality should be resisted. Based upon our review of the data, such an assertion does not stand up to scrutiny. Our Nation's record in addressing these issues, even with a dramatically increased supply of physicians is far from adequate. For example, an abundance of physicians has not so far and by itsef will not solve the problems of maldistribution by geographic area or specialty; only targeted programs will.

- Having far more physicians than needed to meet the nation's requirements is a waste of some of the federal resources currently spent on physician graduate education, and it may also be a poor personal investment for prospective medical students.

- The current use of very large numbers of IMG trainees here lowers opportunities for able young persons from the United States to enter the medical profession, particularly underrepresented minorities and women, and some might argue that it also deprives the citizens of other nations of their own talented youth.

Strategies for Addressing Physician Supply Issues: IOM Recommendations

I. Freeze the Output of Physicians from U.S. Medical Schools

Specifically, **the committee recommends that no new schools of allopathic or osteopathic medicine be opened, that class sizes in existing schools not be increased, and that public funds not be made available to open new schools or expand class size.**

II. Revamp Graduate Medical Training

The present system of Medicare reimbursement for residencies through direct and indirect medical education (DME, IME) payments is a major incentive for teaching institutions to keep their numbers of residency positions high and expanding. **The committee recommends that the federal government reform policies relating to the funding of graduate medical education, with the aim of bringing support for the total number of first-year residency slots much closer to the current number of graduates of U.S. medical schools.** Specifically, the committee believes that the government limit the number of GME positions that it funds through the Medicare program and that this limited number of residency positions should be available first to physicians who have graduated from U.S. medical schools.

III. We Recommend Replacement Funding for Some IMG-Dependent Hospitals

Payments for GME should be decoupled from those related to the demand for health care services. The committee was very aware, however, that for a small number of hospitals (around 77 of 6,000 hospitals in the nation), severe reductions in IMGs in residency slots would constitute a particular hardship for care of the poor, particularly in the nation's inner cities.

The committee believed that policymakers and the professions must not ignore these service responsibilities. Therefore, **the committee recommends that the federal and state governments take immediate steps to develop a mechanism for replacement funding for IMG-dependent hospitals that provide substantial amounts of care to the poor and disadvantaged.**

IV. Data Collection and Information Dissemination

The kinds of steps recommended up to this point could have unanticipated consequences for solving the physician supply problem; moreover, the U.S. physician supply is a moving target, and additional steps may be needed. Thus, the committee offered a pair of recommendations on data collection and research.

The committee recommends that the Department of Health and Human Services, chiefly through the Health Resources and Services Administration, regularly make information on physician supply and requirements and the status of career opportunities in medicine available to policymakers, educators, professional associations, and the public. The committee further recommends that the AMA, the AAMC, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and other professional associations cooperate with the federal government in widely disseminating such information to students indicating an interest in careers in medicine.

In addition, **The committee recommends that the Department of Health and Human Services provide the resources for research on physician supply and requirements; it specifically recommends that relationships between supply and health care expenditures, access to care, quality of care, specialty and geographic maldistribution, inclusion of women and people of color, and other key elements of the health care system be studied in detail.**

CONCLUDING STATEMENT

In summary, the United States now has an abundance of physicians, and is on track to a clear surplus. If policies remain unchanged it definitely will, soon, have a real oversupply. The precise size of that surplus will depend on several unpredictable factors: the extent to which managed care dominates fee-for-service arrangements; technological breakthroughs; the changes that may occur in the production of U.S. medical graduates; changes in the financing for graduate medical education; and so forth.

The IOM committee concluded that the probability of an appreciable surplus of physicians was high enough that steps need to be taken now, since the educational pipeline for physicians is so lengthy.

Thank you, Mr. Chairman. Again, Dr. Vanselow and I appreciate the opportunity to present the results of our study, and would be happy to answer any questions you or Members of the Subcommittee might have.

In Summary...

A brief report from the Institute of Medicine

The Nation's Physician Workforce: Options for Balancing Supply and Requirements

As the twenty-first century draws near, the size and composition of the U.S. physician workforce trouble both health professionals and policymakers, particularly because of the radical, rapid, and unpredictable transformation of the health care delivery system now under way. Three questions are paramount:

1. Is there an aggregate physician surplus?
2. If there is a surplus, what is its likely impact on cost, quality, access to health care, and the efficient use of human resources?
3. What realistic steps might be taken to deal with any surplus that exists?

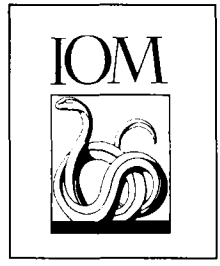
An Institute of Medicine (IOM) committee (see over) examines these questions and reports in *The Nation's Physician Workforce* on strategies for achieving a better balance between overall physician supply and requirements.

Key Conclusions

- The nation has an abundant supply—indeed, possibly a surplus—of physicians today.
- Because of increases in the numbers of physicians in training and entering practice each year, future supply will be excessive regardless of the structure of the U.S. health care system.
- A physician oversupply may have no beneficial effects on costs, access, or quality.
- Large numbers of able young persons from the United States aspire to medical careers.
- The 4% annual growth in the number of physicians in residency training comes primarily from the influx of ever-increasing numbers of international medical graduates (IMGs).
- The entry into practice of large numbers of IMGs reduces opportunities for domestic youth to enter the medical profession and deprives other nations of their own talented youth.

Principal Recommendations

- Do *not* open new medical schools, increase class sizes in existing schools, or make public funds available to open new schools or expand class size.
- Reform policies for funding graduate medical education; reduce the number of funded first-year residency positions to bring it more in line with the number of graduates of U.S. medical schools.
- Provide *replacement* funding for IMG-dependent hospitals that deliver substantial amounts of care to the poor and disadvantaged.
- Make information on physician supply and requirements and on career opportunities in medicine more easily available to policymakers, educators, professional associations, the public, and students indicating an interest in careers in medicine.
- Conduct research on the impact of physician supply on costs, access, quality, specialty and geographic maldistribution, and inclusion of women and people of color, because these recommendations may require revisions based on changes in the workforce and better information about those changes.



continued

The Nation's Physician Workforce: Options for Balancing Supply and Requirements is available for sale from the National Academy Press, 2101 Constitution Avenue N.W., Box 285, Washington, DC 20055; call 800-624-6242 or 202-334-3313 (in the Washington metropolitan area) or send e-mail to http:\\www.nas.edu\nap\bookstore. Copies of the report sumary are available in limited supply from the Division of Health Care Services, Institute of Medicine. Call 202-334-2165; fax 202-334-3862.

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The Nation's Physician Workforce: Options for Balancing Supply and Requirements

Kathleen N. Lohr, Neal A. Vanselow, and Don E. Detmer, *Editors*

Division of Health Care Services

Institute of Medicine, Washington, D.C. 1996

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 congressional charter responsibility to be an adviser to the federal government and its own initiative in identifying issues of medical care, research, and education. Dr. Kenneth I. Shine is president of the Institute of Medicine.

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The image adopted as a logotype by the Institute of Medicine is based on a relief carving from ancient Greece, now held by the Staatlichemuseen in Berlin.

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Another attachment is being held in the Committee's files.

Mr. THOMAS. Thank you, Dr. Detmer.

In comparing the two reports, they are not dissimilar by any means, in a number of ways, including that they are not very bold on the suggestions that you might be offering; and I can understand that happening when you pull together a cross section in focusing on the issue.

One of the things I know you agreed on was that however you might characterize it, as an oversupply or an abundant supply of physicians currently, if you continue on the same track, clearly there will be. So, you are looking at ways to reduce the number of residents.

If you had an option of beginning to close down some teaching hospitals versus a kind of a fair share distribution of reduction, which would you choose and why?

Dr. DETMER. Our committee did not specifically address that; I think the Pew report did. But I will be happy to comment personally perhaps after Governor Lamm has responded.

Mr. LAMM. Mr. Chairman, I believe that when you look at the overcapacity of hospitals, particularly training hospitals, there are two different issues. You did not ask about medical schools; you asked about the training sites. Is that correct?

Mr. THOMAS. Yes.

Mr. LAMM. I think the evidence is overwhelming that we have too many hospitals in most parts of the United States, in some areas far too many. When you look at the utilization of hospital beds, we definitely are going to have to close some hospitals. I think it is much better to maintain quality hospitals and have fewer of them than to have quantity hospitals and not have first-rate ones.

Mr. THOMAS. The problem is that if you begin focusing on where you have the international graduates, the hospitals that they are focusing on tend to concentrate geographically, don't they?

Dr. DETMER. Yes, they do during their training years. Seventy-seven hospitals by one report are dependent upon international medical graduates, and that is a problem we think is a very high priority. But allowing a large number of international medical graduates who, by the way, when they come into the United States, move in the same patterns as other American doctors—they move to the suburbs—and number two, they go into specialties in even larger numbers than American doctors, is a very inefficient and in the long term, counterproductive way to solve the problem that we are speaking of. It certainly is a problem.

Mr. THOMAS. If they in profile look like the American graduates in terms of where they wind up practicing medicine and are even more concentrated in specialties, what do they look like in terms of competency? Is there a measure of that available? Do they tend to be as competent?

Dr. DETMER. Not really. Generally, on average, they take generally what are considered to be less desirable residencies, but as our report says, there are any number of very excellent international medical graduates who are physicians in this country.

I think the challenge is, in my opinion, not so much focusing on that per se, but that we have record numbers of very talented young Americans who are trying hard to get into a medical career,

and those U.S. positions have been steady in our medical schools for a number of years. The challenge to get more women and minorities of our own population into this career is the tension in this, and there is no question it is a real tension. And America does have highly qualified students and very good schools.

I would like to come back for a moment to your earlier point. The committee looked at how would we get to curing this problem, and there were three options available to us. One would be to let the market do it totally, one would be a totally regulated approach, and the other would be a regulated marketplace. We came down on the side of a regulated marketplace.

The committee feels that with all the turbulence and change in the U.S. hospital system as well as medical schools—some of the points that Mr. Stark mentioned as we started—there will be a lot of change going on, candidly, inside our borders as in fact is happening with the number of hospital beds and these and other things will be occurring. And I think the feeling, although it was not an explicit sentiment of the committee, was that market forces could result in downsizing as academic hospitals and medical schools close. Despite this, we felt a need to deal with the overall supply and give our own citizens a chance to complete their education, because medical education is a very long pipeline.

Mr. THOMAS. We are talking about immigration, and immigration is an issue that is hotly contested in a number of areas, but this seems to me to follow somewhat of a classic pattern of immigration, and that is that the foreigners are coming in and taking positions that would otherwise go wanting.

So my question is if in fact we begin to limit the number of residency slots more nearly proportional to the number of medical school graduates of the United States, to what extent would those hospitals that are now utilizing the non-U.S., international medical graduates, as residencies, be able to pick up the American position—would there be a match there, or would we go wanting?

Dr. DETMER. I think what we are saying is that you need to break that connection between resident education and service requirements. Break that connection, and if you have service requirements that are needed to meet the needs of some of those populations, use some of the moneys that you are currently spending to overeducate ultimately a work force that goes on into the future for an entire career; and instead pay for some care to meet access needs.

The Institute of Medicine a couple of years ago actually advocated universal access to basic health care services. That is something that our committee underscored, and we built off that recommendation.

So the point is to disconnect this education-service issue, deal with the service issue as a separate issue, as it is for a few hospitals—but use doctors who are already trained. The Institute of Medicine recently put out a study on primary care physicians and other primary workers, that is, both nurses as well as physician assistants and such; find a way to fund and meet those service needs for that group, but disconnect a system that then creates an entire career of a very large oversupply of physicians.

Mr. THOMAS. Go ahead, Governor Lamm.

Mr. LAMM. I totally agree with that, but let me give you one additional perspective. We are on the cusp of change. If we look in the rearview mirror, we make a great mistake because we have had this blank check medicine that has been labeled—you know, there is something in medical economics called "Roehmer's law"—Milt Roehmer at UCLA—about how doctors create their own demand. Well, that is changing now, and all of a sudden, we are going to have a new reality. A cardiologist can hardly find a cardiologist position west of the Mississippi. So there is a new reality that doctors are understanding and I think they are going to go into those areas that were previously unserved.

But mainly, Dr. Detmer's point is very true. This is not a very efficient way to solve that problem.

Dr. DETMER. And I would say the National Health Service Corps—targeted policy programs to meet underserved areas—do in fact work. But I do not think you do it by just simply expecting the market to work uniformly everywhere. I think it is going to be a combination of regulation and marketplace.

Mr. THOMAS. I understand that. If we are talking principally about New York City, New Jersey, and perhaps Chicago, if in fact these should not be residency slots and simply that is the way to fund it, and they are trying to meet a need, if we were to talk about funding it differently, wouldn't we also probably talk about supplying medical care significantly differently than the hospital structure that is currently there? That opens up a whole new series of problems about State versus Federal, who funds it, what is the structure going to be, how do you break it down.

So I appreciated the one liner that we ought to create mechanisms to fund it, but it creates a whole series of issues associated with, all right, now that we have agreed not to fund it through the residency structure, what do we do next? And that is just one of the things that we all appreciate.

Governor Lamm—and I will end on this—you indicated that Adam Smith was alive and well in the area. What is wrong with just deciding that as policy, we obviously would conform the number of residency slots to American graduates, but then also say we are only going to fund to the first certificate, and let the marketplace determine who goes on with loans or other kinds of appropriate supports. In fact, these new, emerging, integrated health structures, if they want particular specialists, could make arrangements in the marketplace with individuals who have gone through the subsidized funding through the first certificate and figure out a way to share those costs in specialty training beyond a 3- or 4-year residency. Was that talked about at all in either of the group's proposals?

Mr. LAMM. I would have to speak for myself on this because this was not discussed in our commission, but I would think that would certainly be a better system than the one we do right now.

Mr. THOMAS. Well, isn't it true that almost anything we come up with is better than the one that we have in the United States? That is part of the problem.

Mr. LAMM. Yes, sir. But I do think that any way you can stop the excess production of physicians, I think is in the national interest.

Mr. THOMAS. But is it a good policy to let the marketplace begin to determine who does what, when and how, beyond that general physician, the first certificate level?

Mr. LAMM. Well, in California, for instance, you have some of those large, integrated delivery systems doing more training than anybody else. In other words, you have again a whole new training system, so they have now a new economic interest. And under an all-payer pool of some sort, well, I think you would have a number of responses to fill that void.

Dr. DETMER. I am not here to speak for Kenneth Shine, president of the Institute of Medicine, and we had a fairly delineated study here, but I think the IOM would be delighted to entertain some requests from the Committee to look at some of these policy options in a much closer way.

We talked about a voucher as perhaps one way, but we just did not have either the time or scope in this particular study to address that.

I think that actually, we could offer you some further advice, but it went beyond this particular study.

Mr. THOMAS. Thank you both very much.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I would like to just restate that for I think at least 10 years, I have been perplexed as to why medical education ever got into the Medicare system to begin with.

Research shows that it was added at the last minute because the hospitals and the doctors said, "Oh-oh—who is going to subsidize education?" and Mr. Mills and others tossed it in without any thought or any reason as to why Medicare and the seniors' health care system should fund or subsidize medical education—not to suggest that perhaps it is not in the Federal interest to do it, but it has grown up in the Medicare system with no rhyme or reason.

The questions that you raise really just create more problems. In other words, I have yet to meet a resident who does not say he or she is working 80 hours a week for very little money, in a hospital that would tell me that they are slackers and not actually providing an economic benefit to the hospital.

So perhaps, if we are going to close a bunch of hospitals as a result of the change, the problem will take care of itself. Some teaching hospitals will close in proportion as others do.

I do not see the problem with U.S. citizens finding a job. There is a shortage of jobs for graduates in English; very few tenured positions for English professors in this country, but nobody has been so homophobic as to suggest that we would restrict those jobs to U.S. citizens—or xenophobic, excuse me.

There are some problems. HMOs, for instance, do not collect money basically for graduate medical education, and they do not send any patients to Centers of Excellence because it is cheaper to send them to general hospitals. It has been suggested that we not pay any GME money to the HMOs in their capitated payment, and put that into a trust fund. I have no trouble with that.

There is a variation. From the 25th to the 75th percentile, to compare the variation, hospitals collect between $58,000 and $102,000 per resident. Now, they only pay those residents $35,000

to $41,000. So the guy who gets $58,000 only pays him $35,000; the guy who gets $102,000 only pays him $41,000. There is a little spread there.

I guess that I would say someone, whether it is the Medicare system or the Federal, might pay hospitals a subsidy based on hospital revenue or patient days. It makes no sense to me to pay—as Governor Lamm has suggested, if you get more per resident, you are going to rush out and get more residents. There is no sense doing that. We pay under disproportionate share an increase in the revenue. That makes a little sense. People are not going to rush out and get more poor people just to raise their disproportionate share payment.

So this is kind of a "one shoe on and one shoe off" report; on the one hand, you want to go into letting the free market decide, and on the other hand, you have an awful lot of those foreign graduates who are U.S. citizens or are legal residents. I am very reluctant to start picking and choosing, whether it is educating children or providing welfare benefits or anything else, between those people who have been here long enough to pass their citizenship test and those who are here legally, paying taxes, serving in the service, doing everything else, but do not happen to be citizens. I am not sympathetic to that.

So my guess is that the medical profession and the hospitals have a problem. It should not be solved by Congress. We might find a better way to subsidize them more fairly, but I think we should stay out. I do not think we should be in there, deciding whether engineering schools should bring more chemical engineers, or more life science engineers to speed up genetic research, or more history teachers. That is something that is not purely market; some of it is choice, personal choice in professions. I think we should stay out. Pay whatever subsidy it is determined in the public's interest we should to foster education and research in the field of medicine or space exploration, if you choose, and let the chips fall where they may, and let the graduate medical students take care of it.

As I say, the report raises some questions and not many answers, and I think we would just continue to do a spastic job of subsidizing. I do not think it is to anybody's detriment, but I think we would solve this problem by having less distinction as to how we distribute the funds and deciding how much should be passed out in general subsidies.

That is a long-winded statement, and if the Chairman would indulge me a minute or two, I would like to hear a response.

Mr. THOMAS. Of course.

Mr. LAMM. Congressman Stark, there are not a lot of public funds in training English majors, and the market really does decide. The problem that we are raising is that you in Congress are funding with public funds, training in a profession that the market is signaling us very strongly is in oversupply.

Mr. STARK. I raise the question of oversupply. Maybe the doctors are not getting as much money as they want. That is not oversupply. We have many areas where there are no doctors, and the people are telling me there are too few primary care doctors. That is not something that we should be——

Mr. LAMM. Between 1982 and 1992, we increased the number of physicians in the United States by 100,000, and the number of underserved areas increased. In other words, training additional physicians to deal with that problem of undersupply in rural areas and inner cities has never worked in this country. As Dr. Detmer says, you need focused programs like the National Health Service Corps. Put some more money into the National Health Service Corps.

Mr. STARK. OK. Do you want us to cut money out of training, generally?

Mr. LAMM. I guess what I think we were trying to——

Mr. STARK. I do not want to do it by just saying we are only going to do it for citizens, or that we are only going to do it for white folks and not other folks.

Mr. LAMM. Wait 1 minute, wait 1 minute, Congressman. Why are we taking doctors from other parts of the world that desperately need their doctors and——

Mr. STARK. For the same reason we are taking lawyers from other parts of the word, and engineers, and computer programmers—because they offer something that people want; there are slots in these hospitals, and the hospitals want them. Why should I get in the way?

Mr. LAMM. Because we have got every evidence—as Dr. Detmer says, going back to 1981, you look at the GMENAC report, you look at the Macy Commission report, you look at PPRC and COGME's reports—every one of these groups warned Congress that you are training too many physicians, and you continue to bring in international medical graduates, number one, and number two, fund the production of——

Mr. STARK. I do not bring them in. They are here.

Mr. LAMM. Yes, sir, you do bring them in.

Mr. STARK. I do not bring them in any more than I bring in lawyers.

Mr. LAMM. Yes, sir, you do bring them in. This is how you are bringing them in—by spending $6 billion on graduate medical education and paying for international medical graduates.

Mr. STARK. The school pays for them. We do not.

Mr. LAMM. But they do it with your money. They do it with your money. They do it with your money.

Mr. STARK. Well, they do a lot of things with our money, Governor, but my point is many of these people are highly skilled and are desirable.

Mr. LAMM. But we do not need them. We do not need them. And in fact, I would like to clarify——

Mr. STARK. We do not need lawyers, either.

Mr. LAMM. You are right. I agree. Let us do both. Let us work on both.

Dr. DETMER. As I heard it, I am not sure that——

Mr. THOMAS. Do I hear a third profession?

Dr. DETMER. I would like to repeat if I could the recommendation because I am not sure it was, as I heard it, at least, interpreted correctly.

We did not in fact say bring the number down to exactly the supply of U.S. graduates. We said we need to bring it down closer to the current output of U.S. graduates. We are at something like 145

percent of U.S. graduates right now, and we did not come to 110, which COGME had said; we just said we ought to move in that direction.

So I think the point, as I see——

Mr. STARK. Doctor, where does the oversupply come—do the hospitals have too many residents, so they have them sitting around playing cribbage while they wait for their chance to get in the operating room, or is it after they get out of their training, and the other doctors do not like the lower-priced competition that may come into the market?

I have seen no evidence that in the medical schools, there is an oversupply of residents; is there?

Dr. DETMER. This year, there is a recent report that just came out in the New England Journal of Medicine that said about 10 percent of specialists coming out, U.S. graduates, now are having difficulty finding a job.

Mr. STARK. That is all I asked. Is there an oversupply of residents?

Dr. DETMER. No, no. I am saying they have finished their training and are now going out to work.

The point is—and I think this is a question, and you folks, it is your job, clearly, and it is a policy question—the educational pipeline for a doctor is very, very long, and it only really prepares you to practice medicine; it is not really a great entry career to another line of work. The average graduate of our school——

Mr. STARK. You can talk to Columbia Hospital Corp.

Dr. DETMER. The average graduate comes out of medical school with a $50,000 personal debt on average. So again, I am saying you need to decide——

Mr. STARK. That is bargain debt. I will buy all of that debt if you will give me the increase in your average earning over the increase of an engineer, and I will make a lot of money. That debt thing falls on deaf ears.

Mr. THOMAS. The gentleman's time has expired.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you, and we welcome your testimony and the very important work that you have been doing.

I do not know whether you have been tracking the current actions in the health care market, the hospital mergers and the mergers in the making, but you are absolutely right that without government controls, it is happening at a pace we frankly never imagined possible.

Given that pace, I guess I am a little more reluctant than I was 6 months ago, to try to manage it. Have you looked at it closely enough, and particularly the deals that are in the talking stages, to have any opinion on whether or not these mergers are going to reduce the number of residency slots so that they are far closer to the number of U.S. graduates? If that begins to happen, then the competition for the slots in the inner-city hospitals is going to be keen, and we will not have to make special programs to get residents into those slots. We may still have a maldistribution problem nationwide, but if there are indeed 10 percent who are having a hard time finding a job, the word is going to spread: Do not bother

to get that extra specialty training. Get out there, with lower debt, and plan to get out in a lower-cost section of the country.

To what extent do you think the market is going to reduce the number of residencies so that they are closer to the number of U.S. graduates, and to what extent is the market going to drive people to be better allocated throughout the Nation, both in terms of the inner-city hospital problem and in terms of the rural physician access problem?

Dr. DETMER. Candidly, I think the data is not what you would really like to see to really, truly respond to that question. That data is not yet there. We have never faced something quite like this. So the problem is that it is really tough to project what will happen.

Mrs. JOHNSON. But when you look at the pace of just the talk of what is going on in Boston and in Chicago and in New York, might it not be wise to wait for 1 year?

Dr. DETMER. Well, as I said, the whole question that I think you need to consider is that medical education is an extraordinarily long process, and if we have been producing for over a decade physicians at 1.5 times the growth rate of the population, you know you are going to have a problem even without any change. The issue is whether an over-over-oversupply is better than a relative oversupply in all of this, and honestly, the data are not there.

Mrs. JOHNSON. I am a little reluctant to focus on the oversupply to the extent that I felt it was a problem 6 months ago, because when you look at what is happening in the market, the real problem may be oversupply of highly specialized trained individuals.

That is why our proposal to offer a lower subsidy for second-level certification which started out as a proposal to offer no subsidy at second-level certification, I think looking at how much subsidy we should provide for various levels is probably the best thing we could do right now, combining that with some right of citizen preference for available slots, requiring foreign medical graduates to return to their native countries for at least a period of 5 to 10 years, and subsidizing certification at varying levels would help to begin to discourage the superspecialization that is going on now in terms of the numbers of those people and discourage foreign medical graduates from staying in America, which a large proportion of them do not.

Would those kinds of measures be enough at this time, while we get the data on what is happening to the number of residency positions?

Mr. LAMM. Could I add one more to that? First of all, that is definitely a big part of the problem. One of the problems we have is maintaining quality programs, and if you would give the residency review committees of ACGME—if you would give them the power to be able to close down some less effective residency programs—and if you would just allow them some protection from the FTC to be able to rationalize the system a little bit, that would be a very valuable addition. At present, the residency review committees do not have enough power to close programs in oversupplied specialties.

Mrs. JOHNSON. Governor Lamm, when you look at what is happening in New York and Boston, where you do have high-quality

programs working together in a different way, in the end, I think you are going to see a merging of programs.

I am not yet convinced that quality is an issue. I am not convinced that the market is not folding the weaker educational programs into the stronger educational programs. I am not aware of any instance in which it looks like the weaker educational program is winning the race because it is part of a stronger, economically viable hospital. Do you see what I mean?

Mr. LAMM. I am a public member of the ACGME and I think that we can give you instances of——

Mrs. JOHNSON. Well, any thoughts that you might have about steering that or maybe just relieving FTC—I do think we have a public interest in the quality programs, the stronger programs, being the ones that survive this merger process.

Dr. DETMER. I really appreciate your question, and I will need to think about it, but I would be delighted to try to get some response back to you.

Mrs. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman, and thank you, gentlemen, for your testimony.

Governor Lamm, in your opening remarks, you particularly talked about the difficulty of reconciling market forces with government input. I share that frustration, but you did not really give us any answers explicitly, and I am wondering—we, at least on this side of the aisle, in trying to craft a Medicare reform proposal, tried to look ahead and envision a time when the government would have less influence on the market than it does now. And I would certainly like to arrive at that. I am not sure we can, though, frankly. But I would be interested if you all have thought about the training system in this country absent the current system, absent the government input. How would you construct it if you could just start anew? Give us some idea of the framework.

Dr. DETMER. I think that—and this is begging the issue—but that is a very central question, and in fact the Institute of Medicine, the American Association of Medical Colleges, the Association of Academic Health Centers all have study groups funded by a variety of foundations to really look at that very central question because it is very important.

These organizations are complex, the academic health centers; they meet a lot of different needs—research as well. They give at least 40 percent-plus of the uncompensated care in this country. There is a whole raft of very critical and valuable goods that come out of this fairly small number of organizations.

So the issue is how should they in fact position themselves best in the public interest at this time. What can the market do, what should the market do, and what are the Federal and State roles as relates to this are absolutely immediate issues, and there are in fact groups working on that. I would anticipate that in 6 months, we would be able to at least tell you some things.

Mr. MCCRERY. Well, since it looks like we are not going to be able to get major reform this year, we have 6 months, and we would be glad to entertain that when you get it.

Mr. LAMM. But Congressman, do not overlook what all of these groups do agree on, and that is reducing the number of residency positions to 110 percent of U.S. medical graduates. That is one recommendation in every report that has looked at physician supply. So in spite of our inability to answer your more cosmic question, which is a central question, do not overlook the fact that we have come up with some very important first steps.

Mr. MCCRERY. You have come up with some first steps not wholly dissimilar from some of the recommendations we made in our reform effort. However, there are some questions that remain, and let me just ask a couple of those.

Mr. Thomas, for example, posed the question that you never answered, of these underserved areas—and I am speaking of rural areas as well as inner city—which seem to be able to attract foreign graduates but not American-born graduates. He asked what happens if you take those foreign graduates away; who is going to fill those slots in those underserved areas? And you said well, put more money into the National Health Service Corps. It is fine to provide subsidies to individuals to get care and get access to care, but if there are no providers there to give the care, they do not have much access.

Dr. DETMER. The National Health Service Corps was at one point when it was receiving funding, doing really, by a lot of people's views, a good job for the investment. So we have had some experience with programs that you can in fact, in a targeted policy way, truly start addressing access in a much more precise and candidly, I think, a much more cost-effective manner. But Governor, you may want to add to that.

Mr. LAMM. Again, we are in a point of transition, and my answer to the Chairman was that with a combination of the National Health Service Corps and the new operation of the market, all of a sudden you have a dose of reality therapy hitting the medical schools. All of a sudden U.S. medical graduates are considering practicing in rural areas and other places where they never looked before. You cannot look too far into the past because we have had this open-ended system. So there are only two answers, and they are inadequate, but at least they are a start. One would be the new realities that medical students are facing, where all of a sudden they are looking at new places that they never looked before, like underserved areas, and second is to provide some additional money to the National Health Service Corps.

Mr. MCCRERY. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Washington, Mr. McDermott, wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman. I am glad you are having this hearing. I do, however, disagree with you. The first rule of the Hippocratic oath is "Above all things, do no harm."

It is possible to make this system worse, and I think we have got to be careful in how we move forward. And I would like to pose a question to both of you.

You both emphasized the depth and the length of the training program. I would suggest to you that the average student debt at the University of Washington Medical School among graduates who take loans is $75,000 when they leave medical school. Students look at specialties in terms of how are they going to pay off that debt. If you are 25 years old, going out into the world $75,000 in debt or, as one young woman medical student from George Washington, who was in my office and who is president of a student medical association, and is $150,000 in debt, you look at a specialty as a way of paying that off, and you look for a training program which will help you specialize. And the whole of our system has been directed by how do you pay off the debts you accumulate.

When I graduated from medical school in 1963, I was $500 in debt. So you can see what has happened to medical students between now and then, and I think it is a much larger factor than people really want to admit.

There is another factor that I would add in here. When I graduated from medical school, I had a 2-year obligation to this country which was called military service. Now, because of the Vietnam war we eliminated all of that mandatory military service. But first I would like to know was there any consideration in either one of your committees of a requirement that physicians serve the national interest for 2 or 3 years, as is done in many other countries, as a way of dealing with this underserved population question. That is my first question.

But my second question is a more complicated one, and it addresses something happening already. The managed care companies are now approaching medical schools at the medical school student level to make agreements with them so that they can begin training students in the managed care philosophy of how medicine should be practiced and actually enlisting them in the health maintenance managed care organizations at the beginning of medical school so they have got them trained exactly as they want them when they graduate.

That is happening already in New York. I know of a medical school there that already has been approached by one of these managed care organizations. I wonder why you do not trust the market to reduce the number of doctors. Why isn't that the solution that Mr. McCrery and Mr. Thomas are talking about? Let the market do it. Let the managed care companies buy the medical students right at the beginning, train them the way they want, or else go to a government where we require students who come out of this program to serve 3 years somewhere—in Littleton, Colorado, or someplace where there is nobody who wants to go into practice—maybe Littleton is not the right place, but I can think of maybe Gunnison or someplace like that. Those kinds of places, you are only going to get somebody there if they are required to go there or if they figure they can pay off their college debts one way or another. You are not going to go out to rural Montana making $30,000 under the WAMI Program in the State of Washington if you are not going to be able to pay your debts.

So the issue is more complicated than just let us eliminate all of the foreign medical graduates. If you took all 40,000 Indians who practice medicine in the United States and sent them back tomorrow, the problem would not be fixed.

So I think it is a red herring to focus on that one part of it, and I would like to hear your response.

Dr. DETMER. I think that the IOM committee did not speak to the obligatory national service notion. I did my time at NIH, as it turned out, and was quite proud to do that. Personally, I think that that is a very sound idea. I think that if the public is directly investing to help underwrite these costs of education, this lengthy and expensive education, then that is not an inappropriate option.

I also think, though, that we still need to have some element of all-payer contribution to an educational trust fund that also then helps support some of that as the tradeoff, so that indeed you do not have somebody with a $120,000 debt, and candidly, only the rich then can go to medical school.

The other side of this I think is important, the point you made about managed care essentially creating a variant of a voucher system, really, by approaching the students and assuring them through the rest of their training and into a job.

So from that perspective, I think that that kind of thing in fact may well be a part of the way to both help us reform some of our education to a little more what practice is moving to, making education, actually, somewhat more appropriate, but at the same time will help address part of this issue. It does not deal with the international graduate who trains somewhere else in medical school and such, but it certainly deals, I think, with a component of our own issues.

Mr. LAMM. We thought the enlarging of the National Health Service Corps would do exactly what you say. In other words, we saw that as one——

Mr. MCDERMOTT. That is a voluntary thing. I am talking about saying you must serve 3 years in the national interest.

Mr. LAMM. Yes. Speaking only for myself, who served in the Army, I would agree with that. I am very intrigued with the National Service Corps.

But if I could just speak for a moment about the human side of this. In other words, the international medical graduate is a major problem and it is not xenophobic to acknowledge this problem. It is simply recognizing that we are training too many doctors among our own citizens and that a nation ought to train its own citizens first. Furthermore, training large numbers of international medical graduates in the United States is really not doing any good to those sending countries, who often desperately need their doctors. Nor are our interests served by an oversupply of physicians in the United States.

Dr. John Eisenberg talks about the human side of training too many doctors. He says:

> In the meantime, thousands of young physicians will have wasted their time and several years of residency to learn skills they will not use and will be forced to enter practices for which they have been poorly educated or will need to recycle themselves to become adequately trained in a specialty that is more in demand. Training young physicians in hospitals that want immediate services, but in specialties where career prospects are bleak, is a professional variant of a species eating its young.

Those are very strong words, but I agree with him. I see a whole bunch of idealistic young medical students at the University of Colorado who are going to get out into a glutted market, trained in specialties that are in oversupply from the moment they graduate.

Mr. MCDERMOTT. May I just offer, with the Chairman's indulgence—the University of Washington under the WAMI Program turns out 62 percent of its graduates into primary care. It can be designed at that level. If you see no alternative to it, you have got to do it. Essentially, Wyoming is now wanting into the WAMI Program. Their legislature is poised to vote to join the WAMI Program to train physicians, and if they are trained in a rural area, they will proceed that way. The question is whether or not you think the government is the best one to do that through something like the WAMI Program, or is the private sector through the managed care operation going into the medical schools, estimating what they are going to need in 20 years, and training people for those positions in advance.

You tell me the quality, Dr. Detmer, and which doctor you would want to go see—trained by the medical school under a public program, or trained under a managed care operation through having bought the Cornell Medical Hospital in New York City, and away we go.

Dr. DETMER. Well, that is certainly projecting forward. I was vice president for health sciences at Utah for 4 years, so I am very familiar. I think those programs have an awful lot to be said for them. It is also true, however, that the students—that is why one of our recommendations is let us make sure we have valid, reliable information out there so that young people do know what they are getting into because we are starting to see, for example, an awful lot of our students now moving preferentially in the last couple of years, fairly dramatically shifting toward generalist programs and such.

So I think it is a combination of things, but clearly, having valid, timely data is absolutely important if a market is to work.

Chairman THOMAS. Thank you, but I do say—although that is an impassioned statement—that oftentimes it is not only what they want to do, but it is where they want to do it, and that gets back to the maldistribution question. Some kind of payment back to society for this wonderful training in which society has an opportunity to indicate that service would be better rendered here rather than there would go a long way toward making sure these people have a place to practice, rather than where they want to practice, at least for the amount of time they pay back the debt to society. I do not think you are going to find much quarrel with that on the Committee.

Does the gentleman from Nebraska, Mr. Christensen, wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman, and I will make my questions short so Mr. Ensign can get in before we go to this vote.

Among the things that the law schools have been doing in Nebraska is they have purposely reduced, gradually and on a voluntary basis, the number of admittants. I think the medical schools

have a duty, more than just this first step that we have talked about here, to do the same.

I know you have stated that it is the Congress that holds the purse strings here and that it is almost our responsibility, but I think it is a shared responsibility. If you look at what the Nebraska University Law School has done, they have brought 170 graduates down to 120 in terms of enrollees. I think that is more than just an important first step. That is a major voluntary reduction that I believe the medical schools need to start following.

I do question one thing in your statement, Governor. In an exchange you had with Congressman Stark you said we do not need the foreign medical graduates. My father passed away about 1 month ago. He was in an underserved area of greater Nebraska, and his life was extended because of a young graduate from Turkey who was an oncologist at Grand Island-St. Francis Hospital. They could not get any oncologists to come to Grand Island, but this young man did, and I will be forever grateful for the fact that he came and was able to give my father the kind of care that he needed.

I think I would share Congressman McCrery's concerns about getting American-born graduates to these underserved areas. Is there a way, in a regulated marketplace—which you have stated is the route we should follow—for us to do that, because I am not sure it is getting done now without the foreign medical graduates.

Mr. LAMM. You are right. It is not getting done now. And I think if you look to the past, you are absolutely right. International medical graduates have done a wonderful job meeting a very desperate need. If I could leave anything carved over the State Capitol, however, it would be something like beware of policies that were appropriate to the past but are unfortunate or disastrous to the future. I think that that is really what you are saying, that they have done a wonderful job, and whether it is Bob Dole's Armenian doctor or whether it is your father's doctor, you bet. That is not a personal statement. But when you look ahead, and you see the coming oversupply of physicians, you ask yourself: Shouldn't we train people from Nebraska and Colorado before we train somebody from a foreign country? That would be number one.

And number two, just allowing a large number of international medical graduates to train in the United States who, as soon as they do their short period of time and get into this country, then move to the suburbs; they come down to Denver; they leave Nebraska and come down to Denver. Let us not shoot with a shotgun; let us shoot with a rifle here and find a program that will keep physicians in those communities over the long term.

Dr. DETMER. I am also grateful that your father got care, and I am disappointed, candidly, that in a shared responsibility way, we have not met more of the access needs of our population in this country, and I think all of us must continue to focus and work on that. I really want to underscore that.

Our own school, for example, is decreasing its specialty slots starting this year by 10 percent, and I think we are clearly having to do that, but want to do that and see that that is our responsibility as well.

I am delighted, actually, that we have had this opportunity to have this sort of discourse because these are tough issues, tough questions, but they clearly are our questions for our time, and I think we do need to address not only the cost issues but the quality and the access issues.

Thank you.

Mr. CHRISTENSEN. Thank you. Thank you both for testifying.

Mr. Chairman.

Mr. ENSIGN [presiding]. I will go ahead and question until I have to go over and vote. I just want to engage in a little colloquy with you about this whole process. I have heard some good ideas coming from both sides today.

It seems to me that if you are going to allow more free market decisions to be made instead of just the government, that first of all, the money should follow the resident, instead of just going to a specific school. That would seem to me to be a fundamental change that absolutely has to occur.

Second, as a matter of fact, in veterinary school, of which I am a proud graduate, we had a program in the State of Nevada where the State of Nevada subsidized your education to be able to go out of State because we do not have a veterinary school. But then they required you to come back to Nevada to practice for 3 out of the first 5 years. I think it is entirely appropriate, as colleagues over here have said, that if the government is subsidizing you in some way, then it is entirely appropriate for the government then to expect something of you.

And I think that if we can design a system that says here is money for *x* amount of residencies, but attached to these residencies is a requirement to serve underserved areas for *x* amount of years. It is pretty easy to put a pencil to how many we need in the inner cities, how many doctors we need, at what levels we need them in rural areas, and you say OK, we need *x* amount of primary care physicians to serve rural areas, and there is *x* number of primary physician residencies that we are going to subsidize at this level, maybe help them a little bit with their loans or whatever we are going to do, but you are going to be required to serve 3 or 4 years in this rural area.

Could I hear your comments on that?

Dr. DETMER. Well, I think your first comment about the concept of a voucher that follows the student was again something that we saw as very promising and definitely deserving further study. We did not get further than that, but we absolutely got that far.

And then, second, I think the idea of——

Mr. ENSIGN. You sound like you are running for office, by the way, by not taking a firm stand—I am just kidding.

Dr. DETMER. The second item, I think we have already commented on, and that is that some sense of public service that is required and mandated, I think if it is structured properly and funded properly really is very sensible, and I think could be quite helpful.

Mr. ENSIGN. OK.

Mrs. JOHNSON [presiding]. Thank you. While the Chairman is voting, I am going to continue with questions.

We spent a lot of time talking about the 110-percent recommendation, but the difficulty with implementing that is that you have to couple it with a variety of involvements by the government to see that you allocate more slots to the quality programs than to the lower quality programs. In other words, if you allocate the 110 slots across all the existing programs, I am not sure that that is the best way to downsize the system. If you are going to allocate them differentially based on quality, then you get another whole level of involvement and evaluation at a time that I think may not be appropriate; in a sense, the market is already doing that evaluation, and programs are merging.

So one of the problems with the 110 percent is that it is the right goal, but I am not sure whether we should implement it or whether we should see what the market is doing and what progress it is making toward that goal on its own, because it is difficult to allocate, and it is particularly difficult to allocate as things are moving and changing. We looked at just allocating it in the Boston area at the time we were looking at this, and things were changing so rapidly. We could have in a sense overstocked with residents programs that eventually merged and did not need all of those slots.

So I am concerned about the implementation of some of the policies that you recommend that I actually agree with, and I wonder what your thoughts are on delaying implementation of those policies to see how much the market is going to do and what, really, our role ought to be in preserving the quality programs, if any.

Mr. LAMM. Let us say you would wait 3 years and with the existing amount of money. Would you not have a substantial increase in the number of international medical graduates under your—I mean——

Mrs. JOHNSON. Well, if you have a decline in the number of institutions and the number of training programs, which I think is inevitable when I look at what is happening in Boston and New York, I am not sure that you will not have a decline in the total number of slots.

Mr. LAMM. But why are you spending public money, then—the $6 billion in GME—to train people who are in oversupply? I know I keep coming back to that, but it seems to me that the market will take 2 or 3 years to work, and at the same time——

Mrs. JOHNSON. I guess what I am asking is won't the merger of those institutions downsize the number of resident slots available.

Mr. LAMM. It will in certain areas. I do not think it will in all areas. I mean, you will still have a number of—if the whole staffing patterns of California, where Congressman Stark is from were carried out across the United States, you would have this immense oversupply in both hospitals, specialists and everything else. So there is a great deal of regional variation, and what you are seeing in this Dartmouth Atlas of Health Care, which I really recommend, Jon Wennberg is coming up with some really wonderful stuff—illustrates how much variation there is from one place in the country to another.

Mrs. JOHNSON. Well, if that is your conclusion, if you do not think the market is going to, through consolidation, reduce the number of residency slots adequately, then I look forward to your getting back to us on how you would implement some of these

goals. I do not think you can just allocate the downsized slots evenly across the programs.

Mr. LAMM. Why not give the RRCs some ability to be able to identify quality programs and close less than quality programs? In other words, through that process——

Mrs. JOHNSON. It is going to be risky for the government to make those judgments at a time of such enormous change. Also, we might find a program of lesser quality but in a sort of backwater area that we want to preserve, and it should survive and should actually improve in quality as there are fewer programs available. So I am a little nervous about——

Dr. DETMER. I would like to underscore one thing that I think is something that we should not lose sight of. All the time that we are waiting to see what will happen, we will also start seeing strange things starting to happen to our health care system simply because of an oversupply.

Mrs. JOHNSON. I appreciate that.

Dr. DETMER. And I do not think we should ignore that because, for example, what States may do——

Mrs. JOHNSON. I appreciate that, but we are still keenly aware of areas of undersupply, and I think the downsizing will force people to choose those less desirable positions, and it does seem to me important that programs be required to preference citizens and permanent residents. That way, you are sure to get the people who are going to devote their lives to health care in America into the residency positions, and then I think also an immediate change in how much we subsidize various levels of certification, which we began in the bill that the President vetoed, but will need to go further, will influence who we are, what level of experience we are producing, and what level of expertise we are investing in.

Mr. LAMM. Let me talk about the dynamics of a merger. I do not know what is going on in the Boston area, but in a lot of parts of the country, when a merger occurs, the merged organization does not reduce the amount of residencies because they get this big Federal pot of GME money. They do not reduce the number of residencies appreciably because you are paying for a lot of the work that they will do, so you continue to drive the systems.

Mrs. JOHNSON. You are saying that on top of the current requirements—I mean, there are legal requirements, though, for the number of beds per resident.

Mr. LAMM. Yes.

Mrs. JOHNSON. If you downsize the beds dramatically, you have to downsize the residencies.

Mr. LAMM. All I can say is that I know of a number—I think we can furnish you with a number of instances. I cannot answer that particular question about what the ratio was.

Mrs. JOHNSON. Yes. We need to look at whether we need to actually force that, whether it is happening, and if we need to force it, how do we manage it, because in the first round of this a year ago, we did not know enough to tell you how to manage it.

Mr. LAMM. But if you and I are both heads of a hospital, and we merge our hospitals, one of the last things we are going to want to do is reduce the number of residents because we get $70,000 on average per resident.

Mrs. JOHNSON. But that brings me to the second question I was going to ask. In our proposal to the President—and it is unfortunate that he vetoed it—but it is particularly unfortunate that we cannot seem to get the public's attention to many of the important provisions in our Medicare reform bill that had nothing to do with the sort of macropolitical controversy because in that bill, we did allow consortia to apply to be the funding mechanism. How do we accelerate that? How do we do that? Can we do that under current law, because that will address a lot of the concerns that you raise.

If the consortia control the money, there will not be the number of residency slots that are in-hospital, and the amount of dependence of teaching hospitals on residents for sheer work will decline because a lot of their training will go on in what are now currently more appropriate sites.

So what is your evaluation? That ties in with my last question—because the Chairman is back and other Members are back—but have you looked at the impact of managed care on current funding of educational programs, because what I am beginning to hear from my educational institutions now is that managed care deals are pulling those education dollars out from under the educational programs, they are flowing into profit, and our failure to act in this area is now upsizing the profitability of the managed care companies, downsizing the resources for medical education, and is not only going to cost us residency slots, but is going to cost us quality of training.

Dr. DETMER. I think that is certainly what everyone I talk to is also saying.

Mrs. JOHNSON. So you are hearing that, too.

Dr. DETMER. Yes.

Mrs. JOHNSON. Well, we need to get some data on that, what actually is happening, what money is going, and then if you can get back to us on your thoughts about the trust fund proposal in our proposal—our Medicare reform proposal was really very comprehensive. It did try to go to consortia, it did try to move medical education money out of the Medicare reimbursement system, and—what was it, $17.5 billion ended up in the trust fund—moving that from just a taxpayer source and out of the reimbursement system, so it was a very progressive and forward-looking reform and addressed many of the issues that you raised. So I look forward to working with you on the details, and if you would get back to me on some of the things I have raised, I would appreciate it.

Thank you.

Mr. THOMAS. Let me ask a transition question, Dr. Detmer. You talked about oversupply and the horrors of oversupply out there in the world. Just give us some idea of what our problems are if we have an oversupply—if we do not already—although there is still a debate as to whether there is just an abundance or an oversupply.

Dr. DETMER. First of all, I really want to make clear, as I said earlier, and underscore my comments, that I am entering the era and level of speculation on this, but at your urging, I am doing this, OK? It is not based on what I have seen as really firm data at this point.

But I think that what we can predict is that you will see some States that are producing very large numbers of doctors and other States that in fact are producing essentially fairly right-sized numbers, if you will, looking at this.

Right now, we have a system that allows essentially fairly open migration, if you will, within the United States to different States to practice. Canada recently has very directly tied work opportunities to production function, and I think that when you see States worrying about the cost issues where they are in fact specifically putting in programs to deal with access and such, I believe they will start looking at ways to regulate the open inmigration of physicians into some of their borders.

Personally, I think the idea of having a more national approach to education for medicine for the country's population ultimately has a lot to be said for it. What worries me is that if we really essentially balkanize our educational system so that it is more atomized State-by-State to deal with this in the void and lack of some Federal leadership—excuse me—direction on this, because that is where the main dollars for graduate education are coming from, from the Federal Government, we will inherit, frankly, a much more perplexing and more difficult system to try to deal with because we will be approaching it much more State-by-State.

Now, that is all projection, and I want to make that very clear, but I do not think it is beyond happening.

Mr. THOMAS. Well, in the Federal system, I think you will find, given the citizenship of an individual of a State as well as the Federal, that in terms of trying to create barriers for movement of people for economic means has never been successful historically, and it would be far better to deal with incentives such as money, which is largely controlled at the Federal level for desirable movement rather than restrictive, undesirable movement. I think the Supreme Court would be faced with several cases if in fact some States tried that.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Thank you, Mr. Chairman, and I thank you, gentlemen, for being here.

I have ducked in and out of the room, so I may be repeating a question or two, so please bear with me. I guess I come at my questioning from two standpoints—one, the rural concept and the other, the New York State concept.

I used to be in business, and for about 20 years, I lived in a small town in upstate New York, 12,500 people. It had a hospital, but it could not get doctors to come in; it just could not do it. Therefore, we made a real attempt to get some of the international medical graduates to come in. They came in, they worked, they made a tremendous contribution to the community. Some of the finest specialists and some of the finest general practitioners came from India, Pakistan, and places like that.

I am loathe to snuff out that flow of medical talent. I know that you answered Mr. McCrery's question about the new reality, but I have not seen the new reality in my part of the country.

Second, I know the Pew report said there are something like 50 or 60 percent too many hospitals or hospital beds already in this country. The problem I have with that is that the hospitals often,

in the area in which I live, are not just medical, but they are economic units; sometimes they hire more people than anybody else, more than possibly the school system. If you want to get good doctors, competent doctors, particularly with interactive television coming in and being able to link up with the teaching and the research hospitals, but to come into your community and live there and be citizens there, and if they do not have a hospital to use or to go to, that is also demagnetizing the problem.

So to me, we are talking about an area which is obviously important, but I hate to see a law of unintended consequences come into play so that those of us in upstate New York who have somehow found a formula as far as the international medical graduates are concerned, but also in terms of reconfiguring our hospitals in terms of providing clinical service, outpatient, long-term care, meals-on-wheels and things like that. So to arbitrarily put in place a plan or a financing plan which cuts that off bothers me.

The other thing, of course, is as far as New York State is concerned—New York hospitals, the basic hospitals, I think have a tremendous percentage of international medical graduates there, and if that supply is shut off, somebody is going to have to make up the difference. They are already struggling, and to have another funding source coming along, that bothers me.

So those are the two basic questions and issues that I am interested in.

Mr. LAMM. I have been looking at six cities that I think are harbingers for the delivery of health care in a metropolitan area—this is not directly responsive to your question because you have got two almost separate problems—how do we deliver services in a metropolitan area, and then rural America has its own challenges. But when you look at St. Paul-Minneapolis, Portland, Oregon, Sacramento, San Diego and Albuquerque, I think you start to get a hint of what is happening when Adam Smith arrives, and large employers start to save money and hospitals consolidate.

There were 17 hospitals in St. Paul 15 years ago; today there are 6 hospitals run by only 4 different systems.

Mr. HOUGHTON. But you see, Governor, I am not talking about St. Paul. I am talking about a little town of 12,500 people, and there is only one hospital there.

Mr. LAMM. Yes, I understand that, but I am saying that when we are making national policy—I did reflect that rural America has a different situation, but of course, most of the hospitals and most of the people are in metropolitan areas.

But let me also say that I had three towns in Colorado when I was Governor. Each of them had a hospital. They were within 15 miles of each other and each of them had an occupancy of three people. Now, it was not in the long-term interest of that community not to consolidate those hospitals.

I look at Nebraska, where there are 4.7 hospital beds per thousand people, whereas the market is using 1.5 in more efficient areas. So I think there will have to be a number of consolidations.

Mr. HOUGHTON. Could I just interrupt—and I am probably taking more than my time. I see a red light there. Red means to stop; isn't that right? [Laughter.]

And I understand the problem, you see, and I know that you are trying to work through the supply and demand issue and the participation of the government in this. But all I am talking about is a particular area. And when you flip something on its ear and change the dynamics of it, sometimes you throw a body blow at rural communities that do not understand it and cannot adapt to it, whereas now they are beginning to adapt to it.

Dr. DETMER. I would like to add to that because I just came, in fact, from a very exciting 2-day conference that the National Library of Medicine had on where telemedicine and the information infrastructure is going to take it—particularly, I think, rural care, but also hopefully rural care generally and particularly central city care as well. But I think that as we have just said, managed care is upsetting our cart in a lot of ways, and so will, I think, this information age.

I hear exactly what you describe. I am from a little town in central Kansas, and I think the same dynamics have been very relevant there. I think also if you go out to Hayes, Kansas right now, you are starting to see telemedicine starting to really change some of those smaller community dynamics.

So I am also just saying again—not to disagree, really—but I am just saying that we are living in a time of some real change, and I think we are going to see some of those dynamics, if you will, also turned on their ear. And it is too early, in my opinion, candidly, to really say how it will all shake out, but there is some promise. I have seen some very exciting things in the last couple of days that to me, at least, I think really offer some promise—and some Federal support, actually. It has been very well-spent in that area.

Mr. LAMM. Congressman, I ran some of these programs for 10 years. Let me tell you about the little town of Fair Play, Colorado. They did everything they could to try to get a doctor and a hospital there. They bonded themselves a great deal to get a hospital there and try to keep it open. Nobody in that community would really want to stay in that hospital for very long, other than if they were immediately stabilized. If they had a serious condition, they would want to get to Colorado Springs.

So we took an emergency response vehicle, an ambulance, up there, and we showed them that a current ambulance is a much more effective tool than an inadequate hospital. So they right now are happier than anything. They have a nurse practitioner and an emergency response system in place of a hospital. They are healthier; they can resolve their problems more quickly.

Mr. HOUGHTON. Yes, but let me just take one more crack at this, Mr. Chairman, and then I will shut up. I understand what you are dealing with, and I understand the dynamics and the funding and trying to put this thing into a more modern context. Yet, at the same time, I see rural communities adjusting themselves pretty well. We have just passed a thing called a telecommunications bill—I am sure you know about this—and it is really breathtaking in terms of the impact it is going to have not just on medicine, but on education and on business and rural communities. And the hospital is not just a hospital. It is no longer a hospital. It is something else. It is a health care or service provider. But it is making these adjustments along with telemedicine or interactive television,

which is going along pretty well, and I just hate to upset that. Do you see what I mean?

Mr. LAMM. Yes.

Mr. HOUGHTON. Thank you very much.

Mr. THOMAS. I thank the gentleman.

Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Let me thank both of our witnesses for their testimony and their report to this Committee.

Governor Lamm, I agree with your statement in which you recommend the creation of a public-private payment pool. I interpret that to be an all-payer funding source for dealing with graduate medical education costs in this country, recognizing full well that we can no longer rely upon the Federal Government to pay the full cost of training, and in the competitive marketplace, we need some form other than Medicare rates to reimburse for graduate medical education.

I assume that when you say all insurance premiums, you also refer to the self-insured plans paying their share also of the cost of the training of graduate medical education.

But let me go to the other side of that coin. It seems to me that if we in Washington provide the funding for education and do not deal with work force reform, we are missing the golden opportunity to address the work force issues. It is easy to provide the money. It is difficult to get agreement within the medical community as to what to do on work force issues.

And I am somewhat troubled by a statement in your remarks, which I agree with, and that is that under market forces, we will always find the "rationalization of physician utilization across the country." We can train more and more people in medicine, and the system will find a use for those individuals, and we will find a greater and greater percentage of our economy going to health care.

So my question is how much should the Federal Government get involved in restricting the number of people trained in medicine, in what specialty areas they can be trained in, whether we should be training more in primary care, as you point out? How does the Federal Government perform its responsibility in carrying out those policy issues without being too intrusive into the market as to the training of physicians or where they should be able to practice medicine, and so forth?

Mr. LAMM. When you look at Spain and some of those other European countries that train too many doctors, the market does have its effect, but what it does is have doctors driving taxicabs and doing a lot of things that they are not trained to do. So I do think that the market is ruthless, and what you are seeing is that we are changing from this system where you could almost absorb an unlimited amount of physicians because of Medicare and all this other blank check medicine to a system that is rationalizing the utilization of physicians. I think in the future you will no longer find a market absorbing as many physicians as are trained today, which then raises your question.

I think what I come down to is that I have my primary faith in the market. I think the market will give the signals, but what I find problematic is this juxtaposition between what the market is

telling us and the Federal Government continuing to throw $6 billion to train a surplus of specialist physicians.

Is that responsive?

Mr. CARDIN. It is. But if we provide a funding source independent of Medicare, independent of the rates that hospitals charge, that will finance graduate medical education, whether it is a trust fund or a premiums tax or whatever we find, in order to guarantee the financing of graduate medical education in this country, and do it in a way without also determining how many physicians we will have residency slots for, what type of residency slots, and so forth, do you have enough confidence in the market that we will train the right medical personnel, or should we not use the time that we develop this funding source as the vehicle to also guarantee that we have the appropriate number of physicians trained?

Mr. LAMM. I definitely agree with your last statement. We have recommended that you upweight, for instance, payments for residents training in primary care disciplines, and that you downweight specialties that are in serious oversupply, and that you try to use this process, as you said, as a tool to solve both problems at once.

Dr. DETMER. I think you are going to have to strike a balance between regulation and marketplace. I just honestly think this is too important to each citizen's life and the lives of his loved ones to leave totally to the marketplace. So the issue is going to be an ongoing discussion of what is that tension between the right kind and the right size and side of regulation, versus the market. But clearly I think we are going to have to develop some kind of fund, and I do think that it is prudent to at least have some piece of this that is looking at the sizing and the distribution and specific programs. I think it is too important to the public's well-being.

Mr. CARDIN. Well, I again thank both of you for your testimony. I think you have pointed out the dilemma that we face here. But we are all going to have to be a little bit more bold in coming forward with recommendations that preserve the quality of health care in this country while recognizing the economic reality that we have to have a more efficient work force for medical care in this country.

Thank you, Mr. Chairman.

Mr. THOMAS. Thank you.

Does the gentleman from Louisiana wish to further inquire?

Mr. MCCRERY. Yes, Mr. Chairman, for just a couple minutes.

You may recall that I was the one who wistfully looked back in time to when the government was not so involved and wondered how we could get back there. Why did the government get involved in the first place in financing medical education in this country? Do either of you know?

Mr. LAMM. There was a perceived undersupply of doctors.

Dr. DETMER. Yes, it is a very interesting question. In fact, it was specifically Federal initiatives in the sixties and seventies that actually increased both the size and number of medical education institutions, and I think there was a general sentiment actually at the time—for right or wrong—that in fact this would ultimately create more physicians than the country would need.

So that is how at least I read history, and I think a lot of other folks do, but I do not know how the Governor reads it.

Mr. LAMM. I think your point applies to Hill-Burton, in which the government got involved in hospitals. Every time the government gets involved, there is a tendency for people to get in and lobby in the medical schools and everything else, and all of a sudden, you have this oversupply. I am not at all sure it would not have been better if we had not gotten into that business. Now, there also is the whole research function which is very important.

Dr. DETMER. That is not to say that having valid information and valid data, so that you do know at least what is happening, so at least the market can function as the best market one can have, is very important, and I think that is one of the central government pieces of this is to make sure you have valid information because you may not have it.

Mr. MCCRERY. Going back to something that Dr. McDermott brought up about the cost of medical education today and some of these graduates leaving school with 150,000 dollars' worth of debt for their education, Mrs. Johnson leaned over and said that when her husband got out of medical school, they had no debt, and then somebody else said that yes, somebody he knew had 500 dollars' worth of debt—maybe that was Jim. They graduated at a time when the government was not involved in graduate medical education. Is there any connection between the tremendous escalation of costs and the government's involvement?

Dr. DETMER. I was right at that break. I went through medical school without any debt, and I decided by the time we had two children that we would in fact take government loans, against all my roots of Kansas heritage, so that my children would have a mother at home because she had worked through medical school. And we paid off our last debts at age 44. I am grateful for that support. I think our family actually was more of a family when I was out of the house. But these are very personal kinds of questions, ultimately.

Mr. MCCRERY. I am not posing the question should we get out of the loan business; I am posing the question is there any connection between the size of your loan versus the size of the young student's loan who was in Dr. McDermott's office, and the point at which the government became involved in financing graduate medical education, particularly in this country.

Dr. DETMER. I must say—and I am not an expert in this particular area—but on balance, I would say those programs have not operated that poorly at all; in fact, I think that on balance they have been pretty well managed. But I am not an expert at this.

Mr. MCCRERY. Well, then, how do you account for the tremendous escalation in cost in financing graduate medical education? How do you account for the difference between Jim McDermott's $500 in debt and the $150,000 in debt for the youngster who came into his office?

Mr. LAMM. As I recall, the cost of higher education is accelerating almost faster than any other good or service. I mean, it is a broader question. Higher education all over the place is rising incredibly fast, and it is one of the problems that is going to have to be dealt with.

Mr. MCDERMOTT. If the gentleman would yield——

Mr. MCCRERY. But Governor, are you trying to tell us that the cost of undergraduate education in Colorado has increased on the same scale as the cost of medical education?

Mr. LAMM. I do not know that. I really do not know that. Let me find that out and answer you. But I do know that across the board the cost of higher education is going up at a very dramatic rate.

Mr. MCDERMOTT. Would the gentleman yield?

Mr. LAMM. Sure.

Mr. MCDERMOTT. I think you are raising the right questions in that you are raising the multifactorial problem that creates this. When I went to medical school, the University of Illinois was receiving Federal money. It was called the National Education in Medical Defense. So the Federal Government was contributing money under that program and we had lectures called "MEND" lectures. So they were putting it in in another way. This was before Medicare. And in addition to that, the cost of a medical education at that point was $800 a semester for me, or $1,600 a year; that is what I spent.

Now, that has gone up by a factor of 10 in most medical schools. The tuition is about $16,000 for starters, and then you have to live on top of that.

So there have been some other factors which have gone into it. I think there were hardly any members of my class who could not in the summertime earn enough money to actually pay for their medical school. I worked on an oar boat on the Great Lakes and made $1,500 for a whole summer, $500 a month, and I could pay, then, for my medical school tuition.

So it really is a much more complicated issue than just saying the Federal Government came in with GME and indirect medical education money, and that is what caused the escalation. There were a whole lot of other factors driving up the cost.

Mr. MCCRERY. Oh, I am sure of that, but it seems to me that there is at least a coincidence that the government got involved, and all of a sudden, costs went through the roof.

Dr. DETMER. There has been an enormous ramping up of technology, though——

Mr. MCCRERY. If you would just let me finish, there is also perhaps a coincidence in the fact that the government got involved in paying for elderly care in this country, and physicians' incomes have gone up substantially.

I just think—and I think your report raises this—that the market goes to where the money is, and the government has spent an awful, awful, awful lot of money in the medical system in the last 30 years, and we are continually chasing our tail trying to guide the market where we think it ought to go, and the market is smarter than we are.

So I appreciate your testimony. I think there is some worth to your research, and perhaps the bottom line is that we ought to restrict the money that we put directly into medical education from the government and let the market work more.

Chairman THOMAS. One of the things that I think is affecting this is partly generational, and I think it has to do with the mental set of those going in to practice medicine. I have begun to see, as

I talk to different groups—and you can almost break it down in any country's medical society along generational lines in terms of what it means to go into medicine and what you should be able to get out of it. I think to a certain extent, this affects the definition of whether there is an oversupply or not. They look at it from an economic point of view almost always in terms of making a living, and if you cannot make the living you thought you were going to make, there is an oversupply, while I think the primary problem is maldistribution.

On the international medical graduates, I think you get a feeling here that although we believe that society ought to get its money's worth, I think we also have to face the fact that in my opinion, we created the "problem" because of the funding structure that we have and the way in which hospitals can make money to run their programs based upon who is willing to participate in the programs funded the way we fund them.

Adam Smith always liked a good market, and there was a willing buyer and a willing seller, and I think to a certain extent that as we move to this trust fund concept, trying to pull the money away from the hospital distribution structure, while that is still the dominant structure—the longer we wait, the more difficult it is going to be—if in fact we put the money in a trust fund, what would be the better way of distributing it? I think we have to go back and look at the buyer versus the seller and perhaps put more money in the hands of the buyer to help determine what the program would be, but also figure out a way in which this so-called public good, which got us into the business in the first place because we had too few doctors and that we are successful in creating this public good because some people would argue we have too many doctors, can in part be solved, going back to the initial statement that I made about where and how is society's contribution most appropriate, and I think it might be to that first certificate.

If in fact you have integrated operations as Mr. Stark was talking about, picking up students early on, not just to assist them financially, but to get them into the mental set and the culture of managed care, that those folks then have a way to meet their cost for the advanced certificates.

And if we put in a program of mandatory public service on a loan basis for those who do not have sufficient funds, that would help us in the maldistribution aspect being able for a portion of their early career to direct them where we felt this public good was most needed.

And for those who can fund themselves, who are not obligated to any kind of an integrated structure, or who do not need to obligate themselves to the loans to pay for it, I say caveat emptor, and let them get involved.

Of course, undergirding all of this is a clearinghouse for information approach, a knowledge approach, that to the best we are able, as frequently as we were able, to provide information to these students to make the best judgment possible so that you do have the options available to them not only in terms of funding, but in terms of the career choices that they make.

I cannot envision any larger role for government than that without getting into the problem of creating an undersupply in certain

areas and an oversupply in other areas and using government to recorrect the problem caused by government in which you are going to constantly have a rocking boat, based upon where you want to put the money, because politically the money is going to go sometimes for services from these facilities that is not necessarily conceived initially for its original purpose. And that gets us into the New York hospital problem and the rest, and as I said, I think that is our fault for creating it in terms of the way in which we fund.

How does that sound in terms of an approach moving forward?

Dr. DETMER. Well, I think you certainly captured very well the threads of our conversations. From our own perspective, as I said, I would like to really reflect on this and see if there are other pieces or some difference in balance, but I think that is a very good summary.

Mr. LAMM. Mr. Chairman, I think you were out of the room when I mentioned that in St. Paul, there were 17 hospitals, and now there are 6 hospitals. What has happened is that if you and I are going to consolidate our hospitals, the dynamics of this are that we continue to want to keep a maximum amount of residents because you people, the Federal Government, pay for it.

So you have a dynamic that continues to be at work where the Federal Government continues to disrupt the market in such a way as to promote excess production of residents.

Mr. THOMAS. But I want to change the way in which we fund it from direct medical, indirect, and Medicare disproportionate share hospital payments, to a trust fund which redistributes the money for that public good, i.e., doctors, in a different way, perhaps only funding to the first certificate.

Mr. LAMM. Got it.

Mr. THOMAS. And one of the things that I like about the idea of the managed care folk getting involved is that more and more, we tend to take our product and produce a product which does not conform to tomorrow's marketplace in that they are not getting their residencies out in the clinics, out in the suburban areas, into other structures. Perhaps these folks would be willing to provide a portion of that, funded by themselves, for the purpose of getting people who fit their needs, and that produces a product that has a ready home, but it would be a willing buyer and a willing seller, and we might want to attach some of the money to the buyer, that is, the doctor student, for the residency purposes, seeking the kind of training they believe will most equip them for the marketplace if there is adequate information available in making that decision. In this way, you do not just have a government study for a government intervention to change the way in which government funds it in the hope that you will recorrect the imbalance of the supply of doctors in various levels of expertise.

I think that the best way to involve the private sector is in funding a product that they want and need, with those people who have the money being able to spend it where they think they can get the best kind of education.

I think we have taken the first step in agreeing that we have got to pull the money out of the primary funder, Medicare, now and put it into a trust fund. The next stage of how you spend that

money in the trust fund is an area in which I believe we can use your resources to advantage in assisting us.

Mr. Stark provided an example of the differential of funding compensation to the teaching hospitals and funding to the residents, which is clearly a mismatch, and perhaps that could be adjusted. But I think the National Services Corps, the public service aspect, in essence as you said, Dr. Detmer, the voucher concept, which would be that funding, and let people match up not just in terms of the residents seeking slots that are funded by the Federal Government, but to figure out a way in which they match up with various funding sources which will determine what they do immediately following their graduation. That, I think, gives us an opportunity, both through the government service aspect on the maldistribution and through the funding beyond the first certificate, perhaps even the first certificate, by the managed care folks in getting a product they believe better serves them in the marketplace as well.

Are there any additional questions? The gentleman from Washington.

Mr. MCDERMOTT. I just have one question, and I am sorry if you may have talked about this before. But I was struck by two similarities in your reports. The first, obviously, is the one where you both believe in 110 percent of slots for American graduates—in other words, graduates plus 10 percent. You commonly agree on that.

But in my staff analysis of your two reports, there is another agreement which is interesting. On the one hand, in 10 years, 80 to 90 percent of the population will be in some sort of managed care. That is one report. The other one says two-thirds will be in managed care by the year 2000.

So they both agree that all doctors are going to be working, or most doctors are going to be working for managed care operations by the year 2000.

Now, why shouldn't we just simply allow the medical schools to cut any deal they can with the managed care operations, and why should we at a public policy level worry about that? Why don't we just say, hey, you are on your own, go out and make a deal—because we have made the decision that we are going to let the private insurance industry run this whole thing. The government is getting out of it. All the moves are to end Medicare, to put all the senior citizens out into the private managed care operations, and so we are backing out of the government role.

Why not just let the medical schools—survival of the fittest, basically. That is really what Adam Smith talked about, and I think you have really got to answer that question for us. Why should we intervene ourselves—because we are going to get into terrible political fights protecting my State medical school, or Ben will be here defending not only Maryland, but also Johns Hopkins. So if you have a private and public, you are going to have to decide. So why should we get into that fight? Politically, we generally try to stay out of them. I know Governor Lamm occasionally has wandered into a few, but generally, you try to stay out of them.

Dr. DETMER. Let me take a shot at that. Actually, to be precise—as I had said, but I think it was when you were on the vote—our

report did not in fact say explicitly 110 percent. It said let us move down to close to the U.S. graduating size. But that is a minor point.

The second one, though, is a very interesting and different question. Managed care is a delivery system primarily. We do have an abundance of resources—of beds, of doctors, of nurses. Almost every dimension right now, it appears, of our health care system has a sufficient supply that if you are interested in managed care, the last player oftentimes that you want to go and negotiate with is your friendly local neighborhood medical school and center, because in addition to doing health care, you are doing research for the country, you are doing a lot of teaching for the country, not all of which is getting its full-cost reimbursement—some of which it is, but some of which it is not—and so you have a joint product that is also, candidly, less efficient because it is doing multiple things at the same time.

So it is not necessarily that the managed care players are going to come to you, or if you go to them, that they are going to want to deal with you at anything other than the best deal they can find plus 1 percent.

So that is the tension that we are hearing.

Mr. MCDERMOTT. If I could then push that—so they do not come to the University of Illinois, to the research and educational hospital where I trained. They close that down, and the medical school has to put its students out into hospitals, and they have to put their interns and their residents out into hospitals run by managed care operations.

Dr. DETMER. Yes, and really, that is what we are heading into. The issue is will these changes be too cataclysmic to candidly manage and still ultimately come out at the end of the day with a system. And I think that that is our question. Those things are happening, and that is underway. I think the issue is will this be so dramatic that in fact we cannot manage to change even when we want to, even when we are decided that in fact we would like to do it.

Mr. LAMM. Congressman, we found that 80 to 90 percent of people would be in managed care at the end of the next decade, which would be 2005. That is a little bit different from the HMOs, and I do not mean to quibble, but our finding was that 80 to 90 percent will be in managed care by 2005.

Mr. MCDERMOTT. But why not just let this thing work out with them being the drivers? Why should we get in from a public policy standpoint? Why should we try to fiddle with it?

Mr. LAMM. I keep coming back to the fact that you are already fiddling with it.

Mr. MCDERMOTT. But if we pull our money out, we can end the graduate medical education program and design ourselves a formula for this trust fund, and give so much to the University of Minnesota and so much to the University of New York and the University of Pennsylvania and so forth. Each would get their little piece, and they will do what they can. But why should we get beyond that? Why should we be worrying about how many slots or anything else?

Dr. DETMER. Clearly, I think the idea of trying to separately cost-account, if you will, what is educational cost, what is service cost, what is research cost—I think that is in fact very profound and very important because then, at least if you are going to take that strategy—and we do also want to at the end of that shakeout, if you will, have research left and have education left—we have to know what those costs are, because managed care is primarily delivery. It is primarily delivery.

Mr. MCDERMOTT. My point is——

Mr. THOMAS. Would the gentleman yield, briefly?

Mr. MCDERMOTT. Certainly.

Mr. THOMAS. On that point, in sitting down with the teaching hospitals, though, I was amazed to find out that every one of them skinned the cat slightly differently; some rely on the DMEs, some on the IMEs, some on the disproportionate share, based upon the different profile and purposes. So when you try to break it out in terms of what their cost centers are, they have constructed themselves so many different ways that you have a very difficult time creating a simple trust fund that reimburses for teaching, research and the rest. It is not nearly that simple.

Dr. DETMER. I agree, and the old story that if you have seen one academic health center, you have seen one academic health center. I mean, even if you do cost it out, that is not saying there is not going to be variance within that even if you use a similar method for cost accounting. But at least you have a better handle on what you are dealing with. That is really my point. I was not arguing with it.

Mr. THOMAS. I thank the gentleman.

Mr. MCDERMOTT. You are absolutely correct that cost accounting is a problem. At the University of Washington, which I know intimately, 11 percent is State money, 39 percent is from practice of doctors, and 50 percent is one form or another of Federal money.

Now, I do not know what the medical schools in most States are like, but I suspect the numbers are somewhat like that. And one of the problems I had in dealing with the graduate medical education slots is that you are trying with the tail of the donkey to direct where it goes and how much it carries and everything else, and it is too complicated to do it simply with that. I mean, it is a very blunt instrument. You can cut off the tail, and I guess you still have a donkey, but it is going to be different, and it is going to act differently than it is presently if the Federal Government just slides out some part of that 50 percent at the University of Washington or whatever it is in each State.

It is the complexity of this thing and the way the different schools are wired together that I think is not taken into account by sort of saying, well, we will just pull those pieces out and stick them in a trust fund, and then we will pull them out by a formula, and somehow it will all work out all right at the end of the day.

I think it could be worse, actually.

Dr. DETMER. I agree.

Mr. MCDERMOTT. Thank you.

Mr. THOMAS. Again, I want to thank both witnesses. Obviously, what you tried to do from your committee positions was to open a window slightly, and what we are trying to do is lift the roof off.

We would very much appreciate as we go forward in this, if we are able to focus on some specific investigations that would assist us, and frankly, the one we were just discussing is one that interests me because we do believe the trust fund is a better idea than the specific pots of money now, because I believe, if you will allow an analogy, it is flood irrigation to the schools, and I would like to do a little drip irrigation; the problem is I do not know what that structure would look like, either on an equity basis or on a cost basis, and that may be an area in which we could utilize your services.

Nevertheless, the Subcommittee thanks you very much for your participation.

Dr. DETMER. Thank you. I appreciate this opportunity.

Mr. LAMM. Thank you, Mr. Chairman.

Mr. THOMAS. Thank you again.

The Subcommittee stands adjourned.

[Whereupon, at 12:04 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF AMERICAN ASSOCIATION OF COLLEGES OF NURSING

The American Association of Colleges of Nursing (AACN), representing 480 baccalaureate and graduate nursing education institutions, urges that Medicare funds now focused on entry level nursing education be redirected for clinical training of graduate nurses. This innovation would provide an on-going revenue source, not subject to the uncertainties of the annual appropriations process, to expand the production of advanced practice nurses, a vital resource for meeting future Medicare population needs.

The Committee's concern about physician workforce is understandable in view of the extent of Medicare financial support and the types of physicians it produces. But the Committee should not overlook the relevance of other health care professionals such as advanced practice nurses, in meeting the needs of the health care system for workforce. As the Committee examines Medicare funding and services for the nation's elderly, Medicare's lesser-known side--the system's financial support of training for nurses, physicians, and other professionals--itself is in dire need of reform. For example, Medicare supports the costs of training resident physicians with direct and indirect Graduate Medical Education funds amounting to over $5 billion per year. At an estimated $250 million in 1994, Medicare is the largest single source of federal support to train America's largest health care profession--registered nurses. Yet 70 percent of every Medicare dollar for nursing education goes to hospitals that operate diploma programs that not only produce less than 10 percent of the nation's RNs, but are geared to the needs of a dwindling in-patient population and fail to meet the more sophisticated demands of today's patient care. By the year 2000, Medicare payments to hospitals for nursing education are projected to reach $420 million. In addition, hospitals receiving these payments are concentrated in Pennsylvania, New Jersey, and Ohio, and receive nearly half of the Medicare nursing education funds.

At the same time, growing specialization among physicians, the health system's increasing demand for front-line primary care, and the accelerating drive toward managed care, prevention, and cost-efficiency are spurring the nation's need for nurse practitioners, certified nurse-midwives, and other RNs with advanced practice skills. While there has been much discussion in the media and in Congress on how Medicare redesign may ultimately affect funding for physician residencies in the nation's teaching hospitals, nursing and other health care leaders are focusing on a concern equally as big--the need to produce sufficient supplies of advanced practice nurses for an increasingly outpatient world where more needs of current and future Medicare patients will lie. Reforming Medicare will require more effective targeting of Medicare dollars that support the training of health professionals who provide that care. Since its creation in 1965, Medicare has reimbursed hospitals for a portion of their clinical, classroom and other costs to train nurses, physicians and other health personnel with the aim of providing high-quality inpatient care for Medicare recipients. With recent and dramatic shifts in where and how health care is delivered, the time is long overdue to overhaul the other side of Medicare--its health professions education expenditures that increasingly have become irrelevant and misdirected.

At no additional cost to Medicare, money presently spent to educate diploma nurses with skills limited to basic hospital service could be used to educate Advanced Practice Nurses (APNs). APNs are expert clinicians trained to deliver primary care, manage chronic medical conditions, and address other needs of the Medicare population. They include nurse practitioners, nurse midwives, nurse anesthetists, or clinical nurse specialists. APNs are educated in graduate nurse education (GNE) programs that are post-baccalaureate, advanced practice professional nursing programs accredited by nationally recognized accrediting bodies.

Redirecting Medicare funds to the education of advanced registered nurses not only makes clear sense for a health system dominated increasingly by the competing concerns of quality and cost, but would support preparation of the nurses in greatest demand by today's Medicare patients. In 1965 at Medicare's inception, most categories of advanced practice nursing had not yet emerged. In the years since, Medicare policy has not kept pace with the growing prevalence and documented quality and cost-effectiveness of APNs. Annually, millions of Medicare dollars that could support the preparation of the APN instead have funded the continued production of diploma graduates, fueling an imbalance in the nation's nursing pool.

Reports from other national organizations forecast greater demand for the APN than ever before.

In a 1994 report, the Pew Health Professions Commission urged doubling the number of nurse practitioner graduates by the year 2000 to offset the shortages of primary care physicians in major metropolitan centers, rural sites, and inner cities. Among their roles, the nation's approximately 48,000 nurse practitioners (NPs) conduct physical exams; diagnose and treat common acute illnesses and injuries; provide immunizations; manage high blood pressure, diabetes and other chronic problems; order and interpret lab tests; and counsel patients on adopting healthy lifestyles. Many NPs work in gerontological, pediatric, family health, women's health, and other specialties and some have independent practices. In 48 states, nurse practitioners can prescribe medications, while 20 states have given NPs authority to practice independently without physician supervision or collaboration.

More importantly, the NPs often provide services of the type most needed by Medicare patients: primary care at easily accessible, community based sites. These services are available at lower cost than would be possible in a hospital setting.

In a recently released report by the Institute of Medicine (IOM) on nurse staffing in hospitals and nursing homes, an IOM panel urged that increasing numbers of registered nurses with advanced practice skills be utilized in outpatient and inpatient settings to meet the demand for RNs with management, leadership, and supervisory abilities. As the panel noted, advanced registered nurses such as clinical nurse specialists not only provide high-quality and cost-effective care, especially for patients with complicated or serious clinical conditions such as Medicare patients, but are well-skilled for the sophisticated levels of practice required in today's hospitals. They work on multi-disciplinary teams and deliver a continuum of care across settings rather than focus on a "single event" of hospitalization. IOM also recommended that nursing home care be enhanced through increased presence of gerontological nurse specialists and nurse practitioners. While Medicare's role in nursing homes is limited, the patient population in these facilities is primarily Medicare eligible.

AACN's efforts in the 104th Congress has been to focus on redirecting Medicare funding for hospitals operating diploma programs into APN education. The following Medicare changes would provide a greater benefit to the Medicare population.

1. Redirecting eligibility to add "jointly operated" programs and to phase out diploma programs.

Since the inception of Medicare, nursing education has shifted almost entirely to community colleges, senior colleges, and universities. At present, Medicare reimbursement for nursing education programs is limited by the "provider-operated rule," which directs most of the funding to hospitals that operate diploma programs that produce entry level nurses who are trained in hospital oriented care. Most APNs represent categories of providers not in existence when Medicare educational payment policies were designed, such as nurse practitioners, clinical specialists, and others. Educational costs of these new providers are, with one exception (nurse anesthetists), not eligible for Medicare reimbursement now. Consequently, reimbursement eligibility requirements should be changed to include "jointly-operated" (provider-academic) programs that incur costs for APN education. To be eligible for reimbursement, Medicare providers would have to: 1) demonstrate that they incur clinical costs for the support of graduate nurse education programs, and 2) have a written contractual agreement with the program's academic partner institution. Cost items for determination of Medicare's share of reimbursement could include student stipends, costs of nursing clinical faculty, and supervision of APN students at the clinical site. (Now the students, school, and clinical sites bear these costs.) Determination of the specific cost of education would be based on a modest stipend, an appropriate ratio of training faculty to students, and faculty and supervisory salaries.

A major limitation in educating APNs, is the need for resources to cover costs of clinical faculty. Redirection would allow for additional clinical faculty to expand the number of APNs in training, thus helping to eliminate the waiting lists that all graduate nursing programs are experiencing. Indeed, Medicare reimbursement would give practice sites an incentive to take on additional students for clinical training, particularly because the numbers of specialty physician residencies likely are to be reduced. The lifting of restrictions on Medicare funding for nursing education would result in increasing the production of APNs, (both in terms of number and their program completion time) making cost-effective care more readily available to the Medicare population.

Unlike medical residency programs, most nursing programs pay their own clinical training faculty or make arrangements with preceptors at clinical sites to provide clinical training at patient care sites outside the schools' academic facilities. The cost of faculty at the clinical site and cost of preceptorships for advanced nursing students, however, are actually part of the cost of providing patient care because patients, including Medicare beneficiaries, receive the benefit of the care delivered by graduate students and their faculty. In almost all cases, APN students are RNs licensed to practice in a variety of patient settings, and many have practice experience as well.

2. Clarifying "provider" definition to include outpatient facilities serving Medicare patients.

Medicare defines "provider" as "hospitals, skilled nursing facilities, home health agencies, and other facilities." With health care delivery for Medicare populations evolving beyond the hospital to more accessible and lower cost, community based sites, ambulatory care facilities, as well as tertiary care sites, should be reimbursed for costs incurred for clinical training of APNs. Support for training in these settings where primary care is delivered is critical. The Medicare definition of "other facilities" should be clarified to include those facilities that provide health care to Medicare recipients, with or without links to acute care settings, including, but not limited to, nurse managed centers, ambulatory care facilities, community health clinics, health maintenance organizations, and public health departments. Reimbursing clinical sites for training APN students recognize the value of their services to Medicare patient care. As the number of specialty resident physicians is reduced, APNs could deliver many services formerly performed by resident physicians, as well as nursing care, and maintain quality of care. Acute care nurse practitioners are already working in a number of clinical sites.

Under AACN's proposal, facilities that incur clinical costs for support of APN education would have access to Medicare funds, but only for the portion of the cost attributable to the Medicare patient population. Thus, for a site with 30% Medicare patients, about 30% of the training costs would be eligible for reimbursement. (This is the same formula used now.) Medicare funding would provide resources for added clinical faculty to expand the numbers of APNs in training, and promote quality service to the Medicare beneficiary. With an increasing proportion of older Americans, APNs are precisely the type of health professional the Medicare population will need for its primary care, management of chronic medical conditions affecting older people, and patient education to help this population avoid injury and expensive hospitalization of nursing home care.

The APN is a vital component in increasing access to quality health care services for Medicare patients in a rapidly changing health care environment. This is the time to shift Medicare funding toward the recognized need for advanced practice nurses. Other organizations support the redirection of Medicare dollars to APN education. In April 1995 the Physician Payment Review Commission (PPRC) recommended that advanced degree nursing programs operated by four-year colleges and universities be eligible to receive Medicare funds that otherwise would be available only to hospital-operated programs. In July 1995 the Association of Academic Health Centers (AAHC) supported the allocation of funds for graduate nurse education by directing Medicare funds towards APN programs. Supporting APN education with Medicare dollars also has been urged by the American Association of Nurse Anesthetists and the Tri-Council for Nursing which, together with AACN, includes the American Nurses Association, American Organization of Nurse Executives, and National League for Nursing.

Redirection of the current Medicare monies for nursing education to APN education will increase the numbers of APNs and will ensure that Medicare patients will have the benefit of their skills in the future. Since the vast majority of undergraduate nursing education programs do not currently benefit from Medicare funds, neither the national supply of these personnel nor the quality of hospital care for Medicare beneficiaries will be adversely affected by the redirection of Medicare nursing educational dollars into advanced practice training. The redirection of these funds to APN education requires no new Medicare expenditures and could actually reduce expenditures. By recognizing only clinical costs of APN education and limiting eligibility to full-time APN students, costs would decrease substantially. Funding levels should not be reduced for those APN programs that currently benefit from Medicare support, such as nurse anesthetist programs. Redirection of funds would focus Medicare support on the preparation of the nurse in great

demand by the Medicare beneficiary population, and help meet the needs of a health care delivery system that is changing for Medicare and other patients.

As the Committee considers Medicare reform and health care workforce issues, AACN asks that it examine the current structure of Medicare funding for nursing education and graduate medical education and the on-going changes in health care delivery. AACN urges your support for APN education at a time when these nurses are in great demand and capable of meeting the sophisticated needs of today's Medicare beneficiary.

ar/gac/gne/gnetest.April 96

AACOM

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College of Osteopathic Medicine of the Pacific
Kirksville College of Osteopathic Medicine
Lake Erie College of Osteopathic Medicine
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New York College of Osteopathic Medicine of New York Institute of Technology
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April 30, 1996

The Honorable William Thomas
Chairman, Subcommittee on Health
Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

On behalf of the sixteen colleges of osteopathic medicine that are members of the American Association of Colleges of Osteopathic Medicine (AACOM), I would like to take this opportunity to present our views on physician supply and training requirements. We request that this letter be made part of the Subcommittee's April 16 hearing record on graduate medical education. AACOM supports all Congressional initiatives that both assure the provision of the best health care in a cost-effective delivery system and that maintain the capacity to educate outstanding practitioners to provide these services at a level of quality that the American public expects and deserves. We recognize the responsibility of the Subcommittee to examine the health care delivery system and the workforce of that system, with an eye toward increasing fiscal responsibility while maintaining their effectiveness in meeting the health care needs of all Americans. Congress is rightfully concerned about developing a reasonable health care workforce policy and at the same time achieving dollar savings. We believe that our recommendations are entirely consistent with these objectives, as well as the recommendations of the Council on Graduate Medical Education, and in large part with the Pew Health Professions Commission and Institute of Medicine reports.

While there is general agreement that the nation is faced with an oversupply of specialists, the fact remains that this oversupply does not currently extend to primary care practitioners. In addition, the continued existence of medically underserved areas and the problem of physician maldistribution cannot be ignored.

Both health professions education programs under Title VII of the Public Health Service Act and Graduate Medical Education (GME) funding through Medicare can be modified to produce significant savings to the federal government while enhancing the physician workforce's capacity to meet all the primary care needs of our citizens. Primary care has always been the centerpiece of osteopathic medical education. Indeed more than 60% of osteopathic physicians practice in primary care fields. Similarly, AACOM member schools have a long history of dedication to training primary care physicians to work in America's smaller communities. Throughout the continuum of an osteopathic medical student's education, both undergraduate and graduate, the principles of primary care are imparted and reinforced. Accordingly, AACOM believes that this Subcommittee and the Congress should seriously consider the following recommendations:

1) Consistent with the Council on Graduate Medical Education's (COGME) views, we urge that graduate medical education providers be paid Direct Medical Education (DME) and Indirect Medical Education (IME) payments for all residents who are graduates of U.S. medical schools. In addition, DME and IME payments for International Medical Graduates (IMGs) should be gradually reduced to 25% of the 1994 levels. Support for graduate medical

education positions for IMGs should not be at the expense of U.S. medical school graduates (D.O. or M.D.). While the contributions of IMGs to our citizens are legion, the changing nature of our medical system requires us to re-examine, and then alter, their participation in our graduate medical education system. Reducing the role of IMGs will be particularly an issue for those hospitals serving disadvantaged populations in our cities, who use IMGs for low-cost service delivery. As a nation, we need to explicitly decide how to meet the medical needs of these underserved populations. This should be an important part of our debate over entitlement reform. However, we should not use our medical education system as a proxy for this issue.

2) AACOM recommends that the current funding criteria that encourages the participation of programs in consortia of educational programs should be maintained. Osteopathic teaching hospitals are typically smaller, community-oriented facilities frequently joined with colleges of osteopathic medicine to form consortia which serve to increase the availability of graduate medical education for training in family medicine, internal medicine and other primary care disciplines within the profession. The osteopathic medical profession has taken a leadership role in creating systematic, rational formation of consortia through implementation of the osteopathic postdoctoral training institution (OPTI) concept. The OPTI is a graduate medical education accreditation system by which all osteopathic GME organizations will be reviewed and accredited. The OPTI is required to consist of at least one AOA-accredited hospital and at least one accredited college of osteopathic medicine. Community health centers, ambulatory clinics, and managed care organizations will create opportunities for the required ambulatory components of the training programs and may assist with resource support. The required partnership within an OPTI between the traditional hospital training site and the osteopathic medical school is unique in establishing and assuring a necessary bond of clinical and didactic training. In view of the movement of medical education toward consortia, particularly in the area of GME, AACOM feels that consideration should be given to directing the funding for GME to the consortia rather than to the individual institution as it is currently structured.

3) Primary care training payments should be upweighted to 125% to provide incentives for physicians to train as generalists and to lower the increased cost of primary care training. Correspondingly, DME a· , IME should be downweighted to 75% for non-generalist positions. Primary care physicians provide services that most effectively meet the public's needs generally and Medicare beneficiaries' needs specifically. Both generalist and non-generalist positions should be downweighted at 50% for DME and IME after the lesser of five years or initial board certification. The net effect of these changes should be significant savings in GME expenditures.

4) The DME and IME components of the Average Adjusted Per Capita Cost (AAPCC) should be removed from Medicare capitation rates and these GME funds used specifically for GME purposes. Currently, Medicare GME funds are factored into AAPCC payments which go to HMO contractors whether they have teaching programs or not

5) We recommend that Direct Medical Education payments be made without reference to a base year. The DME base year of 1984 is becoming increasingly outdated and inappropriate especially for osteopathic graduate medical education programs. There is great variation of DME payments around the country. Osteopathic medicine has traditionally been at the lower end of that curve and allopathic medicine had been at the upper end. In 1984, osteopathic graduate medical training sites utilized large numbers of volunteer educators. That number has decreased significantly in the last eleven years with many volunteers being replaced by paid faculty Accordingly, costs associated with osteopathic GME have risen. We, therefore, suggest that in place of the base year formula per resident amounts be based on an adjusted national average of per resident costs.

6) The trend in many cases is to make increasing use of ambulatory care settings for teaching purposes. While all specialities could benefit from education in ambulatory settings, it is critical for the primary care disciplines, namely, family medicine, general internal medicine and pediatrics that reimbursements for this training be increased to recognize the higher cost of

ambulatory education. To encourage ambulatory care training, GME payments should be made for primary care physicians' resident time spent in walk-in clinics, physicians' offices, group practices, community health centers, and managed care facilities.

We also recommend that special reimbursement be provided to clinical settings which are used for the education of undergraduate medical students. Osteopathic medical schools have relied heavily on the use of volunteer primary care practitioners to provide community-based ambulatory training experiences for our students although, as indicated above, the numbers of these volunteers have dropped. This emphasis on community-based, ambulatory clinical education has played a major role in maintaining our students' interests and competencies in primary care. The dedication of our volunteer primary care faculty preceptors to the osteopathic medical education process will be in danger of contracting even further as health care reform encourages practitioners to enter the managed care sector.

Health maintenance organizations and similar managed care arrangements have not shown a great interest in undergraduate medical education because it would reduce the number of patients that a preceptor could see during a working day. Ironically, just as the nation has begun to recognize the value of community-based medical education (which has always been at the heart of osteopathic medical education), the economic forces generated by reform may be a barrier to community-based participation in undergraduate medical education. As more and more attention is paid to the "bottom line," colleges will be forced to utilize hospitals and tertiary care centers for almost all of their clinical education, losing the benefits of ambulatory training; or, the costs of that education would substantially increase as a significant number of primary care preceptors drop out of the volunteer faculty network.

With the above concerns in mind, AACOM recommends that special funding be established for undergraduate training in ambulatory care settings when the GME reimbursement formulas are restructured: For example, creation of an all-payor pool for training programs that foster primary care.

Mr. Chairman, AACOM believes that these recommendations will generate significant savings while targeting taxpayer funds to train primary care physicians in both hospital and non-hospital settings. Thank you for your consideration and AACOM looks forward to working with the Subcommittee to achieve these objectives.

Sincerely,

Frederick J. Humphrey, II, D.O.
Chairman, AACOM Board of Governors
Dean, University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine

JOINT STATEMENT OF
AMERICAN COLLEGE OF PREVENTIVE MEDICINE
ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

SUMMARY

As the Congress turns its attention to the physician workforce needs of the United States, particular attention must be paid to supporting the training of physicians in disease prevention and health promotion through residency training in the specialty of preventive medicine. The importance of placing greater emphasis on prevention of disease and disability in our nation's health system is universally acknowledged and the need for more physicians prepared to provide leadership in prevention has been consistently documented. The Third Report of the Pew Health Professions Commission in particular recommends that all health professions schools include the social and population-based health sciences, which are the underpinnings of preventive medicine, in an evidence-based approach to clinical work, and that the traditional public health disciplines and clinical medicine be brought together to address the needs of integrated systems of care.. These objectives are identical to those of preventive medicine, which long has worked to bridge the gap between the individual and population health perspectives. However, our current system of financing physician training severely impedes our ability to produce physicians skilled in prevention and the population-based health sciences.

The American College of Preventive Medicine, the Association of Teachers of Preventive Medicine, and the Association of Schools of Public Health join in urging the Subcommittee to consider the unique aspects of physician training in preventive medicine and public health as it works to devise a system of financing graduate medical education that will meet the needs of the 21st century. In particular, they strongly support payment for graduate medical education through a new accountable system separate and distinct from reimbursement for patient care. Such a system should provide for training in preventive and population-based medicine in the variety of settings where such training takes place and should be financed equitably by all health care payers, both public and private.

WHAT IS PREVENTIVE MEDICINE?

Prevention, in its broadest sense, is practiced by all physicians and other health professionals who help their patients stay healthy. Preventive medicine, however, is also a distinct medical specialty, one of 25 recognized by the American Board of Medical Specialties.

The specialty of preventive medicine is based on our knowledge that promoting health and preventing disease require work with both individuals and communities. It is the only medical specialty whose objective is to equip physicians to care for both individuals and populations. The distinctive aspects of preventive medicine include knowledge and competence in:

- biostatistics
- epidemiology
- environmental and occupational health
- planning, administration, and evaluation of health services
- the social and behavioral aspects of health and disease
- the practice of prevention in clinical medicine

The American Board of Preventive Medicine grants certificates to physicians who have successfully completed three years of supervised training, one year of work experience, and a written examination in any one of three areas: general preventive medicine/public health; occupational medicine; or aerospace medicine Specialists in general preventive medicine/public health focus their skills on population groups, such as the residents of a particular community or state, or the patient population of a managed care plan, health center or hospital.. Occupational physicians focus on health and safety in the workplace, while the community associated with aviation, including passengers, is the domain of the aerospace physician. There currently are about 4200 physicians board-certified in preventive medicine.

Preventive medicine specialists work in a wide variety of settings, including public health and community agencies, organized health plans and health maintenance organizations, outpatient and primary care settings, and academia. These physicians usually engage in multiple activities, including disease surveillance, planning, administration and evaluation of disease prevention and

health promotion programs, quality management and outcomes measurement, research, teaching, and direct patient care.

HOW ARE PHYSICIANS TRAINED IN PREVENTIVE MEDICINE?

There are 87 preventive medicine residency programs accredited by the Accreditation Council for Graduate Medical Education. These include 43 in general preventive medicine/public health, 41 in occupational medicine, and three in aerospace medicine. The first of the three years of training is in clinical medicine. Most preventive medicine residency programs do not offer this first year, so residents complete it in training programs in other specialties, usually a primary care specialty. The second and third years consist of academic training in the fundamental disciplines of preventive medicine and supervised practicum experiences. Rotations take place in a wide variety of public and private settings, including outpatient facilities, health departments, managed care organizations, and worksites. About 500 residents currently are engaged in some phase of training in an accredited preventive medicine residency.

Physicians in specialties other than preventive medicine also acquire skills in prevention and the population-based health sciences by studying in academic programs in schools of public health or medical schools. There are 27 accredited schools of public health and 14 accredited graduate programs in preventive medicine/public health located in medical schools.

Accredited preventive medicine residencies are located in a variety of institutions. About half of the programs in general preventive medicine/public health and occupational medicine are located in medical schools. The department conducting the training may be called a department of preventive medicine, or family and community medicine, or occupational and environmental medicine. About 20% of residencies are located in schools of public health. The remainder are in health departments, military or other federal facilities, or hospitals. The three aerospace residencies are run by or closely connected with military facilities.

It is important to note that all but a handful of accredited residencies are not in teaching hospitals. Residents learn through working under supervision in community and outpatient settings, where prevention is most effective. Therefore, traditional sources of financing for graduate medical education through reimbursement for hospital inpatient services are not routinely available to preventive medicine residencies..

DO WE NEED MORE PHYSICIANS TRAINED IN PREVENTIVE MEDICINE?

Every major study of national health workforce needs has concluded that there is a shortage of physicians trained in preventive medicine. The October 1992 report of the Council on Graduate Medical Education (COGME) reported continued shortages in the field of preventive medicine and recommended increasing the percentage of physicians trained and certified in preventive medicine as a national goal COGME's June 1995 report recommended upweighting Medicare graduate medical education payments for preventive medicine residents.

In addition to the need for more physicians trained in the specialty of preventive medicine, there is a need for more training in prevention in all the other medical specialties, especially in primary care. In many cases, those specialties are initiating efforts to strengthen prevention education, particularly in relation to individual patient care. Specialists in preventive medicine, who have skills in population-based prevention as well as individual preventive interventions, can assist the other specialties in the further development of education in prevention for residents and medical students alike.

Recent major studies of the implications of managed health care for medical education conducted by COGME and by the Pew Health Commission's Advisory Panel on Health Professions Education and Managed Care have urged strongly that medical education emphasize the population-based health sciences. These are competencies needed by all physicians working in integrated systems of health care that strive to improve both quality and cost-effectiveness based on quantitative evidence. Preventive medicine residency programs, medical school departments of

preventive and community medicine, and schools of public health have long experience in teaching and research in these disciplines and much to contribute to educating a physician workforce equipped to practice medicine well in managed care environments.

HOW CAN WE TRAIN MORE PHYSICIANS IN PREVENTIVE MEDICINE?

The current system of financing for graduate medical education is inconsistent with training needs in preventive medicine. Of particular importance is the fact that Medicare reimbursement for graduate medical education costs is available only to those few programs where residents can be counted toward a hospital's training costs. Most training takes place in non-hospital based settings. Therefore, most preventive medicine residency programs do not receive funds from Medicare or other traditional sources of graduate medical education financing.

Many preventive medicine residency programs report that they turn away qualified applicants because they lack the funds for residents' stipends. The capacity of existing programs to train physicians is only about two-thirds funded. It is, therefore, essential that reforms to graduate medical education financing take into account the distinctive characteristics of training and practice in preventive medicine.

We support strongly two key recommendations of both the Pew Commission and the Institute of Medicine. First, payment for graduate medical education should be severed from payment for patient care. In preventive medicine and public health, the "patient" is often the community or an enrolled population. The interventions that preventive medicine and public health physicians conduct measurably improve the health of groups of people, often by preventing disease, yet the Medicare GME financing system has never enabled payment for training in population-oriented practice. In order to account for the growing diversity of training sites and training activities, it is essential that funding for residency training follow the resident, not remain as a component of reimbursement for inpatient care.

Second, all payers, not simply the federal government, should contribute explicitly to funding of graduate medical education. This is important both as a matter of equity and as a means of establishing accountability for the numbers, types, and quality of physicians that are trained.

The paroxysms of change that are sweeping our health care system require new breeds of health professionals trained to manage not just the care of individual patients, but also the health status of entire populations. Physicians trained in preventive medicine and public health are leaders in such efforts, and the programs that train them are committed to working to meet the needs of a rapidly evolving marketplace. These programs can thrive if they receive equal access to funds for the costs of training, from which they have historically been almost completely cut off. An investment of a tiny percentage of the six billion dollars that Medicare alone spends to subsidize inpatient graduate medical education will enable preventive medicine and public health to help meet the challenges of balancing cost, quality and access in new health systems.

STATEMENT OF AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA) is the only full-service professional organization representing the nation's 2.2 million registered nurses, including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse mid-wives, nurse educators, nurse managers and certified registered nurse anesthetists through its 53 state and territorial nurses associations.

ANA appreciates the opportunity to submit written testimony on graduate nurse education. ANA has long advocated for high quality, affordable health care for everyone in this nation. America's registered nurses deliver many of these essential health care services in the United States in a variety of settings -- hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice, and in managed care settings. As the health care delivery system continues to evolve rapidly, it is crucial that all available health care professionals be fully prepared to deliver essential primary care services. Nurses are well-positioned to fill many of the current gaps in availability of and access to primary and preventive health care services. To meet the increasing demands on our health care system, funding must be guaranteed to strengthen existing advanced practice nurse education programs and to establish new programs to ensure an adequate supply of these primary care providers.

BACKGROUND

Since its inception in 1965, the Medicare program (Medicare Part A) has paid a portion of the costs of training health professionals. Graduate Medical Education (GME) expenditures for nursing education are intended to cover a portion of the costs of nurse education to promote quality inpatient care for Medicare beneficiaries. Thus, Medicare has traditionally made payments to hospitals for the "training" of nurses in hospital-based nurse education programs. A majority of these programs are hospital-based programs that grant a diploma rather than a Bachelor of Science degree as is granted by most university-based nursing education programs, or an associate degree granted by community colleges. Medicare reimburses hospitals based on a formula payment for a portion of the cost of these hospital operated nurses education programs including classroom and clinical training. In cases where the hospital acts as the training site, but the educational program or institution is separate (but with a written joint venture agreement with the hospital), only the clinical training costs are reimbursed under Medicare. As of 1989, no new jointly operated programs have been eligible for Medicare funds. Medicare currently spends approximately $200 million a year on reimbursement to hospitals for a portion of the costs of hospital owned or operated nursing programs.

NURSING IN THE FUTURE

Despite the need for nurses to care for sicker patients in the hospital settings and the need for nurses to provide primary care in the community-based settings, the majority of newly graduated nurses (65 percent) graduate from associate degree, community colleges or diploma programs. This mix of nurses by educational background does not reflect the needs of the changing health care market.

In a report released in January, the Institute of Medicine (IOM) examined the role of nursing staff in hospitals and nursing homes. In the study, the IOM argued that to meet the changing needs of health care, "more advanced, or more broadly trained, RNs will be needed in the future." The study went on to note that, "Such training is essentially like that now provided for RNs who receive certification as, for example, advanced practice nurses." In the recommendations of the study, the IOM suggests that, "hospitals expand the use of registered nurses with advanced practice preparation and skills to provide clinical leadership and cost-effective care..." The ANA agrees with the IOM that there is a growing need for advanced practice nurses and nurses with advanced training. If we are to meet the needs outlined in the IOM report, we will have to reexamine nursing education.

In a related issue, the IOM report called for a requirement for a 24-hour presence of registered nurse coverage in nursing homes. Currently, nursing homes need to have an RN present eight hours a day. The report also recommended adjustments in Medicare and Medicaid payment levels to cover the additional cost of such a staffing requirement. ANA strongly supports this proposal. The phenomenon of "nursing homes without nurses" must become a thing of the past. The

changing needs of nursing home residents, including increased acuity and increased needs for rehabilitative and therapeutic care, demands it. The report also called for increased use of gerontological clinical nurse specialists and nurse practitioners in nursing homes, recognizing their growing importance in providing and assuring quality services for nursing home residents.

ANA supports policy that encourages full participation by registered nurses in the health care delivery system and removes barriers and discriminatory practices that prevent the public from accessing nurses as primary care providers.

We strongly encourage the Committee to consider the research supporting the role of advanced practice nurses as affordable and effective primary care givers. Among those studies is a 1993 meta-analysis assessing the effectiveness of nurse practitioner care when compared to physician care. The results indicated that nurses provided more health promotion activities than physicians and scored higher on quality-of-care measures. Nurses ordered laboratory tests for 36 percent of their patients but the cost of these tests was eight percent lower than the tests ordered by physicians. Both NPs and physicians were equivalent in rates of prescribing medications. Regarding clinical outcomes, nurses achieved equivalent outcomes or scored more favorably than physicians on most variables. The patients of the nurses, compared to physician patients demonstrated equivalent or equal: (1) satisfaction with their health care provider, (2) compliance with treatment recommendations; and (3) knowledge of their health status and treatment recommendations. In addition, the nurses' patients experienced slightly fewer hospitalizations than the physicians' patients; and the cost per visit for NP patients was 39 percent lower than cost per physician visit.

As the need increases for community-based and primary care providers, nursing will be forced to expand the number and capacity of its graduate level education programs. These programs do not currently receive Medicare funding. In order to educate adequate numbers of skilled advanced practice nurses who provide high quality and cost-effective services to Medicare recipients, there must be a reliable revenue stream that is not subject to the uncertainties of the annual appropriations process. **We urge this Committee to redirect, over a phase-in period, a portion of the Medicare Part A funds currently diploma nursing programs in hospital institutions to programs that educate advanced practice nurses. However, since there is also a continued need for four-year BSN prepared nurses to play a variety of critical roles in the evolving health care system, we believe that the current Medicare funds reimbursing hospitals for those programs should be maintained.**

We also believe that funding must be available to programs offering what is termed an "RN to MSN" program. In essence, these are accelerated nursing education programs for diploma or associate degree nurses with clinical experience to become master's prepared and hence, better able to meet the primary health care needs of the nation. These programs allow for a readily-available pool of skilled experienced health care professionals to become educated as advanced practice nurses in a shorter amount of time.

A graduate nurse education program would help many graduate nursing students who are currently attending school part-time due to financial constraints to become full time students. The current cost of attaining a nurse practitioner education is similar to students pursuing master's degrees in other areas of study. A 1994 Lewin-VHI study commissioned by the Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing estimated that the average cost of nurse practitioner and certified nurse midwife programs per student year is $15,591. The average costs for all nurse practitioner programs are $17,544 per student year and $34,096 per graduate.

A large portion of a graduate nursing student's programs are in clinical practice. Some certifying exams require that the nurse graduate spend one-third of his or her advanced nurse education in the classroom and two-thirds in clinical practice, although in most cases, the classroom and clinical studies are integrated through the graduate student's curriculum. *Even as advanced practice nurses are training for their degrees, their services are utilized in providing much needed health care services to patients.*

NURSING IN THE MANAGED CARE ENVIRONMENT

The health care delivery system is a rapidly changing environment that needs a provider infrastructure to better deliver coordinated quality care in a cost effective manner. Medicare has always paid for the training of providers in the hospitals. As health care is increasingly moving to ambulatory care sites and as health maintenance organizations (HMOs) and other non-inpatient sites become the focus for the practice of the "provider of the future" it follows that new systems must be developed for Medicare to provide clinical training for practitioners in these settings. Managed care plans are hiring new practitioners and developing teams of practitioners including nurse practitioners. Managed care plans are attracting practitioners whose training they have not subsidized. Managed care plans currently neither contribute to this training nor do they qualify for training dollars. Some managed care plans train in-house at their own expense. New systems such as community partnerships will have to be developed between the managed care networks, teaching hospitals and nursing programs. Policy makers must begin to shift a significant amount of training to ambulatory sites in order both to match the training to service and to provide practitioners and site role models for future clinicians to follow.

The delivery of health care services in this country is moving increasingly to ambulatory sites. Changes in hospital admission, use of various ambulatory facilities as well as health expenditures reflect this shift. Increasing number and types of surgeries are being performed in the outpatient setting. The training of the health practitioner exclusively in an inpatient sector is outmoded. In the 19th century individual apprenticeships, training and education moved to group experiences in hospital settings as public hospitals increased in number. After World War II, education become linked to inpatient care and research as Medicare financed support center on inpatient specialty services. Despite the clear and increasing demand for more primary care providers, academic health centers continue to train specialty care physicians and nurses. Because advanced nurse training focuses on the integration of services and developing teams of providers, these practitioners are better suited to community based primary care settings (National Governor's Association Report 1994).

CONCLUSION

ANA believes that nursing is the profession best prepared to meet the challenge of this changing health care environment. However, to accomplish this, ANA recommends that:

* Medicare funds currently used for educational programs that culminate in a diploma should be re-directed on a phased-in basis to graduate nurse education. A Graduate Nurse Education program would help many graduate nursing students who currently attend school part-time because of financial constraints to become full-time students.

* Since there is a continued need for BSN-prepared nurses in the health care system, ANA believes that current Medicare funds reimbursing hospitals for those programs be maintained.

* ANA also supports funding for the programs offering an "RN to MSN" program. These accelerated nursing education programs offer nurses with diplomas or associated degrees an opportunity to become Master's prepared and hence, better able to meet health care needs for this nation.

Finally, there is a need for additional data on the relationship between the workforce trends and advanced practice nurses. We urge the Members of this Committee to take the lead in urging the appropriate agencies of the Federal Government to track workforce trends as they relate to the advanced practice nurse. In tracking such trends, the supply and demand for physicians and other health professionals should be assessed.

Mr. Chairman, ANA thanks you for holding these hearings today on graduate medical and nurse education. ANA applauds this Committee for its strong commitment to the improvement of the health care systems in this country, and we appreciate the opportunity to share our views with you. Thank you.

JOINT STATEMENT ON GRADUATE MEDICAL EDUCATION
BY THE
AMERICAN PSYCHIATRIC ASSOCIATION
AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY
PRESENTED TO
THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
Tuesday, April 16, 1996

Mr. Chairman, this statement is submitted on behalf of the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Association for Geriatric Psychiatry. The American Psychiatric Association (APA) is the medical specialty society representing the 40,000 psychiatric physicians nationwide. The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 6,000 child and adolescent psychiatrists (physicians with at least five years of additional training beyond medical school in general and child and adolescent psychiatry). The American Association for Geriatric Psychiatry (AAGP) represents more than 1,400 psychiatrists with a special interest in geriatrics.

I. The Scope of Mental Illness:

Mental illnesses, including substance abuse, are among the most widespread, destructive and costly public health problems confronting our nation. Patients and their families wrestle daily with severely disrupted lives and with the personal and social costs of their disorders, including the stigma which - even in this enlightened age - still surrounds mental illness.

- Over 50 million adults in the U.S. suffer from mental disorders or alcohol or other substance abuse disorders on an annual basis. Our nation's direct medical care costs and indirect costs (e.g., productivity losses) from alcohol, drug abuse, and mental illnesses totaled more than $313 billion in 1990. That was more than cancer ($104 billion in 1987), respiratory disease ($99 billion in 1990), AIDS ($66 billion in 1991), or coronary artery disease ($43 billion in 1987).

- Severe mental disorders (i.e., schizophrenia, manic depressive illness, and severe forms of depression, panic disorder, and obsessive compulsive disorder) affect 2.8 percent of the adult population or approximately 5 million people and account for approximately 25 percent of all federal disability payments (SSI and SSDI).

- An estimated 50 percent of all homicides, 30 percent of all suicides, and 30 percent of accidental deaths are associated with alcohol abuse.

- Over 30,000 Americans commit suicide each year. Suicide is the third leading cause of death for individuals between the ages of 15 and 24 years. Individuals over age 65 account for more than 25% of suicides. White males over the age of 80 have the highest rate of suicide in the U.S. population.

- Some 18 million Americans are affected by depression on an annual basis - twice as many as are affected by coronary artery disease. A recent study examining six major medical conditions - including hypertension, diabetes, lung diseases and arthritis - found only severe heart disease to be associated with more disability and interruption of daily functioning than this profoundly debilitating form of mental illness.

- Among the 700,000 to 1 million homeless persons in the country, nearly one-third are mentally ill, and 35 to 40 percent of the homeless population also have alcohol or other drug problems.

- More than 5 million American women of childbearing age have used illicit drugs during the past year, placing a generation of infants at risk for developmental problems. Nearly three-fourths of all pediatric AIDS cases are related to the mother's injecting drug use or having sex with an injecting drug user.

- While the overall rates of major psychiatric disorders do not differ for women and men, certain disorders are more likely to affect women. Major depression, dysthymia, panic disorder and phobias strike approximately twice the number of women as men. The eating disorders, anorexia nervosa and bulimia, are almost exclusively seen in women.

II. Beneficial Impact of Psychiatric Research and Treatment:

As the scientific knowledge base of the field has expanded at an unprecedented rate, psychiatric research and treatment has made a real difference in millions of people's lives:

- Major depressive disorder, among the most common of all clinical problems in primary care, can be treated successfully by antidepressant medications or psychotherapy in 65 percent of cases. The rate of treatment response increases to more than 80 percent when alternative or adjunctive medications are used or psychotherapy is combined with medications in accordance with science-based practice guidelines.

- A recent comprehensive study financed by the state found that California taxpayers saved $7 for every dollar spent on treatment of drug and alcohol abuse. Savings of $1.5 billion were largely due to reductions in crime and health care costs.

- Health services research has demonstrated that comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay and reduce average days of detention by approximately 40 percent.

- In the treatment of Alzheimer's disease, a significant late-life mental disorder, we are on the verge of tremendous advancement in delaying onset and the need for institutional care which would save the nation over $50 billion annually.

- A new medication to treat alcoholism, naltrexone, blocks both the craving for alcohol and the pleasure of getting high. Studies show that when combined with behavioral interventions, naltrexone allows as many as 75 percent of those being treated to avoid relapse, compared with fewer than 50 percent of those who receive counseling alone.

- Researchers funded by NIDA have successfully immunized rats against the psychostimulant effects of cocaine. These results open up the possibility of developing a vaccination against cocaine addiction.

- Recent research has expanded the array of available treatments for bipolar (manic-depressive) disorder to prevent recurrent episodes for 75 to 80 percent of individuals suffering from this condition. Lithium alone has been estimated to have saved the U.S. economy more than $145 billion since 1970. This is more than 200 times the entire current research budget for NIMH.

- The 1993 Report to Congress on "Health Care Reform for Americans with Severe Mental Illnesses" by the National Advisory Mental Health Council found that non-discriminatory coverage of treatment of severe mental illnesses provides compelling evidence that eliminating treatment "discrimination by diagnosis" against persons with mental illness yields society substantial benefits. As the Council reported, "The enormous but often hidden costs of untreated or undertreated severe mental illness, which are now borne by the general health care system and society at large, can be appreciably reduced."

- The National Advisory Council report demonstrates that psychiatric treatment reduces medical costs: "(C)ommensurate coverage for severe mental disorders can be expected to produce a 10% decrease in the use and cost of medical services for individuals with these conditions. The annual savings in indirect costs and general medical services would amount to approximately $8.7 billion . . . and would represent a net economic benefit for the nation of $2.2 billion annually."

III. Federal Policy and Medical Education and Residency Training:

Congress has repeatedly demonstrated its interest in restructuring Federal support for Graduate Medical Education. For example, various legislative versions of the Health Security Act (103rd Congress) generally proposed to require that 55 percent of medical residents be in approved primary care programs, and also that the number of residency slots would be subject to a cap, effectively limiting the supply of International Medical Graduates.

More recently, the 1995 budget reconciliation bill conference agreement included a number of provisions relevant to Federal support of Graduate Medical Education. These included:

- Establishment of a GME Trust Fund, funded both by the general Treasury, and by payments from Medicare.

- Reduction in Indirect Medical Education adjustments from the current 7.7% to: 6.7% in FY 1996; 6.0% in FY 1997-1998; 5.6% in FY 1999; and, 5.3% in FY 2000, 5.0% in FY 2001 and thereafter.

- Changes in Direct Medical Education payments included a reduction of the weighting factor for residents not in their initial residency period to 0.25 Full Time Equivalents for cost reporting periods beginning in FY 1998; capping of total payments for residents (but not the number of residents) in each year for FY 1996 through FY 2002 so that the total payments did not exceed the level which would have been paid for the number of residents in approved programs on August 1, 1995.

With respect to International Medical Graduates (IMGs), as you know, the House proposed to reduce residency payments for IMGs to .75% in FY 1996; .50% in FY 1997, and .25% in FY 1998 and thereafter. This provision was dropped by House and Senate conferees.

IV. Psychiatric Work Force Issues:

APA certainly understands the Federal interest in tightening controls over the overall physician supply, reducing a perceived oversupply of physician specialists, and encouraging greater numbers of primary care physicians. However, in order to ensure that the clinical needs of patients with mental illness are properly addressed, care should be taken in the move to training more primary care physicians to ensure that there is a sufficient supply of psychiatrists.

General Psychiatric Work Force

Epidemiologic studies, such as the Epidemiologic Cachement Area and National Comorbidity Survey indicate a high prevalence of mental illness, including substance abuse disorders. The ECA found a one-year prevalence to be as high as 28.1% of U.S. adults had a diagnosable mental illness. Severe mental illness affects 2.8% of the adult population, or about 5 million adults. Child data is less well developed, but studies suggest that about 12% will develop a diagnosable mental illness in any given year, with about 3.2% constituting severe mental illness.

The Report of the Graduate Medical Education National Advisory Committee (GMENAC) in 1980 found a clear shortage of psychiatrists, especially child psychiatrists. More recently, Abt Associates reexamined the 1980 GMENAC report using estimates based on the presumption that in any given year 7.1% of adults and 6.7% of children will have a mental illness requiring treatment by a mental health professional. The Abt study found that in 1990, national psychiatrist work force needs were 43-51,000. By 2010, the national work force needs would be 51-60,000. This compares with current APA membership of about 40,000.

It must be noted clearly that work force estimates are affected by a wide range of variables, not the least of which are the decisions which Congress -- and the national marketplace -- makes about the design of the health care system. Nevertheless, we believe the data clearly shows that psychiatry -- general, child and adolescent, and geriatric -- is in shortage. Accordingly, we believe that Congressional policy should be targeted to expand the current psychiatric work force, or, failing that, to at least ensure that current work force and residency levels are protected as resources are redirected to "primary care" specialties other than psychiatry.

In recent years, Federal studies have repeatedly highlighted the need to ensure an appropriate supply of psychiatric physicians. Both adult and child psychiatry have been targeted by the Council on Graduate Medical Education (COGME) as one of three medical specialties -- prevention medicine and general surgery were the other two specialties cited by COGME -- which should be "protected" against any reduction in residency slots as the nation moves towards the training of more generalists physicians.

The COGME report underscores the unmet need for psychiatric care in our country, that recent Federal initiatives do not address. Worse, the net result of primary care oriented only programs will only be to worsen this situation particularly among the nation's public health programs where needs with respect to mental illness are not being met with the current psychiatric physician work force, and projections indicate this situation will worsen under primary care oriented only health manpower initiatives.

In recognition of the need to address shortage physician specialties, the health reform proposal reported out of the Senate Labor and Human Resources Committee in the 103rd Congress, for example, included specific language "protecting" psychiatric residency training from any reductions due to that bill's mandate that 55 percent of all residents go into primary care (defined in the legislation as general internal medicine, family medicine, pediatrics, and obstetrics/gynecology).

We urge the Congress to support "protection" of certain shortage specialties in any attempt -- comprehensive or other changes in Medicare graduate medical education financing -- to require more medical residents to choose primary care training programs.

We emphasize there is to our knowledge no well-defined study on primary versus specialty patient needs generically or by site of service and with due regard for quality of care outcomes. Accordingly, meat axe proposals to address perceived overspecialization may unintentionally create or exacerbate shortages in needed specialties.

We believe that a more appropriate response to health manpower issues would be to expand opportunities to low-cost cognitive services in shortage, particularly emphasizing underserved geographic areas and public sector service (state hospitals, VA, etc.), rather than simply asserting a fixed policy that a specified percentage of all new physicians should be "primary care" (however defined).

Child and Adolescent Psychiatry

Our most precious resource is our children. More than 12 percent of this population (7.5 million children) suffer from mental disorders. We need to be better prepared to address their needs. Child and adolescent disorders (which include autism, major depression, attention deficit hyperactivity disorder, and other mood and anxiety disorders) can have a long-term, even life-long impact. Prompt, clinically effective medical interventions can have an immediate and long-term impact on mitigating the impact of mental illnesses in this special population. To do this, we need a robust work force.

The current number of fully-trained child and adolescent psychiatrists is estimated at 6,000. The 1980 Graduate Medical Education National Advisory Council (GMENAC) set the national requirements for child and adolescent psychiatrists in 1980 at 8,000 - 10,000, which was drastically scaled back from original justifiable estimates based on need for over 30,000.

The 1991 updated report on the country's physician workforce put the recommendations back to over 30,000. Under current Federal policy, there is little chance of reaching this goal in the near future. About 300 child and adolescent psychiatrists complete training each year. It will take forceful implementation of a wide range of legislative and regulatory policies to increase the number of child and adolescent psychiatry residents in the next few years. Congressional support for specialties in shortage is a critical policy area requiring attention when addressing capacity-building for accessible treatment for children and adolescents with mental illnesses.

Again, we agree that primary care providers are in shortage, and that this shortage should be addressed by Federal policy. However, we believe that it is a mistake for Congressional and other Federal policy leaders to assume that primary care providers are the *only* shortage specialty. Clearly, general, child and adolescent, and geriatric psychiatry are in shortage. Federal policy should stipulate that *shortage* specialties, not simply primary care specialties, be included in programs designed to increase their numbers.

Geriatric Psychiatry

The need for specialists in geriatric psychiatry is additional evidence of the danger of following the broad stroke recommendations from the Institute of Medicine and the Pew Commission. There are more than 35 million Americans over the age of 65. That number will more than double by the year 2030. More than 6 million elderly are likely to experience clinical depression. An additional 4 million suffer from Alzheimer's disease, the incidence of which increases with age, striking about 20% of persons over age 80. These patients, because of their age and their medical condition, have substantial comorbid psychiatric illnesses with associated disabilities and medical complications.

Geriatric psychiatrists play a major role in the treatment of elderly persons with late-life mental disorders. Care of these patients, including medical oversight of multidisciplinary care provided in various institutions, and treatment of their complex medical and mental problems, requires more time and expertise than primary care physicians can typically provide. Primary care physicians who have access to geriatric psychiatrists consider them to be a critical part of the health care team and rely heavily upon their expertise and services.

Currently, however, there are only 1,010 psychiatrists with added qualifications in geriatric psychiatry. Many parts of the country, particularly in rural and underserved urban areas, have no access to geriatric psychiatrists. Less than 75 individuals complete a geriatric psychiatry training fellowship each year. The shortage is acute and there is a great need to train additional geriatric psychiatrists both to provide clinical care and to perform the clinical research that has and will continue to greatly improve treatment options and quality of life for the elderly suffering from Alzheimer's disease, late-life depression, and other late-life mental disorders.

With respect to specific issues in Graduate Medical Education Reform, we support the efforts of the Congress to ensure that residency training in geriatrics is fully funded for two years beyond the first board eligibility or certification (5 years). It is our position that the exception is clearly applicable to geriatric psychiatry training, and indeed is further evidence of Congressional intent to protect geriatric psychiatry training. There is ample precedent for this. For example, Congress specifically references the inclusion of geriatric psychiatry under programs of the Public Health Service Act which fund the training of physicians who plan to teach. Further, programs in geriatrics are defined to include programs in geriatric psychiatry.

Public Psychiatry

Epidemiological data demonstrate that a significant percentage (2%-3%) of the United States population suffers from severe and persistent mental illness and perhaps ten times that number will suffer from a mental disorder during their lifetimes. Many of these individuals end up in the public health system due to the lack of adequate health insurance coverage. Consider the following:

- 12 million children suffer from some form of mental disorder and maternal alcohol abuse is the leading *preventable* cause of mental retardation in children.
- Severe mental disorders (i.e., schizophrenia, manic depressive illness, and severe forms of depression, panic disorder, and obsessive compulsive disorder) affect 2.8 percent of the adult population or approximately 5 million people.
- One third of the nation's homeless persons suffer from severe mental disorders.

- 30,000 Americans commit suicide each year. The suicide rate for the elderly is twice that for the general population. Suicide is the third leading cause of death for individuals between the ages of 15 and 24. Among adolescents, suicide has increased by 30 percent since 1950.

Public psychiatry (state mental hospitals, community health centers, forensic settings etc.) is an historically unique system of public care without a comparable system in general medical care. Recruitment and retention of physicians with training in psychiatry to work in these systems is critical, as our specialty provides primary care for the mental illnesses these patients suffer. There must be established federal incentives to address the critical needs of public psychiatry.

The Substance Abuse and Mental Health Services Administration has been expending federal financial resources to help recruit needed mental health providers in underserved areas. At the same time, these Health Research and Services Administration (HRSA) announcements send a contradictory message, creating another barrier to assure a sufficient supply of psychiatrists.

The Federal Government, and specifically HRSA, must address the public need for psychiatrist services, and certainly one approach is to include psychiatry as part of the proposed definition of residency training programs in primary health care. Failing this approach, we strongly urge HRSA to identify and list psychiatry as an exceptional shortage specialty to be treated in the same manner as the listed primary care specialties--family medicine, general internal medicine, general pediatrics, preventive medicine, and osteopathic medicine--so to fulfill an urgent need.

Instead, we find that psychiatry is excluded from the programs such as Primary Care Loan (PCL), Exceptional Financial Need (EFN), and Financial Assistance for Disadvantaged Health Professions Students (FADHPS) programs. This sends a negative message to medical students considering a psychiatry residency and to residency training programs in psychiatry. This is particularly troublesome as psychiatry as a medical specialty becomes ever more intimately involved in primary care medicine. The PCL, EFN and the FADHPS loan programs must be made available for those individuals choosing a residency program in psychiatry.

As the primary physician specialist that treats mental illness, our country needs to encourage the training and placement of psychiatrists to meet this public health need of our country. One approach for example, would be to improve recruitment into public psychiatry so psychiatry as a medical specialty can more effectively meet the needs of underserved populations. This could be accomplished through student loan programs that require a public service payback, similar to those in place for primary care.

International Medical Graduates

Most current proposals to "reform" Federal support for Graduate Medical Education would cap the number of residents at a fixed percentage of U.S. medical school graduates. Some proposals would further phase out or sharply reduce Federal payments for residents who are graduates of international medical schools.

While we understand the impetus to focus Federal dollars on "American" medical residents, we oppose efforts to curb Federal support for residency training programs which include International Medical Graduates. "IMGs" typically serve in inner city and remote rural hospitals which often have great difficulty in attracting U.S. medical graduates. Short-sighted proposals which would rapidly reduce Federal support for IMGs will most likely have a devastating impact on those areas of the country which are typically most in need.

IMGs are a robust cadre within the psychiatric work force, and represent an important source for meeting the nation's psychiatric work force requirements in the coming years. We urge the Congress to reconsider efforts to cut Federal support to medical residents simply because they are graduates of non-U.S. medical schools.

V. Conclusion:

In closing, the clinical needs of patients with mental illness can only be met with a sufficient supply of psychiatrists, who are the only physicians specifically trained in the diagnosis and treatment of mental illness, and the only "mental health" providers who are physicians. In order to assure a sufficient supply of psychiatric physicians, we recommend the following:

1. Psychiatric residency training slots should be "protected" against any reduction as the nation moves towards the training of more generalists physicians.

2. We oppose "meat axe" proposals which specify draconian shifts in support to unrealistic specified required percentages of medical residency training slots which must be designated for primary care.

3. We oppose targeting of International Medical Graduates for elimination of, or disproportionate reductions in, Federal support.

4. Health professions training programs must be established with incentives to address the critical needs of public psychiatry (i.e., state mental hospitals, community health centers, forensic settings, etc.) which historically have been unique systems of public care without a comparable system in the general medical care arena.

5. Federal loan programs for health professions and graduate medical education that are primary care in orientation such as those operated under the jurisdiction of HRSA or SAMHSA, should include shortage specialties such as psychiatry within their definition of eligible participants.

STATEMENT OF

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

April 26, 1996

RE: Graduate Medical Education

The American Society of Plastic and Reconstructive Surgeons (ASPRS) represents 97% of the nearly 5,000 board certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services which improve both the functional capacity and quality of life of our patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer.

ASPRS agrees with subcommittee Chairman Bill Thomas (R-CA), who has said that a "revolution is underway in health care which has significant implications for the future health manpower needs of the nation as well as the destiny of our major teaching hospitals." Health care reform that does not support and foster medical education will not be viable in the long run as the quality of any health system depends on the renewal of its work force.

Based on a 1994 study of the plastic surgery market and workforce, we learned that substantial increases in provider workforce are expected in the next 20 years, although many underserved areas will require a long time to attract a plastic surgeon.

Taking into account the study's findings, ASPRS adopted the following positions, which are now recommended for Congressional action:

1. Continue Federal Support for Graduate Medical Education

Federal support for graduate medical education must continue to ensure that the United States will maintain a well-trained and highly qualified physician workforce. In recent years, we have observed a trend toward lower payments by third-party payers to physicians and hospitals. As a result, teaching programs have become even more dependent on Medicare financial support and are less able to compensate for any funding shortfalls through payments they receive for services provided to non-Medicare patients. This problem is especially acute for specialties with longer training periods, such as plastic surgery, which already receives reduced financial support from Medicare beyond the first five years of training.

ASPRS opposes proposals that would further limit Medicare direct graduate medical education support to only the first three or four years of residency training. Specialities with longer training periods are as critical to the health care needs of our nation as those with the shortest training.

2. Require Third-Payer Participation in Funding Graduate Medical Education

Further, all third-party payers should participate explicitly and uniformly to the financing of graduate medical education. Provisions must be made for adequate transition payments for institutions that lose residency programs.

The shift of patient care from the inpatient to the outpatient setting justifies the encouragement of residency training programs to support training in outpatient settings including clinics, outpatient surgery facilities, and physician office settings. A method of appropriately and uniformly credentialing and financing outpatient training programs should be included in any reforms Congress will consider.

3. Provide Antitrust Relief for Workforce Planning

ASPRS supports antitrust relief designed to facilitate workforce planning activities by the medical profession, including residency program directors, residency review committees, and specialty societies.

Currently, antitrust laws put severe constraints on the ability of specialty societies and residency program directors to address effectively the issue of workforce planning. Absent appropriate changes in the antitrust laws, the medical profession may be unable to effect meaningful and timely change based on the findings from workforce research.

4. Conduct Workforce Planning on National Basis

Workforce planning in plastic surgery should be conducted on a national, rather than state or regional, basis. Due to the nature and size of the speciality of plastic surgery, workforce planning for the specialty is most appropriate at the national level. We do not support the concept of using academic consortia to determine physician workforce issues because, among other things, such a mechanism would likely lead to inconsistent decisions across various regions and could be dominated by special interests.

5. Limit Number of First-Year Residency Positions to 110% of Number of U.S. Medical Graduates

The number of first-year residency positions should be decreased so that they are more closely aligned with the number of graduates from U.S.-accredited schools. This position is consistent with the views of the Physician Payment Review Commission and the federal Council on Graduate Medical Education, and has been included in a number of previous legislative initiatives. Given the emerging problem of physician oversupply, Congress should strongly consider reducing the number of medical graduates who enter, train, and practice, while taking into account and accommodating the impact of any reductions on medical services to urban and underserved populations.

6. Allot Residency Positions Based on Program Quality

If the number of residency positions in any specialty needs to be reduced, the quality of the training program should be the primary determining factor in the allocation of slots. Determinations of quality should be left to the existing Residency Review Committees and the Accreditation Council of Graduate Medical Education system.

Conclusion

ASPRS gained a variety of valuable insights through its workforce study, although the Society's and the specialty's ability to utilize that information to make appropriate changes in plastic surgeon workforce supply is limited because of current antitrust prohibitions.

ASPRS appreciates the opportunity to testify on the topic of graduate medical education before the Subcommittee on Health, and would be happy to be a resource as the Subcommittee and full committee continues its work on this complex issue.

STATEMENT OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Recent analytic studies that project a substantial excess of physicians by the year 2000 raise serious questions for policymakers and the leaders in academic medicine on what implications this may have for the nation's health care system. While the Association of American Medical Colleges (AAMC) agrees that the United States may be on the verge of an oversupply of physicians, we caution against any precipitous action that could result in irreparable harm to the education and training of our nation's doctors. In order to reduce the rate of growth of practicing physicians, we need to focus attention on the number of first year residency training positions. The number of physicians entering practice each year is determined, not by the number graduating from U.S. allopathic and osteopathic medical schools, but by the number graduating from residency programs. By bringing the number of first year residency positions in the country more closely into alignment with the current number of graduates from accredited medical and osteopathic schools, we would take an important step toward curbing physician supply.

The AAMC has reached this conclusion and other conclusions regarding the appropriate number and mix of physicians and mechanisms necessary to support the education of physicians, after thorough and ongoing analysis throughout the past decade. Our efforts are briefly summarized as follows:

- In 1984, the AAMC formed the Committee on Financing Graduate Medical Education to consider contemporary issues related to the organization and financing of graduate medical education (GME) and the impact of the GME system on the size and specialty composition of the physician workforce. The committee's final report concluded that sufficient capacity existed in U.S. medical schools to educate an adequate number of physicians to meet the needs of the public. Based on this observation and the belief that medical school accreditation improved the quality of undergraduate medical education, the Committee recommended that, 1) Medicare funding for the direct costs of GME be limited to graduates of medical schools approved by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA), and 2) a nationwide private sector effort be made to collect and disseminate information on the supply of physicians by specialty, so that the public would be aware of the specialty balance in the physician workforce and medical students would be informed when making career choices.

- In 1987, the association appointed the Task Force on Physician Supply to explore in more detail certain physician supply issues. Its final report concluded that, 1) the size of the physician workforce would continue to increase to the year 2000 and beyond, and this increase would have serious consequences for the health care delivery system; 2) growth in the size of the physician workforce would likely contribute to continued escalation of health care costs, promote overutilization of physician services and other health care resources, and impede the ability of physicians to maintain their clinical skills; and 3) the projected supply of physicians eliminated any need for graduates of foreign medical schools to establish practices in the United States. The task force recommended that the AAMC develop the capability to provide information and advice to its members and others on matters affecting physician manpower.

- In 1992, the AAMC's Generalist Physician Task Force considered the matter of specialty imbalance within the physician workforce. Noting the declining interest of U.S. medical school graduates in careers in generalism, the task force recommended, 1) the AAMC advocate as an overall national goal that the majority of graduating medical students be committed to generalist careers; 2) appropriate efforts be made by all schools to promote interest in generalism among students so that the AAMC goal can be reached within the shortest possible time; and 3) the establishment of a continuous strategic planning process to formulate national policy governing the needs of the physician workforce and to monitor the impact of future changes in the health care delivery system on the need for physician services.

Results of the recent National Residency Matching Program indicate that U.S. medical school seniors are responding to informed counseling and the demands of the healthcare marketplace. For the second year in a row, more than half of graduating U.S. medical school seniors will begin their training in one of the generalist disciplines, while the number of students entering such specialities as anesthesiology and diagnostic radiology dropped significantly.

- In recent months, an AAMC Advisory Panel has reviewed the various policy positions adopted by the Association over time in order to ensure that the positions are consistent and contemporary. The Advisory Panel acknowledged the growing oversupply of physicians and recommended that, 1) the AAMC pursue initiatives to address this problem; and 2) first and foremost there needed to be a decrease in the number of first year residency positions in the country's GME system so that the number of first year positions is more closely aligned with the number of graduates from LCME and AOA accredited schools.

Given our concern about physician supply issues during the past decade, the association applauds the Institute of Medicine and the Pew Health Professions Commission for focusing the attention of opinion leaders and policy makers once again on a number of important physician workforce/medical education issues and for stimulating public debate on how these issues should be addressed. We reviewed the recent reports issued by the IOM and the Commission with considerable interest. Since the physicians entering the workforce each year are, for the most part, products of the educational programs conducted by the AAMC member institutions (allopathic medical schools and teaching hospitals) we feel a special responsibility to contribute to the public debate on physician workforce/medical education issues. In that context, the AAMC welcomes the opportunity to comment on the recent IOM and Pew Commission reports.

Overall, the AAMC endorses the conclusions reached by the IOM Committee on U.S. Physician Supply and the recommendations set forth by that Committee. In fact, several of the Committee's recommendations are consistent both with positions previously adopted by the AAMC and with many of our current activities . For example, the AAMC and IOM both call for a closer alignment of the number of entry level residency positions with the number of U.S. medical school graduates. Recognizing that this policy may have an adverse impact on hospitals that depend upon residents who have graduated from non U.S. accredited medical schools to provide care to the poor and disadvantaged, the association and the IOM have recommended that funding mechanisms be developed to ensure that these essential services are maintained. Similarly, the association has also recognized the need to provide information to medical students on career opportunities as an important means of creating better balance between the specialty mix of physicians being trained and the needs of the public for physician services. We are in the process of developing such a program. The AAMC is prepared to lend its support in establishing policies and programs to achieve the objectives embedded in our common recommendations.

With regard to the report of the Pew Health Professions Commission, the AAMC agrees with the Commission's position on a number of issues. We take strong exception, however, to the Commission's recommendation that U.S. medical schools be closed in order to decrease enrollments by 20 to 25 percent.

First, the AAMC believes the Commission has overreacted to recent analytic projections suggesting that the size of the physician workforce in the future will be excessive. The Commission's position is based solely on the results of analyses that use the physician staffing patterns of closed panel HMOs to project the number of physicians required to meet the needs of the population in the future. All available data suggest that growth in managed care enrollment in the future will occur almost exclusively in organizations which do not resemble closed panel HMOs. Since the physician staffing patterns of closed panel HMOs do not reflect the need for physicians in other organizational configurations, the results of analyses based on these patterns are inherently in error. In addition, changes in physician productivity and predictable increases in the disease burden within the population make it highly likely that there will be continued growth in the need for physician services over time. Because the assumptions that underlie projections of the future needs for physicians are subject to question, they should not be used as a rationale for the Commission's recommendations on decreasing medical school enrollments.

Equally important, the Commission fails to provide a logical and rational explanation for closing medical schools as opposed to downsizing class size as a means of decreasing medical school enrollments. Given the far reaching consequences of this recommendation, the Commission should have treated this issue much more seriously Simply asserting that medical schools are oversized educational institutions as a rationale for closing some schools reflects a fundamental lack of understanding of the diverse missions of medical schools and the varied roles they play in their parent

universities and in the communities in which they are located. The Commission's call for the closure of schools and the manner in which it is presented to the public devalues the contribution that these schools make to the education of biomedical scientists and other health professionals, and their core research, patient care, and community service activities.

We do applaud the Commission, however, for recommending the creation of a public- private payment pool for funding medical and other health professions education, a position that the AAMC has articulated on prior occasions. In fact, we have engaged the services of Health Policy Alternatives, Inc. to develop options for how this objective might be achieved. We find also the Commission's recommendation on training in generalism to be consistent with our position on this issue.

In summary, the AAMC believes it is important to monitor the impact of the market on professional opportunities for physicians. We are establishing processes to provide that information to medical students in a timely manner so they may make informed career choices. We have also made a significant commitment to monitor, analyze and project physician workforce requirements in response to changes occurring in the country's health care delivery system. While we agree that the country is on the verge of an oversupply of physicians, we caution against premature actions that would adversely affect the quality of health care in this country. The initial step in decreasing the rate of supply of practicing physicians should be to adopt policies to align the number of entry level positions available in residency programs more closely to the number of U.S. medical school graduates. We recognize that this is a difficult step to take. Such a course will require careful thought and review before we can move ahead. The AAMC stands ready to work with policymakers to achieve this objective, and we appreciate this opportunity to share our views.

Statement of

The Association of Surgical Technologists

On behalf of the Association of Surgical Technologists and the 50,000 Surgical Technologists we represent, we appreciate your interest in reforming Graduate Medical Education.

Originated during World War II, the Surgical Technologist profession was created in response to the need for highly trained specialized health care personnel for the operating room. From that important beginning, the profession has grown to meet the continuing need for well-educated, highly skilled individuals who can perform a variety of functions in the operative theartre. There are more than 50,000 Surgical Technologists practicing in every state providing high quality, cost-effective health care to millions of Americans.

There are currently over 165 accredited Surgical Technologist programs located throughout the United States. These programs are typically located at junior colleges, universities or hospitals. The core curriculum of the surgical technology program includes courses in anatomy, physiology, microbiology and pharmacology, as well as the principles of patient preparation, operative technique, surgical procedures and the principles of asepsis (maintaining a sterile field).

Surgical technologists commonly hold and pass surgical instruments, sponge or suction the operative site, connect drains and tubing and prepare specimens for subsequent pathologic analysis. In addition, surgical technologists are responsible for applying sterile, as well as applying non-sterile dressings following surgery. Finally, Mr. Chairman, and this is relevant to the topic of this hearing, the scope of the work of surgical technologists who have received additional specialized education has includes first assisting at surgery. Surgical Technologists functioning in the first assistant capacity has become particularly common in community hospitals where surgical residents are typically unavailable.

The Surgical Technologist profession is proud of it's long tradition of providing quality health services to the American people and we look forward to the future contributions Surgical Technologists will make to our health care delivery system.

As you and other members of the Health Subcommittee consider changes in the Medicare payment formulas for physician Graduate Medical Education, we urge you to recognize the direct and indirect effects these changes will have on other equally important health professions.

Both the Institute of Medicine and the Pew Commission have made important contributions to the public debate on the future of the health care delivery workforce. The IOM and Pew Commission reports highlight what many have recognized for some time: We are training far too many physician specialists and too few primary care physicians. In addition, both reports recognize that the health care delivery team is composed of more than just physicians and nurses. The Association of Surgical Technologists strongly supports the team approach to health care delivery.

While many have talked about a team approach to health care delivery, there has been little federal action to encourage this style of practice. In fact, the principle mechanism for paying for specialty physician Graduate Medical Education has actually discouraged a team approach when you look at the operating room.

Teaching hospitals have had a strong financial incentive to train more and more specialty physicians, regardless of whether there was a need for these physicians in the marketplace. By contrast, there has been little incentive for the hospital to train less costly personnel because the GME payment formulas discriminated against these providers.

Beyond having little incentive to train non-physician practitioners, teaching hospitals have had little incentive to utilize specially trained non-physicians to perform services in lieu of residents. This bias occurs because payment formulas discouraged utilization of anyone other than a resident to perform surgical first assisting services.

But eliminating or moderating the adverse financial incentives in the current Medicare physician graduate medical education program, as proposed by the IOM and the Pew Commission, is not enough. The reality is that many teaching hospitals have become dependent upon physician residents not simply because of the additional revenue they generate through GME payments, but also because residents are an integral part of the hospital's workforce. Thus, eliminating or reducing GME payments will not only have an impact on the hospitals revenues, it will also result in the loss of an important part of the workforce.

It is critical, therefore, Mr. Chairman, that in considering changes to the physician graduate medical education program along the lines contemplated by the IOM and the Pew Commission report, that this Committee also consider what the hospital workforce post-GME reform can or should look like.

Who will provide the care previously provided by physician Residents?

How will hospitals pay for the personnel who will be needed to replace lost residents?

Will there be sufficient numbers of personnel who can function as resident substitutes?

What can be done to ensure that the future mix of health professionals is appropriate to the needs of the market?

These are just a few of the questions this Committee must be prepared to address.

Some have suggested, Mr. Chairman, that the federal government should simply let the market make health workforce decisions. Afterall, the argument goes, the federal government does not get directly involved in other workforce issues. The federal government does not determine how many engineers are needed, it doesn't get involved in the education of lawyers or physicists. Typically, the supply of these professionals is determined by the marketplace. Why should healthcare be different?

Healthcare, however, is different, Mr. Chairman.

It is different because the government is the single largest purchaser of healthcare in this country. Whether through Medicare, Medicaid or the VA system, the government exerts unprecedented control on the health care workforce. So unlike other areas of the economy where the government can take a laissez-faire approach, this cannot occur in healthcare.

Because of this unprecedented impact, the Congress must act diligently to ensure that in making changes in physician workforce it does not inadvertently harm other health professions. In fact, we believe the federal government has a vested interest in promoting a more cost-effective workforce.

Given the education, training, and job experience of surgical technologists, we anticipate that CSTs will be called upon to perform many of the functions previously performed by surgical residents. In a neutral environment, we believe that hospitals, faced with the prospect of having to replace lost residents, would often choose specially trained surgical technologists to substitute for lost residents.

This would not occur, however, if whatever replaces the existing system were to perpetuate inappropriate incentives to utilize one type of provider over another or to train one type of provider over another.

Consider, for example, the way Medicare pays for assisting at surgery.

Medicare Part B recognizes physicians and physician assistants for coverage as assistants at surgery. Resident physicians commonly function as first assistants at surgery as part of their training. However, their services are not reimbursed separately by Medicare Part B. Rather, payment for this is included in the hospitals GME payments.

If, as a result of changes in Medicare GME, hospitals lose surgical residents, it will be necessary for the institution to find someone to replace that lost resident. It would not be surprising, given current Medicare Part B policy, if the hospital chose to use a physician or physician assistant to substitute for the lost resident.

However, Mr. Chairman, if the decision on who to use were made exclusively on a clinical basis, it would be reasonable to assume that some teaching hospital would consider using a surgical technologist. Unfortunately, the failure of Medicare to recognize practitioners other than physicians and PAs results in a bias towards those providers, even though the hospital might find it more cost-effective to utilize someone other than a physician or PA.

We hope you share our belief that there is a role for surgical technologists as part of the health care delivery team and that you consider the impact changes in physician graduate medical education payments will have on other health professions as you consider alternatives to the current system.

You should not consider changes in GME in a vacuum. Changes in physician graduate medical education must be reviewed with the impact on the training of other health professionals, as well as possible changes in payment policy so as to recognize other health professionals.

The Association of Surgical Technologists believes that it is important to permit Medicare dollars to be used for the training of health professionals other than physicians and Medicare Part B payment policy should be modified to recognize the broad array of providers who can function as physician/resident substitutes.

Let the market decide who is the most cost-effective, highest quality provider of health care services.



April 30, 1996

Phillip D. Moseley, Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington DC 20515

Dear Mr. Moseley:

I am writing in regards to the request for information on the issue of the future needs in the area of health professions training and the financing of graduate medical education. This letter is being submitted for consideration by the Committee on Ways and Means as it deliberates the above issues, in conjunction with the hearing that occurred on April 16, 1996.

Background

Munson Medical Center (Munson) is a 368-bed acute care hospital located in Traverse City, Michigan. Munson merged with Traverse City Community Hospital on April 1, 1995, and, in so doing, became the sole community hospital in Grand Traverse County. Munson is in the process of enhancing the Family Practice Residency program that was in existence at Traverse City Community Hospital when the two hospitals merged. (Munson did not have a residency program at the time of merger.) Since Munson has had ownership and responsibility, we have received approval as one of the few combined Allopathic-Osteopathic residency programs in the country. This primary care residency program is the only program located between the cities of Midland and Marquette, Michigan, a distance of 370 miles.

Problem Issue

One of the proposed Medicare payment reductions discussed in the 1996 budget talks would restrict the number of full-time equivalent residents to the number in a hospital's residence program as of July 1, 1995. Munson had five (5) residents in its program on

1105 Sixth Street
Traverse City, Michigan 49684-2386
(616) 935-5000

July 1, 1995. As previously mentioned, approval as a combined Allopathic-Osteopathic program has been received, and Munson is currently constructing a primary care and education center that will house fifteen (15) residents by as early as July, 1997. This center will serve residents in Northern Michigan who may not currently have access to a primary care physician.

Medicare provides approximately 50% of the funding for graduate medical education at Munson. Restricting the number of covered residents to five (5), rather than the planned number of fifteen (15), would reduce Medicare's participation in funding Munson's Family Practice Residency Program by 67%, and, therefore, means that funding in total for the program would be reduced by 33%. With other proposed reductions to the hospital operating budget, a reduction of this magnitude would have a devastating effect on the Residency's ability to continue to operate and provide primary care physicians for Northern Michigan.

Proposed Consideration

We understand a proposal is being considered that would create a new Graduate Medical Education and Teaching Hospital Trust Fund to make annual distributions to teaching hospitals. We are asking that any limit on the number of covered full-time equivalent residents proposed under a Trust Fund concept not be applied to those programs that are primary care based, especially those located in rural areas.

Thank you for the opportunity to respond. If you have any questions regarding my comments, please feel free to call me at 616-935-6512.

Sincerely,

Edward B Carlson

Edward B. Carlson
Senior Vice President and
Chief Financial Officer

EBC:pma

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George K. Michalopoulos, MD, PhD
Chairman of Pathology and
Interim Dean

April 30, 1996

Phillip D. Moseley
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Moseley:

On behalf of the University of Pittsburgh Medical Center and the University of Pittsburgh School of Medicine, I wish to submit written testimony for the record of the House Ways and Means Health Subcommittee's hearing of April 16, 1996, on recommendations on the future national needs in health professions training and the financing of graduate medical education (GME). We are reviewing with great interest the reports of the Pew Health Professions Commission and the Institute of Medicine Committee on U.S. Physician Supply.

The University of Pittsburgh has made a significant commitment to health professions training and undergraduate and graduate medical education through the programs of our six Schools of the Health Sciences: Medicine, Nursing, Pharmacy, Dental Medicine, Health and Rehabilitation Sciences, and Graduate School of Public Health. The University of Pittsburgh Medical Center, through graduate medical education programs at Presbyterian University Hospital, Montefiore University Hospital, Eye and Ear Institute and Pavilion, Western Psychiatric Institute and Clinic, and the University of Pittsburgh Cancer Institute, provides residency and fellowship training for approximately 950 residents and fellows.

We are committed to a sound, rigorous, state-of-the-art training program for medical and health personnel. At the same time, we are realistic about the increased need for primary care specialists, the national concern about a surfeit of medical specialists, the geographic maldistribution of physicians to meet patient needs, the strong federal budget pressures to reduce the Medicare components for GME in order to reduce the deficit and balance the federal budget, and the significant impact of managed care on GME and health delivery in general.

We are not so unrealistic or short-sighted as to suggest that the status quo should be maintained for graduate medical education. However, we strongly urge the Subcommittee members to act cautiously in recommending GME changes that may have unanticipated consequences for the health care of Americans, particularly the poor and disadvantaged, and for the appropriate supply of physicians now and in the future. The impact of managed care on health care providers and its implications for GME are continuing influences, the results of which are not clearly known at this time. Changes in the health care market place--WITHOUT ANY FORCED ADJUSTMENTS IN PHYSICIAN SUPPLY--have already caused an increase in the number of medical school graduates entering primary care areas, a sharp decline in the number of graduates entering "surplus" specialties (e.g. anesthesiology and radiology), revamping of medical schools' curricula, a revisiting by medical

schools of the number of students admitted, and review by the specialty boards of the national number of residency positions.

Whether market forces will exert a strong enough effect on graduate medical education remains to be seen, but the preliminary evidence indicates that trends are occurring in the same directions being considered for change.

In general, we endorse the conclusions reached by the Institute of Medicine Committee on U.S. Physician Supply and the Committee's recommendations.

We support the following positions:

1. We believe there should be a closer alignment of the number of entry level residency positions with the number of U.S. medical school graduates. However, there must be replacement funding mechanisms available to assist those teaching hospitals which heavily rely on residents for providing care to their patient communities. Changes in the number of residency slots should be made gradually so as to avoid the disruption of critical medical services at these facilities.

2. We believe that downsizing the number of undergraduate medical school spaces may also be advisable and that medical schools should voluntarily agree to maintain their current class size or decrease it. Strong incentives should be in place to discourage the development of any new allopathic or osteopathic schools of medicine, unless some well-supported justification exists.

We do not support the closure of U.S. medical schools in order to decrease enrollments by 20-25 percent. Such a move would be precipitous and arbitrary and could be proven unnecessary if current market trends continue.

3. We believe that accurate and comprehensive data should be collected and made available by the Department of Health and Human Services (through the Health Resources and Services Administration, the Agency for Health Care Policy and Research, and the Health Care Financing Administration) on physician supply and requirements.

4. Current federal government Medicare funding policies related to GME should be reformed, particularly in light of the increasing role of managed care providers in covering the health care of Medicare beneficiaries. The inclusion of GME components in the adjusted average per capita cost payments (AAPCC) to managed care entities is undesirable and unacceptable, unless the entities actually incur the cost of educating the medical graduates. The fact that managed care companies profit from the mission-related GME components of the AAPCC, without any commensurate educational obligation themselves or any responsibility to pass through the GME components to the providers of GME is not reasonable or fair. The federal government should not be providing compensation to managed care companies for education, if the companies are not providing the education.

5 Related to the point above, we believe there should be a carve-out of the educational component of the AAPCC so that the educational funds are paid to the institutions actually providing the educational experience and incurring the educational costs.

6. If GME funding is removed from the Medicare program, we support an all-payer fund for GME that would be accessed by GME providers according to the quality and size of their GME programs as of a specific date. The outstanding quality of medical care in this country resulting from the quality of undergraduate and graduate medical programs, which inures to the benefit of American citizens and to the financial benefit of all health care providers, including managed care organizations, must be maintained. Market pressures on teaching hospitals increasingly jeopardize their ability to provide high quality programs.

We are at a critical juncture in the history of our national health care policy where difficult choices must be made with respect to allocating Medicare dollars and to administering our nation's medical training programs. The choices we make will reflect how much we as a nation value the excellent health care system we have developed over the years. We hope the decisions will not irreparably harm the future health care of Americans so as to meet short-term objectives.

Thank you for this opportunity to submit this statement for the hearing record. I would be pleased to speak with you in more detail about these issues.

Very truly yours,

George Michalopoulos, M.D.
Dean

cc: Dr. Thomas Detre
Mr. Jeffrey A. Romoff

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LONG-TERM CARE OPTIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

APRIL 18, 1996

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LONG-TERM CARE OPTIONS

THURSDAY, APRIL 18, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in room 1100, Longworth House Office Building, Hon. William M. Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 9, 1996
No. HL-17

CONTACT: (202) 225-3943

Thomas Announces Hearing On Long-Term Care Options

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on long-term care options. **The hearing will take place on Thursday, April 18, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

Legislation was passed in 1983 authorizing the Health Care Financing Administration (HCFA) to establish the first demonstration of the Program of All-Inclusive Care for the Elderly (PACE). This demonstration program was initially developed by On-Lok, Inc., a community-based, long-term care program in San Francisco. In 1986, legislation was passed to replicate this model of integrating acute and long-term care services. PACE programs assume full responsibility for providing their enrollees a comprehensive package of medical and long-term care services, including primary and specialty medical care, adult day health care, home care, physical and occupational therapies, and inpatient nursing home, if necessary. Currently, On-Lok and 10 replication programs serve 2,200 frail, elderly enrollees, and 27 other States have expressed interest in setting up programs. Congress has expanded and extended the program three times since its inception. In 1994, total Medicare and Medicaid reimbursements to PACE programs were $23 million and $51 million, respectively.

The Social Health Maintenance Organization (SHMO) is a public-private health care model that integrates acute care and long-term care services for senior citizens. These SHMO's pool premiums from Medicare, Medicaid, and members to create prepaid, managed health and long-term care systems that are competitive in the Medicare supplement market. These organizations combine primary care services with expanded coverage for community-based long-term care designed to keep functionally impaired older people living at home as long as possible.

HCFA originally selected four organizations as the original demonstration sites in 1984, and they began operating in 1985. More than 50,000 seniors have been served by the program. Congress has extended the demonstration program three times with the latest action extending the program until 1997.

FOCUS OF THE HEARING:

The hearing will focus on these two integrated acute and long-term care models and explore how these two approaches can be expanded to increase choices for Medicare beneficiaries.

(MORE)

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DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, May 2, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

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Chairman THOMAS. The Subcommittee will come to order, please. Today's hearing highlights efforts under Medicare and Medicaid to find ways to remedy problems resulting from divisions between acute and long-term care. These innovative remedies work by bringing these two sectors together in a single, integrated system. While the best known of these demonstration projects are On Lok and its program of all-inclusive care for the elderly called PACE and the social health maintenance organizations, Social HMOs or SHMOs, there are at least a dozen other initiatives underway or in the planning stage.

This hearing will focus on the experiences of the PACE and the Social HMO programs primarily. In addition, we will also hear testimony on other creative alternatives that are being demonstrated across the country. These integrated models of Medicare beneficiaries' additional options for receiving medical care under the Medicare Program create a public/private partnership that offers quality care at potentially lower costs for an increasingly frail elderly population.

We should explore these integrated acute and long-term care models to determine how they would fit into the Medicare Plus structure included in legislation passed by the Congress and provide increased private-sector choices for our Medicare beneficiaries.

I had the pleasure of meeting Jennie Chin Hansen, executive director of On Lok, in my district office in Bakersfield earlier this year. I was very impressed with the success On Lok has achieved in caring for the frail elderly at home and in the community as an alternative to nursing homes, and I in particular look forward to her testimony today. I would just say parenthetically, we could have held this as a field hearing in California and have gotten a pretty good cross section of most of the programs that are going today.

I might add that Senate Majority Leader Dole, who would be with us this morning as our initial witness were he not at a press conference over on the Senate side, is a strong advocate of the On Lok and PACE programs and has introduced legislation, Senate bill 990, to expand the program beyond the current 11 sites and to make the demonstration program permanent within the Medicare Program. This may be an area where the administration and Congress can find some common ground.

It is also important to highlight the Social HMO program as an additional option for Medicare beneficiaries. It is currently a smaller program than PACE, with only three sites up and running. However, such additional sites are in the planning stages.

As our population continues to age, we will need to pursue additional delivery and financial options for providing medical and personal care services at home and in the community, not only for cost savings but for increasing the quality of life of our most vulnerable Medicare population. Today, I am confident we will receive new insights into the lessons learned and greater potential of these private-sector options.

At this time, I yield to the gentleman from California, Mr. Stark, Ranking Member.

Mr. STARK. Mr. Chairman, thank you for calling attention to these alternative methods of care for American people. I wish ev-

eryone in America could participate in a Social HMO or a PACE-type program. I think we could pass an extension of these programs on the suspension calendar.

We do not legislate in vacuums, and I would be interested in hearing Dr. Vladeck talk to us about the realities of Medicare changes that would remove guarantees for low-income seniors or Medicaid and weaken nursing home quality if the Social HMOs or PACEs can make up for that. But we have a program proposed that will turn Medicare into a program where providers are able to charge seniors extra for the basic Medicare benefits. What good does it do them? Can Social HMOs and PACEs make up for the harm that is being done to the Medicaid and Medicare Programs with a few demonstration projects?

My guess is that the net result of the actions of this Committee this year will be harmful to seniors. I wish that indeed, programs like On Lok, which is about to expand, I understand, into my district will continue. It seems somewhat disingenuous, however, and I hope that Dr. Vladeck can explain to us that on the one hand, we can help with a few modest programs like On Lok, yet we make huge cuts in the increase in revenues needed to run a Medicare Program. It is even more difficult when we destroy a Medicaid Program and nursing home quality standards, which are so vital to the health of seniors.

Thank you, Mr. Chairman.

Chairman THOMAS. Well, we almost made it to you, Bruce, in a bipartisan way. Nice to have you with us. I look forward to your testimony.

STATEMENT OF HON. BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman, Mr. Stark, Members of the Subcommittee. I am really particularly pleased to be here to discuss the development of new models of comprehensive care for the frail elderly. It is an issue that has been close to my heart for many years and one in which I have been professionally involved for many years. In fact, I am pleased to count myself among the earlier admirers of On Lok, having first visited the program in 1977 and having helped arrange some of their first national foundation funding.

I want to talk today about the program that we have built on top of the On Lok example, the PACE program or Program of All-Inclusive Care for the Elderly and the social health maintenance organization projects or SHMOs, as well as some of the other things that we are either doing or are in development. We are putting in place building blocks for high-quality, locally-sensitive, customer-oriented, community-based services for those in need of long term care and for better integrating acute and long-term care in Medicare and Medicaid financing.

Before talking specifically about PACE and SHMOs, however, let me just very quickly point out that we are in the midst of a transformation of our long-term care system that has been going on for more than a decade now, increasingly reflecting the preference of clients and their families to receive services at home whenever possible. And while the distribution of services is probably still more

heavily oriented toward an institutional side than many bene ficiaries and advocates would like, in fact, most of the growth i services over the last decade has been on the community-base side.

We are running an average daily census now of a quarter of million frail elderly people in Medicaid home- and community based waiver programs. The Medicare home health benefit is nov providing increasingly long-term care services to more than 2 mil lion beneficiaries a year. For those benefits, the issues of integra tion continue to be significant, but we are building a base in term of a community services infrastructure that will be important as w move forward in the development of more comprehensive service in the future.

HCFA's relationship to the PACE program goes back to 1979 when we first funded On Lok as the model program for providin health, nutritional and recreational case management services t frail elderly adults based upon an adult day care program. On Lo has always been committed to the integration of both financing an of acute and long-term care services, and we have been in the busi ness of supporting On Lok, first through grant funds, and throug waivers of different program requirements ever since.

Now, the PACE program was designed to replicate the On Lo model to specifically target frail elderly persons who are eligible fo nursing home care by reason of the degree of their medical and so cial needs, but who prefer to remain in the community. It is a full capitated program in which all covered services are provide through a single organization or a single provider of care, includin not only the long-term care services and inpatient hospitalizatio but physician services, therapies, prescription drugs and equipmen as well. And while the PACE programs seek to discourage the us of nursing home care, when their enrollees need nursing hom care, PACE also pays for that service.

We currently have about 2,700 enrollees in these programs, i On Lok and 10 additional PACE sites. We have as many as 45 o 50 additional organizations in the process of developing such sites Basically, we pay them the Medicare capitation rate, established a 2.39 times the basic AAPCC in the community for Medicaid. PAC then negotiates capitation rates with each of the states in which i operates, and we have a series of waivers of our HMO require ments, to permit them to operate in such a capitated environment

We have not completed our formal evaluation yet, but we hav done a number of studies, both of quality of care and of custome satisfaction with the PACE programs, and both are quite high. W continue to work on some of the issues of appropriate financin mechanisms and longer term requirements. We have been in th business of SHMOs since 1984, when Congress mandated a test o this notion. Again, the idea was that one could save money and im prove services by providing both the full range of Medicare acut benefits and long-term care benefits through a single, capitated or ganization. SHMOs, as opposed to the PACE program, seek to en roll a cross section of elderly Medicare beneficiaries in their com munities, and while they have relationships with the Medicai Program, they also have a significantly higher proportion of pa tients who are paying additional premiums from private resources

As opposed to PACE, the long-term care benefits in the SHMO programs are generally capped at some dollar maximum and are somewhat more limited in scope. We have had extensive evaluations of the first generation of SHMOs. I think they show very high levels of customer satisfaction, good to excellent levels of quality of care and somewhat equivocal results on cost savings having to do with differences between the SHMOs themselves and over time in the course of the life cycle of any particular SHMO.

In response to the evaluation of the first generation, Congress authorized an extension and established a second generation, which we refer to as SHMO II. We have awarded grants to six organizations to develop SHMO II, delivery systems. The major difference with SHMO I in that regard will be a significantly higher emphasis on geriatric medicine and geriatric case management as the heart of the integration of the acute and long-term care services package.

We are aware of Senator Dole's bill. In fact, the President's balanced budget recommendations for this year contain very similar legislative provisions. There are some differences between what the President has supported and what Senator Dole has proposed, and we think all of them are quite resoluble. Ms. Hansen will speak about some of the specifics of the proposed legislation in her testimony, and we would very much support the enactment of legislation this year to expand and make permanent the PACE benefit as a benefit in the Medicare Program.

We would also support continued extension of the SHMO demonstrations, both the first and second generation projects, which are now set to expire at the end of 1996. But frankly, the broader expansion of the SHMO needs to be connected to and coordinated with other changes that are going on in Medicare and managed care more generally. We believe that if we had the kind of risk adjusters in which we are investing so much time and energy, and some of the other new developments in terms of the choices Medicare beneficiaries have and the way in which supplemental benefits are priced, much of what is now provided through SHMO demonstrations could be provided through existing risk contract statutes, as modified according to some of the President's proposal. It is not clear to us which is the better way to go in that regard.

So, since the existing SHMOs are doing a good job and have happy customers, and we are just starting with the second generation, we would support extension of the demonstration authority pending broader congressional action on changes in Medicare managed care legislation.

In my written testimony—and in the interests of time, I will not go through it—we identify another 8 or 10 initiatives that we are taking to deal with this integration of acute and long-term care under Medicare and Medicaid. I am happy to answer questions about any of them or about any of this testimony. But let me say, just by way of summary, that while it has taken quite awhile, we detect considerable progress in understanding how to provide higher quality, more satisfactory services to the frailest of our beneficiaries in a way that, at worst, is no more expensive than the existing benefit structure. We are committed to continuing to expand our demonstration and research efforts, but we believe we know

enough already to make the PACE model a permanent part of the Medicare Program. We will draw on what we have already learned about SHMOs as we seek to refine the legislative base of Medicare and managed care going forward.

Again, I appreciate the opportunity to share our views on these subjects with you, and, of course, I am happy to answer any questions you might have, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF
BRUCE C. VLADECK, ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, it is a pleasure to appear before you today to discuss an issue close to my heart: the development of new models of comprehensive care for the frail elderly. Specifically, I have been asked to talk about two important demonstration projects in which HCFA has invested years of thought and effort: the Program of All-inclusive Care for the Elderly (PACE) and the Social Health Maintenance Organization (S/HMO) projects. These two projects provide, we believe, important initial building blocks in our effort to develop high quality, locally sensitive, customer-oriented, community-based services for those in need of long-term care.

It is important to begin by talking for just a moment about community-based long-term care. Both PACE and S/HMO emphasize home and community-based services. Most beneficiaries and their families greatly prefer home and community-based care to institutional care, and we want to continue to explore how to best serve their needs. We have come a long way since the early 1970s, when home and community-based care was a fairly new idea and was considered largely as a way to reduce the length of hospital stays or as an alternative to institutionalization in a nursing home.

Today, Medicare and Medicaid each provide substantial amounts of home and community-based care. More than 250,000 people receive long-term care services in a home or community setting under Medicaid's home and community services waiver program alone. More than 2.5 million beneficiaries annually receive services through Medicare's home health benefit. Because of the breadth of services and the capitated payment approaches of the PACE and S/HMO programs, these programs differ from standard home health benefits of Medicare and Medicaid. Both PACE and S/HMO emphasize reducing the burden on informal caregivers, improving social and psychological well-being, improving health status and functional independence, and increasing longevity. Our experiences with the PACE and S/HMO programs are providing us with important information about how best to provide integrated acute and long-term care.

INTEGRATION

Integration of services is very important for the estimated five to six million individuals who are eligible for both Medicare and Medicaid. Many of these "dual eligibles" have multidimensional, interdependent and chronic health care needs. However, as currently structured, the Medicare and Medicaid programs are not sufficiently coordinated to serve many of these complex health needs.

Because the financing, administration, and delivery systems are fragmented, services are often duplicated and access to care can be limited. Further, since care is financed from different funding sources, there are insufficient incentives to integrate services. For example, increased emphasis on rehabilitation in the acute setting might reduce long-term care spending, but Medicare

providers do not have appropriate incentives to invest resources that could save Medicaid money.

Integrating acute and long-term care involves coordinating and integrating the Medicare and Medicaid benefits. Integration and coordination should address both financing and service delivery. Integration of financing involves the pooling of funding from Medicare and Medicaid into a single funding stream. Current managed care models attempt to integrate services using capitated payments to providers, which gives managed care organizations flexibility to tailor benefits to the distinct needs of each beneficiary. However, integration of funding sources alone does not ensure integration of services. Today, various managed care plans coordinate the delivery of acute and long-term care services to differing degrees. Some plans simply facilitate patient transitions between the acute and long-term care settings. Others, such as the PACE demonstration, employ a multidisciplinary team of professionals who work together to manage both medical and social services across the acute and long-term care settings.

The goal of the PACE and the S/HMOs projects is to reduce fragmentation of services, contain costs, and effectively integrate acute and long-term care into a single, seamless system. Funds are combined into a common pool from which providers pay health care expenses. In S/HMOs, providers receive funds mostly from Medicare, although they also receive some Medicaid and private insurance funds. In PACE, providers receive funding from Medicare, Medicaid, and private insurance.

OVERVIEW OF PACE

In 1979, HCFA funded a three-year grant to On Lok, a program based in San Francisco, California, which provides health, nutritional, and recreational services to frail older adults in a day-care setting. On Lok also integrates the provision and financing of medical and long-term care services. Since the initial grant award, HCFA has supported On Lok through waivers for the past 16 years. On Lok is unique because it accepts only those ill enough to be eligible for nursing home care. Medicare and Medicaid pay all of the costs of care, and participants are assigned to an interdisciplinary team that meets regularly to assess their needs and assure that they receive the full range of needed services. This might include anything from housing to medical supplies to a microwave oven for someone who can no longer use a gas oven safely.

PACE is an outgrowth of On Lok. It was authorized by Congress in the Omnibus Budget Reconciliation Act of 1986. PACE was established partly as a result of the success of the On Lok program, but the PACE program is separate from On Lok. Each of the current ten nationwide PACE sites is reviewed at least annually. PACE sites continue to operate under the Secretary's discretionary authority.

PACE specifically targets frail elderly persons eligible for nursing home care, but who are living in the community. PACE seeks to help individuals continue to live at home and not in a nursing home facility. PACE integrates social and medical services through adult day health care. It uses a multidisciplinary team approach, with care provided by physicians, nurses, social workers,

nutritionists, occupational and speech therapists, and health and transportation workers. Through preventative and rehabilitative services, participants' chronic conditions can be stabilized and medical complications prevented. Community living is usually the overwhelming choice of participants. However, should nursing home placement become necessary, PACE also provides that service. PACE enrollees receive all health services through PACE, including physician services, hospitalization, therapies, pharmaceuticals, and equipment.

Currently, there are approximately 2,700 enrollees who participate in the ten PACE sites and On Lok. As many as 48 additional organizations are in various stages of developing PACE sites. The ten operating PACE sites are in the following locations.

- East Boston, Massachusetts;
- Portland, Oregon;
- Columbia, South Carolina;
- Milwaukee, Wisconsin;
- Denver, Colorado;
- El Paso, Texas;
- Bronx, New York;
- Rochester, New York;
- Oakland, California; and
- Sacramento, California.

An additional noteworthy characteristic of PACE is the way in which it has responded to the diversity of populations in need of services. The ethnic and racial distribution of beneficiaries served reflects the communities from which PACE draws its participants. From January 1993 through December 1993, of the beneficiaries served in the PACE program:

38 percent were Caucasian,
28 percent were African-American,
20 percent were Hispanic-American, and
13 percent were Asian-American.

PACE FINANCING

PACE providers receive a fixed monthly fee for each participant. This fee is set to account for the frailty of PACE enrollees, but it does not vary based on the degree of frailty or the services used by the individual participant. PACE providers receive most of their financial support from Medicaid and are paid on a capitation basis. The Medicaid capitation rate is determined by the rate-setting methodology of the state in which PACE operates.

Medicare, Medicaid and private insurance funds are pooled to achieve maximum efficiency and flexibility in the use of resources. The Adjusted Average Per Capita Cost (AAPCC) methodology

used by Medicare to pay for at-risk health maintenance organizations is modified for Medicare capitation payments in PACE. The basic AAPCC rate is multiplied by a "frailty adjustment" of 2.39 to reflect the costs Medicare would bear in caring for the frail elderly in the fee-for-service system.

In order to protect against unanticipated costs, unanticipated disenrollment rates, and the unavailability of stop-loss insurance coverage, PACE demonstration sites share risk with Medicare and Medicaid. During the first three years of operation, sites assume progressively increasing risk, and at the start of the fourth year assume full risk. Currently, special demonstration waivers permit the integration of Medicare and Medicaid funds.

PERFORMANCE OF PACE

A preliminary evaluation of PACE should be available later this year. State participation in PACE is voluntary, and continued states have shown a great deal of interest in continuing their participation. Based on enrollees' low disenrollment rates, enrollees appear satisfied with PACE: the combined rate of voluntary and involuntary disenrollment from PACE is considerably lower than the voluntary rate of disenrollment from other Medicare risk-based health plans. Other states are interested in developing their own demonstration sites.

PACE SHOULD BE MADE PERMANENT

Based on our current knowledge of the success of PACE, we recommend that PACE be shifted from a demonstration project to a permanent program. We support legislation, such as the PACE provision included in the President's Balanced Budget Initiative for Fiscal 1997, to accomplish this goal. Under the President's plan, providers would be monitored closely, while progressively assuming full risk. The President's plan permits the Secretary to continue to set Medicare payments to ensure budget neutrality. We recommend that the budget neutrality language be retained. The President's proposal is supported by both On Lok and the National PACE Association.

OVERVIEW OF S/HMOs

HCFA's Social Health Maintenance Organization demonstrations were established by Congress in 1984 to test whether investing in some long-term care benefits for Medicare HMO enrollees could save money through coordinating care and providing services that might prevent more costly medical complications. The S/HMO demonstrations have provided standard HMO benefits, such as hospital, physician, skilled nursing home, and home health services, together with limited long-term care benefits to Medicare beneficiaries who voluntarily enroll. In addition, expanded benefits, such as eye glasses and prescription drugs, are available. S/HMOs enroll a cross-section of the elderly living in the community. S/HMOs' services range from community-based care to institutional nursing home care. Services provided include personal care aides, homemakers,

medical transportation, adult day health care, respite care, and case management in a community setting.

The S/HMOs program provides more limited long-term care benefits than PACE. S/HMO have a yearly dollar cap for the long-term care benefit, whereas PACE does not have such a cap. Financing is through prepaid capitation, by pooling funds from Medicare, Medicaid, and member premiums and copayments. The level of the beneficiary premium payments vary by site. Benefits and capitation payments vary by state; S/HMOs negotiate independently with respective states to determine financing and benefits.

In 1985, S/HMO projects became operational at the following four sites:

- Kaiser Permanente Northwest established Medicare Plus II in Portland, Oregon;
- Group Health and Ebenezer Society established Seniors Plus in Minneapolis-St. Paul, Minnesota;
- Metropolitan Jewish Geriatric Center established Elderplan in Brooklyn, New York; and
- Senior Health Action Network established SCAN Health Plan in Long Beach, California.

However, in January 1995, the Minneapolis site withdrew its participation because it believed the S/HMO was too costly to administer. Currently, nearly 20,000 Medicare beneficiaries are enrolled in the three remaining demonstration sites. Overall, the Medicare beneficiaries enrolled in S/HMOs were healthier than the average beneficiary.

PERFORMANCE OF S/HMO I

In 1996, HCFA prepared a status report, now pending final approval, on the implementation and evaluation of the S/HMO demonstrations. This report found that the S/HMO projects had lower levels of disenrollment than Medicare's risk contract HMOs. Healthy S/HMO enrollees also expressed overall satisfaction with their participation in the program.

Frail S/HMO enrollees were compared to frail fee-for-service enrollees, based on access to care, interpersonal relationships with their physician, cost and benefits of care, quality or competence of care, and an overall measure of satisfaction. Evidence that the S/HMOs were less costly than fee-for-service were mixed; only some sites demonstrated savings. Also, relative to fee-for-service, no improvements in mortality or active life expectancy were demonstrated. Moreover, frail S/HMO enrollees were more satisfied than their fee-for-service counterparts in only one category, cost and benefits of care.

DEVELOPMENT OF S/HMO II

In 1990, Congress authorized an extension of the demonstrations and established the second generation of the S/HMO demonstrations, known as S/HMO II. One purpose of S/HMO II is to test the effects of linking chronic care case management services and acute care providers. The primary components of the S/HMO II projects include:

1. An expanded case management system, with acute and long-term care linkages;

2. A long-term care benefit package; and

3. A risk-adjusted payment methodology.

S/HMO II will continue to provide many of the expanded benefits offered in S/HMO I. We also expect S/HMO II projects to address some additional goals. S/HMO II is designed to refine the financing methodologies and the benefit design of S/HMOs. The criteria used to target long-term care benefits will also be refined. S/HMO II will target enrollment to special populations such as minorities, beneficiaries eligible for both Medicare and Medicaid, and residents living in rural areas. In 1993, Congress mandated that one of the S/HMO II projects examine the feasibility of serving beneficiaries with end-stage renal disease (ESRD).

IMPLEMENTATION OF S/HMO II

In January 1995, HCFA awarded developmental grants to the following six S/HMO II project sites:

1. CAC-United HealthCare Plans of Florida in Coral Gables, Florida;
2. Contra Costa Health Plan, in Martinez California;
3. Fallon Community Health Plan in Worcester, Massachusetts;
4. Health Plan of Nevada, Inc. in Las Vegas, Nevada;
5. Richland Memorial Hospital in Columbia, South Carolina; and
6. Rocky Mountain HMO in Grand Junction, Colorado.

We expect the Nevada and Florida sites to begin implementing the S/HMO II programs in the summer of 1996. The remaining four sites should begin operation by January 1997.

S/HMO (I and II) DEMONSTRATIONS SHOULD BE EXTENDED

The second generation of S/HMOs are building upon what we learned from the first generation. However, we need to learn more about the capitation payment structure and providing integrated services to the acute and long-term population. To assure that the S/HMO program is cost effective, we recommend that both generations of the S/HMO projects be extended until December 31, 2000, but not expanded. Authorization for both the first and second generation

S/HMOs is now set to expire on December 31, 1997. An extension of the S/HMOs program would provide additional time necessary to establish a comparative study and to assess its performance potential.

OTHER INTEGRATED SERVICE MODELS

HCFA is also testing other approaches to achieve integration. The projects differ in how funding is integrated, the way in which care is coordinated, and in the use of case management or other program elements. Among these projects are the following examples that vary approaches to care delivery.

EverCare is a demonstration designed to study the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners, who function as primary medical caregivers and case managers. EverCare seeks to reduce hospital care when patients can be managed safely in nursing homes if they receive appropriate services. Three sites are operational in Georgia, Maryland, and Massachusetts.

The Wisconsin Special Care Initiative is designed to provide Medicaid-covered medical services and additional social services such as respite care, family training, long-term planning, referral and medication services to up to 3,000 Medicaid eligible SSI recipients in Milwaukee County. About 75 percent of projected enrollees are between 21 and 64 years of age, most are unemployed, and many receive some form of adult day care services. This model includes a physician panel of experienced providers, case management services provided by a multidisciplinary team, and specialized clinics. Enrollment in the three-year demonstration began in July 1994.

Other projects target particular populations:

The Project for Non-Elderly Disabled is a demonstration to develop integrated care models primarily for non-elderly persons with disabilities. HCFA is supporting this initiative in conjunction with the Pew Charitable Trusts, Robert Wood Johnson Foundation, and the Medicaid Working Group. All participants are eligible for Medicaid, 40 percent of whom are dually entitled. Initiatives in Wisconsin, Missouri, New York, and Ohio are in various stages of development.

MAINE-NET emphasizes care to rural populations by promoting the development of regional service delivery networks or health plans. These networks will be responsible for the management, coordination and integration of services, including multidisciplinary approaches to care planning and service delivery. Maine-Net includes a comprehensive package of primary, acute and long-term care services as part of a prepaid capitated health plan. Maine plans to implement the program in January 1997.

CONCLUSION

Our primary goal in PACE, S/HMO, and the other integrated service projects being tested by HCFA is to find the best approaches to coordinating acute and long-term care services. We need to facilitate and advance a beneficiary-centered continuum of care for people who need long-term care, recognizing that people in long-term care have significant acute care needs, as well as chronic care needs. Since Medicaid and Medicare represent over half of all long-term care spending, we recognize the central role our programs must play in developing a more beneficiary-centered system. What we have already seen of PACE warrants shifting PACE from a demonstration to a permanent program. We look forward to working with Congress on legislation which makes this a reality.

We also think there is much to be learned from the S/HMO projects. Because of the importance of implementing an effective managed care program for the chronically-ill and elderly in need of long-term care, we recommend an extension of the S/HMO demonstrations authority.

Chairman THOMAS. Thank you very much, Mr. Vladeck. What I heard was in essence, you support S. 990 as a piece of legislation that directly mirrors the President's budget proposal. Is that it basically?

Mr. VLADECK. We would support it, Mr. Chairman. We would support it on its own terms, with concerns about a couple of specific provisions, which we believe could be resolved relatively straightforwardly.

Chairman THOMAS. Let me say it this way. We do not have the perfect model. We have several that appear to work. You have decided that, perhaps, the administration would support making these permanent. What is it about supporting these and in making them permanent that would allow for other options? Where is the growth factor in what we might be creating in a permanent structure here?

Mr. VLADECK. In terms of the implications of making them both permanent? Well again, here, it is important to distinguish between PACE and the SHMOs. In terms of PACE, all of the existing programs have appeared to max out in terms of service delivery capacity, in the range of 300 or so beneficiaries. And even those that have been in business the longest time, given the stringency of the eligibility criteria tend to level off at a steady state in that range. One could envision, therefore, one or more PACE programs in every community in the United States, which would still be addressing only a fraction of our beneficiaries and perhaps only a fraction of those who are otherwise eligible for long-term care.

We have a long way to go, given the size of the programs, before we make any very consequential dent in the total need in the population.

Chairman THOMAS. Well, in the PACE program, it clearly creates a defined universe which it intends to serve. One of the difficulties with these kinds of hearings is that there will be testimony down the line that I would like you to react to.

Mr. VLADECK. Sure.

Chairman THOMAS. So, I am going to do some of the cross-questioning. Dr. Wiener talks about the fact that if these programs are going to be made permanent, that one of the things we ought to do is to remove the targeted aspect of the programs. That makes some sense, I think, on the Social HMOs.

Mr. VLADECK. Again, that is why I said, Mr. Chairman, that I think we ought to look at making Social HMOs permanent in the context of broader legislation on Medicare and managed care. Clearly, to the extent that we are talking about a specific package of long-term care benefits to which one could attach a premium or an adjusted community-rate calculation, then much of what is being done by SHMOs at the moment is currently available: they are plans our current risk contractors could do under current law.

The two major differences are that the SHMOs get 100 rather than 95 percent of the AAPCC, and have somewhat greater discretion over enrollment processes, both of which, we believe, could be addressed through more sophisticated risk adjustment mechanisms, which we are going to begin to test in the next number of months.

Chairman THOMAS. Are we not all awaiting more sophisticated risk adjustment mechanisms so that AAPCC can be modified in the regular Medicare Program as well?

Mr. VLADECK. That is exactly what I am saying, Mr. Chairman. So, it is not clear whether once we do those things, it will be necessary to have special legislation for SHMOs. That is the point I was seeking to make.

Chairman THOMAS. This is an unfair question, but I would like you to at least spend some time on it anyway, because clearly, what we have done here is remove a lot of the bureaucracy and the preconditions to a lot of specific programs by virtue of the integration, and especially across Medicare and Medicaid. But at the same time, I think, we have taken an integrated approach in which we take a multidisciplinary team with a focus on geriatrics and produce a use of those facilities focused on the needs of the individual. In your estimation, what probably creates any savings? Is it primarily the integration, or is it the knowledge of the team and utilization of the services? Obviously, it is a combination of both, but I am trying to focus on the question of integration as we move toward new delivery systems, not just for defined elderly populations but for populations in general.

Mr. VLADECK. To a large extent, Mr. Chairman, I would defer to the practitioners on that issue. But my own instinct is that the key part of this is that we have loosely defined as the case management function the notion of an individual professional or a team, whose responsibility encompasses the full range of services for which the individual may be eligible, who knows the individual well, and is closely involved in the clinical service of that individual. One of the interesting intellectual questions about how to generalize from these models is how to define and replicate the model of good care management. We get into issues of what the professional training and skills ought to be, and all other like issues. In the On Lok and the best PACE programs, my impression is that is really the heart of what they do.

Chairman THOMAS. Well, I also still have some concerns, especially probably knowing more about On Lok than the others, that there may be some cultural tendencies within the recipient population that might lead toward at least initial receptance of this kind of an approach more so than the population in general. But as we get more into managed care, and people are more familiar with it at the workplace site, as they move into an aging population, they might be more receptive as well.

Mr. VLADECK. Mr. Chairman, one of the really interesting things about these demonstrations is the range of cultures and populations that are being served in the PACE program and in the SHMO program. Now, in many ways, the most interesting cultural variable in all of these programs is the physician culture in the communities in which they are operating and the change in the traditional role of physicians relative to their relationships to other professionals on the team and to long-term care services. And I know they are not among the witnesses today, but I think in some ways, the folks at Kaiser in Portland have had the most interesting experience, given the history of the Permanente groups in terms of the cultural changes among physicians.

Chairman THOMAS. One last comment. Again, I am going back to Dr. Wiener's study, because he does cite so many other studies that have been offered. And what caught my attention on page 3, having read some of the case profiles and the way in which they were handled, in a very humane way, he says: "Within the Social HMOs, at least some disabled groups had higher mortality rates than persons receiving fee-for-service care (Manton, et al., 1993)."

Based upon the way in which there was almost a nurturing hospice concept to this program and choices that were focused by loved ones and relatives, that is not necessarily a negative statement. You have to look, I think, at the individual situation, because oftentimes, strictly, mortality rate divided by dollars does not necessarily produce a quality profile, and what I like about this program is that although we are obviously focusing on the cost of the program, and the quantity aspect is something that is important, I think overall, most people would agree that all things being equal, the quality of these kinds of programs is significant.

Mr. VLADECK. I think it is particularly important, Mr. Chairman, to recognize that whatever the sort of conventional wisdom or stereotypes may be that, in fact, effective case management really empowers individual patients and their families, just as having to deal with a fragmented system can restrict choices. In fact, good programs of this sort like the PACE programs give the patients much greater control over the kinds of services that they receive than the so-called "unrestricted," and confusing array of benefits that might be available otherwise.

Chairman THOMAS. Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

Bruce, maybe you could clear up some definitional stuff here. I would preface this by saying that I think these programs are good, and they are certainly good for the beneficiaries. But the question of cost and which programs save and how much they save, we are not clear on. Let me see if I understand this. In the PACE programs, they are partly paid out of Medicaid and partly Medicare funded. Generally, most of the savings would come out of the Medicaid side, because there are lower long-term care costs. There is probably not a lot of savings in Medicare.

On the SHMO, however, it is mostly paid by Medicare and includes limited long-term care. In the SHMOs, we have seen nothing in the testimony here to say that they really save money. My guess is that the reason they do not save money is that they do not have a big nursing home potential cost to save from. Have I got that?

Mr. VLADECK. You know, it is one of the problems we have in all of the capitated programs under Medicare, since, in a sense, savings are invested in benefits.

Mr. STARK. OK.

Mr. VLADECK. And that is one of the reasons that it is so complicated to draw a conclusion. It is clear that Medicare is not saving money in the way in which it pays SHMOs. The question is, are beneficiaries getting more than they would, and the answer is probably, they are.

Mr. STARK. Medicaid is saving on the PACE side, because arguably, they prevent or postpone admissions to long-term care facilities.

Mr. VLADECK. I think that is fair, yes.

Mr. STARK. The SHMO does not have that opportunity to save. It does not get credit for it.

Mr. VLADECK. It does not get credit for it. It may well have it to a greater extent than we have been able to measure, because most of the folks who are served by SHMOs, or who are at risk for Medicaid-covered nursing home care, are not Medicaid beneficiaries at the time they are enrolled in the SHMOs.

Mr. STARK. OK; I think I have got it. Thank you very much.

Chairman THOMAS. Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you.

Good morning, Mr. Vladeck.

Mr. VLADECK. Good morning.

Mrs. JOHNSON. I am not quite sure that I understand your recommendation in regard to PACE. Are you recommending that only the programs that are in place now be permanent or that the program be made permanent and that new sites be eligible? And would you consider both for profit as well as nonprofit applications?

Mr. VLADECK. Mrs. Johnson, no. We believe that the PACE program should be made a permanent benefit in the Medicare Program. There has been some discussion among the sort of PACE-related community as to whether there should continue to be a limit or a ceiling on the total number of PACE sites or whether it should just become available to any qualified applicant. And my instinct is that that is a traditional issue, that long-term, we ought to have PACE programs in every community in the United States, and in bigger communities, we ought to have multiple PACE programs.

We have no experience with PACE program operators other than not-for-profit community-based organizations. And one of the things that Mr. Thomas alluded to and that I personally think is quite important as a contributor to the success of PACE programs has been how rooted they are in their specific communities and specific community organizations, and so forth. So, I do not have a prejudgment on the legal structure of ownership, but I do have some sense that we want to try to keep these as very much community-based, grassroots-based kinds of organizations, and there are a variety of ways one could seek to achieve that through legislation.

Mrs. JOHNSON. I asked the question because what I see happening out there in the real world, particularly since we have not been able to pass any policy changes, is an incredible change in the organization of medical services so that there are now hospitals that are developing relationships with long-term care facilities, with home-care capability as well as physicians, and they are going to be capable of an integrated care approach that has the same vision and is based on the same beliefs and assumptions as both the PACE and the SHMO programs. And I think it is imperative that we write the law as we make this permanent so that it can be integrated into the changes that are going on as rapidly as possible,

because whether it saves money or not, it certainly improves care. I have not quite focused on how many more services are available. But the breadth of services available make a lot of sense, and one knows that in people's lives, this makes a big difference. It also makes far better use of our Medicare and Medicaid dollars, and is the only avenue through which we can integrate them.

I would be interested in your office working with us on language in the bill that would make clear that these can become a part of HMOs that offer services to seniors, and it ought to be part of a package that the Medicare Select plans can offer as well through the additional benefit approach. It ought to be part of the supplemental insurance benefit that is available to seniors, because some of those supplemental insurance benefits are now coming in at zero premiums in order to enable the managed care plans to compete with the HMOs. And they are part of the package of benefits they are beginning to offer, and particularly as hospital and nursing home and day care facilities integrate. So, I think that we want to be sure that we do not write this too narrowly, because the whole sector is changing so rapidly. We want to be sure that this kind of integrated care benefit, this kind of case management approach, which is probably the very best approach, as we have more and more people moving into the frail elderly category, can be something that all HMOs can offer, that all managed care plans can offer if they want to. So, I would like to work with you and make sure that the legislation is broad enough to not only allow that development but also encourage that development.

Mr. VLADECK. Well, I understand that, and I agree with that. I think it is important to maintain the distinction between a financing mechanism on the one hand and a delivery system on the other, and that is why I said that I think the future legislation relative to SHMOs needs to be integrated with any legislation we eventually agree on about Medicare managed care. On the PACE side, I think we are all eager to find mechanisms through which folks who are not eligible for Medicaid by virtue of income, but who have the same degree of care needs as other PACE clients, could also receive services from PACE programs through a combination of Medicare and private payments, whether they are insured or not.

When you get into the relationships, the capitated plans, some of the economics and the mechanics of that get to be quite complicated. But I think if we can keep some clarity in the distinction between delivery systems on the one hand and the mix of financing sources on the other hand, we can work our way through that.

Mrs. JOHNSON. Now, does your proposal include enabling the states to merge Medicaid and Medicare dollars for this kind of care?

Mr. VLADECK. Well, we feel very strongly that we ought to encourage the expansion of provider types that are funded through some kind of joint Medicare and Medicaid funding. In our discussions with the states, including the New England states, we have continued to oppose the notion of permitting states to function, in effect, as intermediaries or as controllers of Medicare dollars.

Mrs. JOHNSON. But what I hear the facilities trying to get away from is moving people from this group to that group and all of the

administrative complexities involved in that as well as the problems for the individual associated with that. And where there have been those demonstration projects of merging those funds, they have been very fruitful. This seems to me an ideal moment at which also to deal with reducing the amount of administrative costs associated with this kind of care by dealing with the pooling of the resources the Federal Government provides.

Mr. VLADECK. Well, that is what we are doing. And as you know, we are in discussion with a number of states about new ways of doing this, and we believe you can pool funds and should pool funds at the level of the beneficiary or at the level of the provider. There is some question as to the mechanics through which that is done, but we are moving ahead on a number of experiments in that general vein.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Dr. Vladeck, let me thank you for your leadership in this area of expanding opportunities for our Medicare and Medicaid recipients for long-term care needs. The PACE program is a winner, and I hope that we can find some way to make that permanent and available to all of our seniors. I would like to move forward on that.

The alternative to a senior not having PACE if they are a Medicare beneficiary, is that there are very limited services available, and, therefore, the beneficiary needs to use his or her own resources. The beneficiary will probably spend down into Medicaid and then go into long-term nursing care, which is going to end up being more costly and not as beneficial to the beneficiary. So the PACE program, it seems to me, is one in which I would hope that we could handle separately and do something to expand the availability of this service to our seniors, because it is good for them, and it is good for the taxpayers of this country.

If I could just get you to respond a little bit on the SHMO program, because I am not sure I totally appreciate the adequacy of that particular benefit to our seniors. That plan requires seniors to go into an HMO to get limited long-term care coverage, which may or may not be adequate to the need of the senior, as far as the senior's long-term care concerns. In your statement, you indicate that the overall Medicare beneficiaries enrolled in SHMOs were healthier than the average beneficiary. My question is are you referring to the fact that the care that they are receiving in the SHMOs has brought up their health care status? Or is the type of selection of a person who is going to go into an HMO generally healthier than the average, and therefore, we are not accomplishing the diversity that we had hoped to in the SHMO program?

Mr. VLADECK. Mr. Cardin, I think in all fairness, it must be noted that the original designers of the SHMO concept really started from the notion that if you had a broad enough pool and a broad enough base of Medicare beneficiaries, and you used resources for all of your beneficiaries efficiently with some modest additional funding and good clinical and administrative management of the cases, you could, in a sense, insure against additional long-term

care expenses that were not ordinarily part of the Medicare benefit package.

And so, to the extent that much of the work in the development of SHMOs to this point has been an effort to define the size of that supplemental long-term care package in order to create an insurance package within 100 percent of AAPCC plus a market-sensitive premium, I think it has been very successful. Now, that is limited. It is limited compared to what Medicaid beneficiaries are entitled to; it is limited compared to what people who have very extensive long-term care needs require over a period of time. But it is more than is now currently available in conventional Medicare HMOs. So, I guess the question really comes down to one of continuing to identify the long-term care insurance product that can be delivered in conjunction with a more conventional HMO package of services. Then, as the Medicare Program evolves in terms of customer choices, we need to subject that to a market test in terms of how many beneficiaries find that important as opposed to, say, alternative supplemental benefit packages, and how much of a dent that makes over time in the demand for non-Medicare-covered long-term care service.

Mr. CARDIN. The alternative, of course, is that if you do not have a representative group, and it is actually costing Medicare more money to provide the SHMO type of a program, we should be looking at alternatives within traditional Medicare to expand the coverage for all beneficiaries that could save unnecessary utilization on nursing home care.

Mr. VLADECK. Well, I think that is a very good point. And one of the things we are doing a lot of work on at the moment has to do with the notion of case management, which again is, in many ways, the key to these effective integrated programs. If you look at what is happening in the private sector, there are a number of nontraditional so-called managed care plans, which are still very much fee-for-service oriented, or even look more like indemnity plans, except for formal case management functions somewhere in the system.

And one of the questions is the extent to which within the Medicare fee-for-service program we could build in that kind of case management, and the extent to which it would provide an additional benefit for beneficiaries and produce better outcomes and, thereby, produce savings to at least offset the additional costs.

Mr. CARDIN. I hope you will continue to explore that.

Mr. VLADECK. We are working on that very aggressively.

Mr. CARDIN. Good.

Chairman THOMAS. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Thank you, Mr. Chairman.

Mr. Vladeck, nice to see you. Tell me once again what it is we need to do in order to expeditiously extend PACE and SHMO this year.

Mr. VLADECK. We need legislation, Mr. Houghton. We have specific statutory authority to operate our existing levels of demonstration activity. Actually, we have 10 PACE sites; we have authority to go to 15. We are operating all of the SHMOs that are permitted under existing authority, which is going to expire in another 20

months or so. So, we need a statutory basis to expand either or both programs beyond the point at which they are now based.

Mr. HOUGHTON. So, you feel that you could explain to people like myself, who have not been intimately involved in this process, that not only is the program good, but there have been significant in-depth reviews to prove your point?

Mr. VLADECK. I think on the PACE issue, there have been significant, in-depth reviews of the quality of services being provided and of customer satisfaction with those services. There are some issues that still are being very actively studied, including some of the economic issues. But given the pace at which implementation of statutory change works, we believe that even if the Congress were to enact Senator Dole's bill tomorrow, we would have the evaluation results in time. The evaluation results are not going to say yes or no to PACE. They are going to teach us more about standards for PACE programs, about what the essential characteristics are, and about payment levels. We would still have time to incorporate that into the process of expanding the program. The SHMOs have been sort of "studied to death."

Mr. HOUGHTON. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. Vladeck, I want to talk a little bit about a program in my state which you have currently awarded one of the demonstrations in the SHMO IIs that is supposed to start this summer, but first, let me just brag a little bit about it. I was pretty proud of it. Sierra Health Plan of Nevada is a very innovative company in Southern Nevada. It is basically HPN–SHMO II provided by Sierra Health Services. They were in my office yesterday, and it sounds to me like there are some dramatic improvements in SHMO II or SHMO I. One of the concerns that they raised to me was simply that the Medicaid and Medicare waivers be ready on time. Do you think that they will be ready by July 1, when they are scheduled to start up?

Mr. VLADECK. I checked yesterday, sir, and as of close of business yesterday, we are right on schedule for that. Again, the Medicaid waivers require working with the state as well as with our folks, and we have had a very good relationship with the state on this one.

Mr. ENSIGN. OK.

Mr. VLADECK. So as far as I know, we are exactly on track for that.

Mr. ENSIGN. OK; could you explain some of the concepts? Everywhere you go, long-term care with seniors across the board is always one of their biggest concerns. You know, they are the people who have to go through all of their assets before they can get on Medicaid. Certainly, the amendment that I offered to the recent health care reform bill that, in fact, Barbara Kennelly had commented that she has been trying to get passed for the last 12 years, that deals more with people with money, whereas the SHMOs seem to be addressing more the end of the spectrum where the people have fewer assets.

And the whole idea of SHMO II versus PACE would seem that it is much more of a complete program and not just a day care type of a program. Basically, you are talking about building ramps for homes that need a ramp. It involves taking a complete look at the elderly health care wise, mental health care status, the whole thing, to keep them as healthy as possible, because the bottom line is that obviously, that is better for the elderly, and the win-win situation is that the company is going to save money on it in the long run.

Mr. VLADECK. I think that some of the folks from PACE might be concerned about the characterization. I think the PACE programs are very complete in the range of services that they provide as well. They provide them to a more limited population, however.

Mr. ENSIGN. Right; it is more the frail population.

Mr. VLADECK. A more targeted population.

Mr. ENSIGN. This is more of trying to keep people from becoming as——

Mr. VLADECK. We are enthusiastic about SHMO II and the evolution of some of the original SHMO plans, and again, I think Health Plan of Nevada is a very good example of this. One of the things we have talked about with this Committee on prior occasions is that as you have HMOs or other managed care organizations which have developed their organizations treating primarily a conventional, commercially insured population which begin to enroll large numbers of Medicare beneficiaries, the needs of those beneficiaries, the kinds of services they require, and the kinds of physicians you need to provide them with the range of services they need, are very different from that particularly of the typical, commercially insured population. This is particularly true in an area like southern Nevada, which has such a rapidly growing young population driving so much of the growth on the private side of the HMO market. Medicare beneficiaries do not use very much in the way of deliveries or pediatricians, as the simplest example of that.

So, our concern has been that as on the fee-for-service side, the providers of care to all Medicare beneficiaries, not just those who have already been labeled as long-term care clients, should develop the expertise and the skills and the relationship with different kinds of providers. This should be the case whether they are home care providers or community nutrition agencies that are necessary to provide real, high-quality continuing care to the elderly that are less of an issue in routine practice with other populations.

As you do that, the boundaries between what is good "acute care" and what is good "long-term care" start to dissolve altogether, we believe. But how to make that spectrum or that integration of issues where you cannot draw very hard lines is difficult, when you have two public programs with very rigid lines about what they pay for and what they do not, and who they cover and who they do not. This is really the challenge here, and that is the heart of the continued experimentation around these issues.

Mr. ENSIGN. And that is where the heart of the savings would come from, because sometimes, there is no incentive to do preventative care. If the other program is paying for it, there is not necessarily the incentive. But if you have the complete coordinated

type of care, there is the incentive. If this is the most costly end over here, and you put a little money in over here, the patient ends up with better care, and in the long run, you save dollars.

Mr. VLADECK. Mr. Ensign, every well-managed Medicaid Program in the United States has a group of its staff and a set of rules that in New York we were—New Yorkers being New Yorkers—more explicit about, but every other state does it, and we call it the Medicare Maximization Program. And, the basic rules were that for everybody in the long-term care system, both the providers and the state had to do everything that they could to bring in every Medicare dollar before Medicaid would pay something.

And in Medicare, we are not quite as good on the on-site management. We have a lot of policies that are designed either to prevent the shifting of Medicaid costs to us or to dump costs on the Medicaid Program. And, the net result is not only significant inefficiency and additional cost to the system as a whole, but we put our beneficiaries and our providers of service through some ridiculous hoops as a result.

Mr. ENSIGN. Mr. Chairman, I know my time has expired, but just one last comment. And, the comment that Sierra made to me yesterday is an example. CCU is the most expensive area in our health care system on a per-day basis. And obviously, if you are encouraging through preventative health, proper diets, exercise, and counseling in those areas, you are keeping somebody out of a CCU unit. The taxpayer through lower payments to Medicaid and Medicare is going to be better off. The patient is better off because they are healthier and this whole concept of a win-win-win situation is the way we should go, and I thank you for your efforts.

Thank you.

Chairman THOMAS. Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Dr. Vladeck, you are looking at a panel of proof that Tip O'Neill was right when he said that all politics is local. I think on this panel there are at least five of us up here who have a parent in their nineties. So, we all have more than a passing interest in this issue. There have been proposals made in this Congress for climatically changing the structure both of Medicare and Medicaid. Please tell me what the impact of those proposed policy changes would be on the PACE program and the SHMO program.

Mr. VLADECK. Well, I can do this in general terms, because I think there are a lot of specifics as well, for both SHMO and PACE and for other long-term care experiments. We use essentially the current system as the baseline or the template against which we both set prices and compare for standards of quality of care and for customer satisfaction and so forth. Any radical changes in the conventional baseline system are going to reverberate significantly through programs that are tied to that, even if the conventional system is only sort of a counter-example to them in one sense or another.

The most significant issue here, or I think the easiest and most straightforward is probably on the Medicaid side, given the nature of the proposed legislation.

Mr. MCDERMOTT. You mean the proposed legislation to make block grant Medicaid to the States?

Mr. VLADECK. The block grant legislation.

Mr. MCDERMOTT. So, we will have 50 different Medicaid Programs.

Mr. VLADECK. We already have 50 different Medicaid Programs.

Mr. MCDERMOTT. That's true.

Mr. VLADECK. But we cannot do the arithmetic in a way that makes the block grant proposals work out past the fourth or fifth year without a significant loss of coverage for lots of folks who are now getting Medicaid or who would be eligible for Medicaid in the future. We just cannot make the arithmetic compute. So, we are talking about building long-term care programs around folks who would be eligible for Medicaid, and taking the Medicaid and Medicare dollars and pooling them.

Our belief is that in the future under the Balanced Budget Act, a lot of those folks would not be eligible for Medicaid, nor would they be able to afford what would otherwise be paid for Medicaid in terms of a private premium. So these programs may be cheaper than existing Medicare and Medicaid. They are not cheap by any objective standard. And if you take the kinds of cuts that are being talked about in both of the programs out a number of years, again, I would ask the direct providers of these services themselves, we may be able to run PACE for 5 percent, 7 percent lower than what the same client would cost Medicare and Medicaid under current law. I do not think we could run them for 30 percent lower, which is where the Balanced Budget Act would take us in 2001–2002.

Mr. MCDERMOTT. Is it fair to say, then, if we pass legislation extending these programs, it really is a hollow promise if the other changes were to pass in terms of Medicare and Medicaid, particularly the Medicaid proposal, that you are looking at a bill that says yes, you are eligible, but there is no money to give you the services. Is that a fair thing to say?

Mr. VLADECK. Well, I think in all fairness, it is not inappropriate to suggest that we had made it clear that at least during the life of this administration, there will not be cuts of that magnitude in Medicare and Medicaid.

Mr. MCDERMOTT. Thank you.

Chairman THOMAS. Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Just briefly, Mr. Chairman.

Dr. Vladeck, would you just briefly go over for me the qualifications for enrollment in PACE? What does a person have to have in terms of income, or what are the other characteristics to enroll in PACE?

Mr. VLADECK. By and large, the income characteristics per se are not that important. The major criterion in general, which takes different specific forms in every State, is that that person be eligible for nursing home care as defined by the State's Medicaid Program. Now, the reason I say as defined by the State's Medicaid Program is that for private users of nursing homes in most states, eligibility is a determination made by the individual family and the facility. So, the only sort of systematic criteria we have for eligibility for a nursing home level of care, for long-term care, are those adminis-

tered by the State Medicaid Program. And each state has a somewhat different combination of income and assets and medical or clinical need by which they define that threshold, and they are state specific in the PACE program.

Mr. MCCRERY. But basically, these folks entering the PACE program are low-income folks?

Mr. VLADECK. Well, they may not have been low-income previously, but generally——

Mr. MCCRERY. They are either low-income or low-asset?

Mr. VLADECK. They establish eligibility for long-term care. They are not particularly affluent folks, I believe because the more affluent potential users of long-term care service probably are purchasing some mix of other services privately before they get to that.

Mr. MCCRERY. But for a SHMO, anybody can step up and pay the premium and enroll.

Mr. VLADECK. That is correct. And the great, overwhelming majority of SHMO enrollees are not Medicaid-eligible.

Mr. MCCRERY. Thank you.

Chairman THOMAS. Just let me follow on that point to pick up the jab that the gentleman from Washington placed. I appreciate your unwillingness to respond in the way that he wanted you to respond, because I do think that it is an unfair statement.

My concern is that when you take the definitional differences between the PACE program, which will make sense if you have an identified population and you focus your needs on that identified population, my understanding is—and we will find out more from the PACE people—that the cost increases per year are significantly lower than the average Medicare increase. In fact, they are taking care of an identified at-need population, on average, at less of a cost than Medicare in general, which tells me they are doing something good with the program.

But the one that seems to be even more expandable would be the SHMO, because all it does is take an HMO and say if you allow us to ignore certain rules that others have to follow: The 50/50 mix; we get 100 percent rather than the 95 percent with an adjustment. We will add a long-term component to paid prescription and vision, which seems to be a key component structure, and that we will, therefore, offer our services in this area.

One of the things that our colleagues in the minority tried to do was pull out of the AAPCC even for the coordinated care programs, the GME costs. And what we have done, of course, is set up a separate trust fund to get out of trying to pull it out of Medicare, which I think is a far preferable way of dealing with the question of GME, so that you would preserve it at 100 percent of the AAPCC.

I guess my concerns are, are we not getting the message that maybe some of the rules that we have for ordinary Medicare Programs, HMOs and others, probably should be removed like the 50/50 mix and others rather than just providing them for these people who say they are going to take an integrated long-term care approach? Because if we do that, then I think you are going to see even more innovation in the kinds of programs that you offer, and that if you let the market have some influence on it, there will be some that gravitate toward the SHMO model. Others will have modified adjustments to it and then will get that real-world experi-

ence on differing offerings as to how much some folks want, and they could even move between an HMO or a SHMO, moving into more, then, of a PACE kind of a program, and it is that broad option structure that I think will give us the best test environment for what works and does not work, limited only by the dollar amount available for the overall program. Is that——

Mr. VLADECK. Well, I think, as I said earlier, Mr. Thomas, I think that is right. I think the future of SHMOs lies in changes to the underlying legislation affecting Medicare and managed care, and I think under the President's proposal, in fact, it would be possible for many HMOs and other new kinds of plans to offer essentially the SHMO benefit package as one of a number of separately priced supplemental benefit packages. I think the future is in that direction. And I do not think now is the time to talk about the comparisons between the structure of choice in the various proposals, but I think it is not at all inconsistent with what the administration has proposed, let alone what others have proposed as well.

Chairman THOMAS. And I started out by asking the question where do we get the savings if there are any? Is it integration, or is it the multidisciplinary approach? Fairly obviously, with an HMO, there tends to be by definition a multidisciplinary approach in the managed structure. What concerns me is that I think where the savings are going to tend to come from is an elimination of what I consider to be more and more needless bureaucratic hurdles in the utilization of the various services in the old-fashioned fee-for-service that you have eliminated by waiver in the SHMO program, that probably should be eliminated all together. I am looking forward to trying to find some evidence that perhaps the ability to utilize, even in fee-for-service, some removal of barriers for use in a timely fashion for intervention and then pulling out might not save money all across the board for the Medicare Program.

Mr. VLADECK. Well, let me just suggest that the evaluations suggest that even with full capitation, the amount of integration that actually occurs and the amount of multidisciplinary integration in particular across service integration that has occurred in the SHMOs, has been highly variable and not something that occurs automatically by virtue of the financing mechanism.

Chairman THOMAS. Nor do we have a good grasp, as Dr. Wiener and others have indicated, as to whether we are robbing the chronic to pay the acute, or robbing the acute to pay the chronic the way the mix is structured. But frankly, that is less important to me, and it is inside the black box if we can get an overall program that meets a dollar amount regardless of which side the money is going on. If you are getting a product coming out that people like, and they can use, and it is not costing us any more, I think from a quality point of view, you have got to say it is a better program

Thank you very much, Dr. Vladeck. One moment. The gentlewoman from Connecticut has some more questions.

Mrs. JOHNSON. I didn't quite understand your answer to an earlier question. What assumptions did you use in estimating the 3-, 4-, 5-, 6-year money available for Medicare/Medicaid eligible patients under a block grant? You said there would not be sufficient money. What were your growth rate estimate assumptions?

Mr. VLADECK. I am trying to reconstruct this. Those are using CBO baseline estimates on growth in medical costs and growth in Medicaid enrollees.

Mrs. JOHNSON. And those are without reform, correct?

Mr. VLADECK. Well, those are the baseline.

Mrs. JOHNSON. Right; so current CBO estimates are based on the current growth rate in Medicare, which is 10 percent; the current growth rate in Medicaid, which is 12 percent. And without reform, those rates of growth are likely to continue, and the money would run out. With reform, bringing rates of growth down to 7 percent or so in both of those programs would, of course, extend the adequacy of the money. Is that not so?

Mr. VLADECK. Mrs. Johnson, I believe—and I may stand corrected—but I believe on a per capita basis, the current Medicaid baseline both from CBO and from OMB is below 7 percent over the next 6 or 7 years on a per capita basis.

Mrs. JOHNSON. I would be interested in some documentation on that.

Mr. VLADECK. We will provide that.

[The information was not available at the time of printing.]

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Thank you very much, Dr. Vladeck.

Mr. VLADECK. Thank you.

Chairman THOMAS. I look forward to working with you on legislation.

Mr. VLADECK. It will be an interesting change of pace.

Chairman THOMAS. Next panel, please: Jennie Chin Hansen, executive director of On Lok, Inc., San Francisco; Dr. Robert M. McCann, medical director, geriatrics and Independent Living for Seniors, Rochester General Hospital; Sam L. Ervin, president and chief executive officer of SCAN Health Plan/Long Beach; and Rosalie DiPietro, who is a subscriber to Elderplan in Brooklyn, New York.

Having read the testimony, I think it will make more sense for the witnesses to present their testimony in the order that I will call you rather than the order that you are sitting. So Ms. Hansen, if you will address us, any written testimony you may have will be made a part of the record, and you have 5 minutes or so to inform us what you think we need to know about your program. And I would caution to all of you that these microphones are very unidirectional, so you need to have it right in front of you.

Thank you very much.

STATEMENT OF JENNIE CHIN HANSEN, EXECUTIVE DIRECTOR, ON LOK, INC., SAN FRANCISCO, CALIFORNIA

Ms. HANSEN. Thank you, Mr. Chairman as well as Members of the Subcommittee. I am accompanied by Judy Baskins, who is the president of the National PACE Association right behind me, who is also the project director of Palmetto Senior Care, which is the PACE project in Columbia, South Carolina. I am also accompanied by Dr. Chris VanReenen, who sits behind me, and is the executive director of the National PACE Association. And beside me, of course, you will be hearing from Dr. Bob McCann, who is the medi-

cal director of our Rochester, New York project, Independent Living for Seniors.

I would really appreciate the opportunity to comment on a program that has drawn so much response. Having been at On Lok now for my 16th year, it is very satisfying to see the evolution of this unique program much more mainstream. I represent not only On Lok but frankly, the other 10 projects that Dr. Vladeck mentioned which are also operating under full risk and the waivers that span from California to Colorado, Massachusetts, New York, Oregon, South Carolina and Texas as well as Wisconsin. And finally, as you have heard, there are other programs that are greatly interested in this approach that are in the states of Florida, Georgia, Illinois, Maryland, Virginia and Washington. The attachment that you have indicates that besides the 10 projects that are under full waivers, there are actually 59 projects spanning close to 30 states that are interested in this model.

Since 1973, On Lok had started with what was known to be a day program but really has evolved to a whole system of care that integrates acute and long-term care services for adults. And it was in 1986 that Congress authorized a demonstration to continue to test this pilot to see whether or not it could be replicated in other states around the country. And as you have heard, that, in fact, has occurred. There are probably five key elements of the model that I would like to address, some of which were asked in the questions here.

First and foremost, this is unabashedly a targeted program for who are frail elderly people. People qualify for this program as a result of the respective states' approach to certifying them for nursing home care. One question was whether or not this was strictly for the Medicaid population, and the answer is no. Nursing homes oftentimes a U.S. Senator from the State of tend to service low-income, Medicaid individuals, but we all have private-pay individuals in our programs.

Second, the programs provide a comprehensive set of benefits that are both acute and long-term care. This covers medical services as well as comprehensive long-term care services, and this is without limits in terms of dollars or duration of service. Third, PACE programs fully integrate the delivery system of acute and long-term care, and one thing that marks this program is not the financing but frankly, the way the services are actually administered by an interdisciplinary team that is familiar with the frailty and multiple problems in a very intimate way and can respond, frankly, on a dime. The ability to really quickly respond to emergencies, even on a Sunday, 7 days a week, these are the ways that you save money.

Fourth, PACE programs are reimbursed on a capitated basis. And what that means is rates are set for Medicare, for Medicaid in a way that addresses savings for the respective parties. Fifth, the programs assume total financial risk, and thereby, there is no incentive to really bump the cost to somebody else. The fact is we provide the services fully ourselves.

Dr. McCann will really give a clearer example of what a typical enrollee is like, but I brought some pictures to give you a sense of some of the people who are enrolled in the On Lok program, which

is not atypical whatsoever to many of the PACE enrollees. I would like to focus on the outcomes that have been key. One of the questions is where does the money savings really come from? In fact, it is really the hospital utilization, the Medicare funding that has really been able to help finance some of the long-term care services. What is significant is the fact that the hospital utilization for this very frail population whose average age is in the eighties with nine medical problems actually is less than the all 65-and-over, enabling tremendous savings.

The rate setting done by Medicare as well as the states also assure a cost savings, and then, that does not speak to the humane and community aspects of helping support families to continue on. Finally, the quality of care issue is always one that needs to be raised and must be raised. We are under the jurisdiction of HCFA and all of our respective state requirements, and in 1993, we were reviewed as a group by the Community Health Accreditation Program and received excellent survey results in terms of quality of care as well as coordination of services. We are most fortunate at this point to be able to get the grant from the Robert Wood Johnson Foundation that will allow us to develop performance standards as well as an accreditation process in this program.

We have been able to receive a great deal of bipartisan support over the years, mainly, I think, because it achieves the agenda of both parties in one sense, one for access and the other one for cost savings. And the 1995 PACE Provider Act introduced by Senators Dole and Inouye will actually allow us to increase the number of PACE providers as well as allow those providers who have performed well to become permanent providers for the future. Otherwise, they will be in demonstration for perpetuity.

It is urgent to expand the program not only because of the need and because of the quick movement of Medicaid and Medicare managed care, but it is important to see that this really does focus on quality of care. And finally, I would just like to say that this whole plan is not at all inconsistent with what the states are asking for—the flexibility. This program is not being legislated or asked to be legislated in a manner that would require states to do. It is strictly voluntary, and that it be one of the options for states. So, I hope that you would find the merit in supporting provisions of Senate bill 990.

Thank you.

[The prepared statement and attachments follow:]

Statement of Jennie Chin Hansen, M.S. R.N.
Executive Director, On Lok, Inc.

Mr. Chairman and Members of the Subcommittee:

I am accompanied by Judy Baskins, the President of the National PACE Association and Project Director of Palmetto SeniorCare, the PACE site in Columbia, South Carolina. Also here is Dr. Chris van Reenen, the Executive Director of the National PACE Association, and Dr. Bob McCann, a primary care physician at our Rochester PACE site, from whom you will be hearing later on.

Thank you for the opportunity to comment today on the unique health and social service needs of frail older Americans. I am speaking on behalf of On Lok, a non-profit, community-based organization in San Francisco which has, since 1973, provided home and community-based care to thousands of frail elders. On Lok currently serves over 430 older persons. We currently are in the process of expanding our service area to make On Lok an option to frail elderly throughout the San Francisco Area. I also represent ten programs that have successfully replicated On Lok's experience in California, Colorado, Massachusetts, New York, Oregon, South Carolina, Texas and Wisconsin. Many more programs across the country, like On Lok's, are under development in states such as Florida, Georgia, Illinois, Maryland, Virginia and Washington.

Since 1973, On Lok has evolved from a single adult day health care program to a total system of care directly providing a comprehensive package of acute and long-term services on a fully integrated basis. On Lok was designed specifically to address the complex medical and social service needs of frail older adults. Congress has specifically supported and encouraged the On Lok program, virtually from its inception. Then, in 1986, Congress initiated a national demonstration of On Lok's cost-effective, managed care system called PACE -- the Program of All-inclusive Care for the Elderly. The objective of the demonstration was to determine the feasibility of making this unique program more widely, and ultimately, generally available.

All PACE programs share the same basic elements:

- **PACE programs enroll only the very frail** -- older persons who meet their states' eligibility criteria for nursing home care. This approach is fundamental and unique among managed care programs -- there is no mixture of "good risks" with "poor risks." All PACE enrollees are in immediate need of comprehensive and continuing chronic care. A key objective of PACE is to maximize the functioning and independence of enrollees in order to delay or prevent nursing home placement.

- **PACE programs provide their enrollees a comprehensive benefit package** including all necessary medical and long-term

care services, both in the community, and in hospitals and nursing homes without any limits on dollars or duration of service.

- **PACE programs fully integrate the delivery of acute and long-term care** through interdisciplinary teams consisting of physicians; nurses; social workers; physical; occupational and recreational therapists; dietitians; and home care workers.

- **PACE programs are reimbursed on a capitated basis**, at rates that provide payers savings relative to their expenditures in the traditional Medicare, Medicaid and private-pay systems. These payments are pooled by the program, enabling us to provide the most appropriate services in the most appropriate settings in order to best meet the needs of our enrollees.

- **PACE programs assume total financial risk** and responsibility for all medical and long-term care without limitation.

The typical PACE enrollee is an 83 year old widowed woman who lives alone and suffers from several chronic and acute medical conditions, and some degree of cognitive impairment. She requires assistance with various activities of daily living such as bathing, dressing and using the bathroom as well as help with other aspects of her personal care, housekeeping, and managing her medications. In the traditional system, frail older persons or their families or friends must coordinate the delivery of multiple services from multiple providers, leading to fragmentation and duplication of care. In PACE, participants receive all their services through a single agency that assumes total responsibility for providing all care. In this way, integration, not merely coordination, becomes a realistic objective.

To explain what I mean by integration, it is important to describe a fundamental element of the PACE program. That is, the same people who deliver care meet together on a regular basis to discuss and develop an overall assessment and treatment plan for each enrollee. This degree of coordination and management leads to an example of a quick response to medical crisis, which, for example, so happens at 5:00 P.M. on a Friday afternoon. In the PACE system, the participant would be able to be hospitalized, monitored and stabilized by the PACE primary care physician and be discharged on Sunday -- yes, Sunday! -- to a knowledgeable PACE community team and system of services tailored to that person's specific needs at home. Such a response is seldom possible in a traditional world for the frail elderly.

Enrollees attend the PACE Center, on average, two to three times a week. There they receive primary medical care, nursing and social work services, rehabilitative and restorative therapies, personal care, meals and an opportunity to participate in various activities. Participants see their physician an average of twice a month and more frequently if necessary. When enrollees do not come to the Center, services are provided in their homes. An enrollee who requires hospital or nursing home care remains in PACE and care continues to be coordinated and monitored by PACE staff, thus

assuring continuity of care between services provided in the Center, at home and in institutions. Under contracts with hospitals and nursing homes, PACE's medical teams follow our patients right into the hospital or nursing home to both monitor their care as well as to formulate appropriate plans for ongoing care, either in the institution or community.

I would emphasize that by expanding the availability of community-based long-term care services, tightly integrating all aspects of PACE enrollees' care, and emphasizing preventive and supportive services, PACE programs have substantially lowered the utilization of high-cost, inpatient services. In turn, dollars that would have been spent on hospital and nursing home services are used to expand the availability of community-based long-term care which, again, reduces the need for high-cost services.

Hospital utilization rates for PACE enrollees are at or below levels for the general older population, and nursing home rates are way below levels for a comparably frail group. Analyses of costs for individuals enrolled in PACE show that Medicare and Medicaid save between 5% and 15% relative to expenditures for a comparably frail population in the traditional Medicare and Medicaid systems. These savings are apart from the humane aspects of the program to maximize and prolong the capacity of an individual to function independently in his community. It should be emphasized that where a PACE site generates income in excess of program expenditures, these funds are placed in reserve so as to smooth out fluctuations in utilization or reimbursement.

Quality of care at PACE sites is monitored at both federal and state levels -- by HCFA and through states' review processes. In 1993, an independent review by the Community Health Accreditation Program found quality and coordination of care at PACE sites surveyed to be exceptional. And, importantly, the National PACE Association recently received a grant from the Robert Wood Johnson Foundation to develop standards of care for PACE programs and an accreditation process which we believe will help enormously to maintain PACE's present quality of care in the future.

On Lok and PACE have always enjoyed bipartisan encouragement and support which has culminated in the introduction by Senators Dole, Inouye and others of "The PACE Provider Act of 1995." The legislation would: 1) expand the number of PACE programs; and 2) move qualified existing and future PACE sites from demonstration to provider status. Based upon the years of experience of the PACE demonstration, CBO has found S. 990 budget neutral. However, the legislation includes a specific provision limiting provider status to only those programs which the Secretary finds generate cost savings to Medicare and Medicaid.

Since S. 990 was introduced last June, HCFA had raised a couple of concerns regarding its specifics, concerns which we found reasonable and consistent with the overall thrust of the proposal. We support changes designed to address those concerns in a modified version of S. 990 which has been made available to Members and

their staffs. We want to note that the relationship between PACE and HCFA has been collaborative and constructive over some 15 years, and surmise that HCFA may have encouraged the specific recommendation to expand the program in the President's budget.

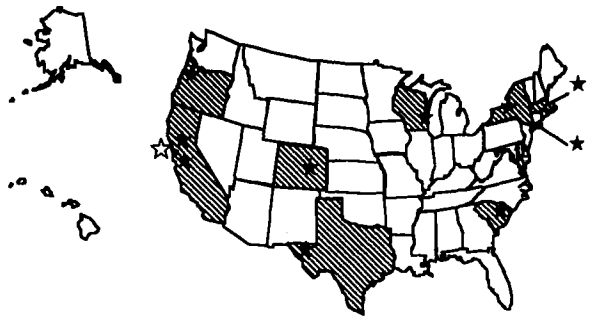
The urgency to expand PACE is generated not just by widespread unmet needs but also by the managed care focus of Medicare and Medicaid reform legislation. Today, PACE is the only managed care program providing services exclusively to enrollees whose health status qualifies them for long-term institutional care. Again, PACE programs have already proven they can effectively meet the needs of the frail elderly, a population considered by many to be increasingly vulnerable in the context of expanded managed care. The frail elderly are not sought after by managed care plans which prefer to avoid the risk and often do not have the capability, interest or focus to address the needs of this high-risk, high-need, chronic care population. In that regard, I would like to point out that provider status for qualified PACE programs is vital to assure that frail individuals have direct access to enrollment in a program designed to fully address their unique needs. Further, provider status would facilitate subcontracting arrangements with managed care plans and other insurers for the provision of PACE services. Parenthetically, without ultimately affording provider status to successful PACE programs, they are almost condemned to demonstration in perpetuity!

S. 990 is consistent with efforts to provide states greater flexibility in administering Medicaid. Stemming from a commitment to develop viable alternatives to high-cost "bricks and mortar" institutionalization, over the last several years states have joined with community charitable and public organizations to develop PACE programs. S. 990 would provide states the option to pursue PACE development and, as under present law, state participation would continue to be voluntary. Thus, states would make their own evaluations of the need for and cost-effectiveness of PACE within their boundaries.

It should be emphasized that enactment of the provisions of S. 990 would not expand the number of individuals eligible for benefits. Rather, it would make more generally available a preferable, less costly, and more humane, community-based and community sponsored alternative to institutionalization for persons who are already or will be eligible for nursing home care. Implementation of the proposal would certainly contribute significantly, on a cost-effective basis, to the care and well-being of frail, older Americans on a basis not inconsistent with broader health care efforts. We urge your support and timely action in the near future on the provisions of S. 990.

Attachment: List of Sites in Development

PACE is replicating the On Lok model . . .



Organizations with Waivers to Operate PACE as of April 1996

CALIFORNIA
- ☆ On Lok Senior Health Services
  San Francisco
- ★ Center for Elders Independence
  Oakland
- ★ Sutter Health's Sutter SeniorCare
  Sacramento

COLORADO
- ★ Total LongTerm Care, Inc.
  Denver

MASSACHUSETTS
- ★ East Boston Neighborhood Health Center's
  Elder Service Plan
  East Boston

NEW YORK
- ★ Beth Abraham Hospital's
  Comprehensive Care Management
  Bronx

NEW YORK (Cont'd)
- ★ Rochester General Hospital's
  Independent Living for Seniors
  Rochester

OREGON
- ★ Sisters of Providence's
  Providence ElderPlace
  Portland

SOUTH CAROLINA
- ★ Richland Memorial Hospital's
  Palmetto SeniorCare
  Columbia

TEXAS
- ★ Bienvivir Senior Health Services
  El Paso

WISCONSIN
- ★ Community Care Organization's
  Community Care for the Elderly
  Milwaukee

Organizations Delivering Services under Medicaid Capitation as of April 1996

CALIFORNIA
- Altamed Senior Buena Care
  Los Angeles

HAWAII
- Maluhia
  Honolulu

ILLINOIS
- REACH
  Chicago

MARYLAND
- Johns Hopkins Elder Plus
  Baltimore

MASSACHUSETTS
- ESP of The Cambridge Hospital
  Somerville
- ESP Fallon
  Worcester

MASSACHUSETTS (Cont'd)
- ESP Harbor Health
  Dorchester
- ESP of Mutual Health Care
  Roxbury/Dorchester
- ESP of The North Shore
  Lynn

MICHIGAN
- Henry Ford Center for Senior Independence
  Detroit

WASHINGTON
- Providence Elderplace of Seattle
  Seattle

WISCONSIN
- Elder Care Options
  Madison

Organizations Delivering Services under Medicaid Capitation by the End of 1996:

NEW MEXICO
SISTERS OF CHARITY HEALTH CARE SYSTEM/ST. JOSEPH'S HEALTH SYSTEM
Albuquerque

NEW YORK
EDDY SENIORCARE
Troy

LORETTO'S INDEPENDENT LIVING SERVICES
SYRACUSE

OHIO
BETHESDA HOSPITAL
Cincinnati

VIRGINIA
SENTARA LIFE CARE CORPORATION
Norfolk

Organizations Exploring Feasibility of PACE Development:

ARIZONA
MARICOPA COUNTY HEALTH CARE AGENCY
Phoenix

CALIFORNIA
ST. JOSEPH HEALTH SYSTEM
Fullerton

LIFE STEPS/DANIEL FREEMAN HOSPITAL
Los Angeles

VERDUGO HILLS HOSPITAL
Glendale

CONNECTICUT
MASONIC HOME AND HOSPITAL
Wallingford

DELAWARE
FRANCISCAN HEALTH SYSTEM
Wilmington

FLORIDA
FLORIDA HOSPITAL
Orlando

GEORGIA
CANDLER HEALTH SYSTEMS
Savannah

ST. JOSEPH'S HOSPITAL
Atlanta

WESLEY WOODS, INC.
Atlanta

KENTUCKY
CHRISTIAN CHURCH HOMES OF KENTUCKY, INC./ SANDERS BROWN CENTER ON AGING
Lexington

MARYLAND
DIMENSIONS HEALTHCARE SYSTEM
Landover

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL
Baltimore

MASSACHUSETTS
ST. LUKES/CHARLTON HOSPITAL
Fall River

MISSOURI
HEARTLAND HOSPITAL
St. Joseph

NEBRASKA
ALEGENT HEALTH
Omaha

NEW JERSEY
BERGEN PINES COUNTY HOSPITAL
Paramus

COMMUNITY-KIMBALL HEALTH CARE SYSTEM
Toms River

CARING, INC.
Pleasantville

SOUTHERN NEW JERSEY VISTING NURSE SYSTEM
Runnemede

ST. FRANCIS MEDICAL CENTER
Trenton

NEW YORK
ARDEN HILL LIFE CARE CENTER
Goshen

OHIO
AKRON GENERAL MEDICAL CENTER
Akron

BENJAMIN ROSE INSTITUTE/UNIVERSITY HOSPITALS HEALTH SYSTEM
Cleveland

PENNSYLVANIA
LUTHERAN AFFILIATED SERVICES
Mars

PITTSBURGH MERCY HEALTH SYSTEM
Pittsburgh

ST. AGNES MEDICAL CENTER
Philadelphia

UNIVERSITY OF PENNSYLVANIA SCHOOL OF NURSING
Philadelphia

VIRGINIA
INOVA HEALTH SYSTEM/FAIRFAX COUNTY HEALTH DEPARTMENT
Fairfax

WASHINGTON
FRANCISCAN HEALTH SYSTEM–CARE CENTER AT TACOMA
Tacoma

WEST VIRGINIA
RALEIGH COUNTY COMMISSION ON AGING
BECKLEY

Chairman THOMAS. Thank you very much, Ms. Hansen.
Dr. McCann.

STATEMENT OF ROBERT MCCANN, M.D., MEDICAL DIRECTOR, INDEPENDENT LIVING FOR SENIORS, ROCHESTER GENERAL HOSPITAL, ROCHESTER, NEW YORK

Dr. MCCANN. Mr. Chairman and Members of the Committee, it is an honor for me to speak with you today. As Jennie said, I am the medical director of the PACE site in Rochester, New York, Independent Living for Seniors, and we currently serve just under 300 older persons in our community who are very frail.

Jennie has mentioned some of the principles of PACE, and what I would like to do is talk about one of our participants in our program to bring some of these principles to life for you. I have some enlarged photographs of the person, whom we shall call "Mr. B," that you can pass around.

Mr. B was 93 years old when he was admitted to the hospital. He had fallen several times, which led to bleeding inside of his head. After the surgery, he never quite regained his previous cognitive function. He became bedbound and noncommunicative, and he was awaiting placement in a nursing home. I was consulted after he had been in the hospital for 3 months. At that time, the area nursing homes were filled nearly to capacity, and he was a very low priority for admission, as his Medicaid had not been approved, so none of the nursing homes were rolling out the red carpet for him.

At this point, our ILS team set to work with Mr. B to enroll him in our PACE program. Our social worker met with his wife, who also had health problems, and a very supported but exhausted daughter. They were both extremely upset about his present state, but they felt considerable anxiety about bringing him home and handling him at home. So, we met many times with them, brought them to our day center. Our social worker dealt with a lot of different issues and made them comfortable with the team that would be caring for their dad.

Our physical therapists went to their house, did a few environmental things like put a bed downstairs, because their bedroom was upstairs; a commode by the bedside, some very simple things, but some things that could make the difference between staying home and going to a nursing home. It is the simple things often that make the biggest difference, and they are some of the hardest things to do sometimes.

He was discharged from the hospital to his home with a plan that included an aide to get him ready to come to the center, and you can see her getting him ready there in his home. She might go there for one-half hour to 45 minutes a day. Now, if you tried to get an aide in the traditional system to go to someone's house, the agencies in town would say 2 hours, 3 hours, or nothing. So again, we have an incredible incentive to use the people who work for our program most efficiently to give a person what they need but not to make them more functionally dependent.

Our nurses and physical therapists worked with him at the day center to help him learn to walk again, and you can see him walking there independently with his walker. This was a man who, only

a month or so before, was totally bedbound. I started him on an antidepressant, which led to an improvement in his appetite and a little bit of improvement in his cognitive function. Over the next few weeks, he really blossomed. He became one of our most social members in our day center. He continued to be incontinent of urine, but this was managed somewhat by just having him get toileted regularly, again, something that sounds simple but is very hard in reality to carry out sometimes, and to train people to do, particularly in the community.

As an enrollee, he did well for about 3 years, becoming again someone that everyone just fell in love with, and he engaged in a lot of activities, including playing checkers at our center, and he usually lost, but his checkers partner was extremely happy about that. And during these days, he did experience one episode of pneumonia. I remember going in to see him on a Saturday at our day center. For this condition, people would almost certainly go to the hospital. We gave him intravenous antibiotics at the center. I made sure that he kept walking. I made sure that he got proper nutrition and he did not get deconditioned and end up sort of in the same spot he had been a few months or years before.

Eventually, he developed abdominal pain and had a bowel obstruction due to a colon cancer. We brought him to the hospital to have this obstruction relieved and after a few days, brought him back out to his home with extensive home care. His wife and daughter were not comfortable with him dying at home, however, so after about 2 weeks, we brought him to a transitional housing apartment that we rent and staff around the clock with aides and with nurses who can visit and with physicians who will visit to make sure that he is comfortable, and that he dies with dignity and without a lot of pain. And he died very comfortably, with his wife and daughter present.

Now, had he not come into our program, he would have certainly ended up in a nursing home. And besides the excellent care that he got, Medicaid's costs were substantially reduced. Today, the nursing home that we will send people to, the Medicaid daily rate is about $122 per day, and this translates to about $3,700 a month, and our payment is about $2,900 per month. And again, when we look at Medicare costs, we look at the first 350 people who came into our program, and they utilized about 21 hospital days per person per year before coming into the program. And now, they spend about 4 to 4.5 days per year in the hospital. So, this is a substantial savings for Medicare.

And how does this work? How does it end up saving money? Well, the incentives are so different. A lot of times, you will have a patient in the hospital, and maybe the lift did not show up at home to be able to transfer them. Well, people will say, OK, we will send them tomorrow. Well, we say no, get them out of the hospital today; get that lift at home today. Because for me, every day in the hospital is a hearing aid, or every day in the hospital is an upper denture. And again, we have got so many incentives to use the money wisely in a capitated system and we know that the money will be used to go back into the system to provide further care that I think this is the reason why we really save money.

You can think capitated, but being capitated, I believe, really provides incentives to give a person what they need when they need it. We have a very low turnover of staff, including our personal care aides. Now, aides in our community generally turn over in nursing homes; 20 percent to 40 percent will turn over in a year. We have a turnover that is somewhere around 10 to 15 percent. This is because our aides participate in this multidisciplinary team. And again, it makes so much sense but is never done. The people who deliver the most hands-on care are frequently the last people who are normally asked how to improve care. We found out that by integrating them into our teams, not only do we bring them to the highest level of their function, but they work well, and they stay with us.

Thank you.

[The prepared statement follows:]

STATEMENT OF
ROBERT MCCANN, M.D., MEDICAL DIRECTOR,
INDEPENDENT LIVING FOR SENIORS, ROCHESTER, NY

Mr. Chairman and Members of the Committee:

It's an honor for me to speak with you today. I am the medical director of the PACE (Program of All-inclusive Care for the Elderly) site in Rochester, New York called Independent Living for Seniors (ILS). We started our program in 1990 and presently serve 300 frail elderly persons in our community. Jennie Chin Hansen has outlined the principles of PACE, and I would like to spend a few minutes talking about how these principles translate into compassionate, appropriate and cost-effective care for our participants and how a truly multidisciplinary approach to care creates a satisfying experience for families and for our employees.

The best way to bring the PACE philosophy to life for you is to discuss a participant whom we have cared for in our program -- Mr. B was 93 years old when he was admitted to the hospital. He had fallen several times, leading to cerebral bleeding that was surgically drained. After the surgery he never quite regained his previous cognitive function, became bed-bound, non-communicative and was awaiting placement in a nursing home. I was consulted after he had been in the hospital for three months. At that time the area nursing homes were filled nearly to capacity; and he was a low priority, as his Medicaid eligibility had not been approved at the time. At this point our ILS team set to work and Mr. B enrolled in our PACE.

Our social worker met with Mr. B's wife (who also has health problems) and a very supportive but exhausted daughter. Both were extremely upset about his present condition but felt considerable anxiety about being able to handle him at home. Our social worker had them visit ILS' Center and meet with some of ILS' team members so that they felt more comfortable pursuing a plan to discharge Mr. B from the hospital. Our physical therapist assessed the patient and his home, making several environmental recommendations. We arranged to have a hospital bed and commode placed on the main floor of his home, as the bedrooms were up one flight of stairs. Mr. B was discharged from the hospital to his home with a plan that included an aide to get him ready to come to ILS' Center seven days per week and an aide to help him into bed each evening. Our nurses and physical therapists worked with him daily at the Center to help him to learn to walk again and to recondition his muscles that had become very weak from extended bedrest. I started him on an antidepressant which led to an improvement in his appetite and some improvement in his cognitive function.

Over the next few weeks he steadily improved to the point of walking independently with his walker. We also supplied him with a hearing aid, which improved his ability to talk with others. He continued to be incontinent of urine which was managed with a regular schedule of toileting.

As an ILS enrollee, Mr. B did very well for about three years, becoming one of our most sociable participants. His wife was extremely happy to have him at home again. He engaged in many activities at the ILS Center and played checkers (usually losing but making his checker-partner very happy!).

During these three years he experienced an episode of pneumonia that was treated with intravenous antibiotics at the ILS Center along with enhanced help walking to prevent deconditioning, and he did very well. A few months later he developed a bowel obstruction from colon cancer, causing considerable pain. We admitted him for surgery to have the obstruction relieved and discharged him from the hospital to home for comfort care. After two weeks he was moved into our transitional housing apartment for around-the-clock care, as his wife was not comfortable with him dying at home. He died comfortably with his wife and daughter present.

If Mr. B had not had the option of enrolling in the ILS program, he would have eventually been discharged from the hospital three years ago to a nursing home with very little or no prospect of ever returning home. Beyond ILS' ability to enhance Mr. B's quality of life, by preventing nursing home placement, Medicaid's costs were reduced substantially. Today, the Medicaid nursing home rate in Rochester is $122 per day. On a monthly basis, this translates to almost $3,700 in contrast to Medicaid's monthly payment to PACE of $2,900 -- a savings of 20 percent.

This case, which is very typical of ILS' enrollees, illustrates the benefits of comprehensive care aimed towards improving psychological and physical function that maximize a person's independence. Many aspects of this care would have been difficult to provide in the traditional fee-for-service system, particularly the coordination of care within our interdisciplinary team. The continuous process of assessment and care planning that occurs at PACE sites contrasts dramatically with the comparatively intermittent approach to case management in the traditional long-term care system. Our unique financing breaks down the barriers between acute and chronic care and allows us to give participants what they need, when they need it.

Prior to my working in geriatrics I worked in a busy hospital emergency department. Emergency departments provide a unique opportunity to see many of the lesions in our health care system for older persons. The fragmentation of care, overuse of medications and testing, and lack of discussion about end of life decisions can lead to interventions that do not improve, and often adversely affect, a person's quality of life. Working in the PACE program has allowed me to work in a stimulating environment that addresses many of the problems in our current medical system for this population and aligns the incentives towards what people really need and not just what can be billed for.

Our participants and their families have been very happy with their care. A three year study of our program was conducted by the Center for Governmental Research (funded by the John Hartford Foundation, Feb. 1994). This study assessed patient and family satisfaction to be very high.

We have a very low turnover of staff including our personal care aides, which speaks to the satisfaction that our workers experience in working as equal team members with a real ability to be heard and influence the plan of care. This satisfaction can only lead to more efficient and compassionate care that we would want our own family members to experience.

Chairman THOMAS. Thank you very much, Dr. McCann.
Mr. Ervin.

STATEMENT OF SAM ERVIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SCAN HEALTH PLAN, LONG BEACH, CALIFORNIA

Mr. ERVIN. Good morning, Mr. Chairman and distinguished Members of the Subcommittee. I am Sam Ervin, president and chief executive officer of SCAN Health Plan, Long Beach, California. We are one of the original Social HMO sites selected by HCFA for the Social HMO demonstration. Directly behind me are representatives of the other two sites: Lucy Nonnenkamp, site director for Kaiser Permanente in Portland, Oregon; Eli Feldman, president of Elderplan, Brooklyn, New York.

I appreciate this opportunity to testify today on behalf of all of the Social HMO sites and to share with you our perspectives on the value of this important demonstration. This is an issue that should touch the heart of everyone in this room, everyone who has a mother and father, grandparents, ourselves as we age: How do we cost effectively enable older people to remain as independent and living in dignity as long as possible?

In the 11 years of operation of the Social HMO, we have served more than 50,000 seniors with this unique marriage of acute and community-based long term care. The program currently serves about 19,000 seniors, 12 percent of whom are classified as nursing home certifiable. This means that almost 2,300 of these members are eligible, based on state Medicaid guidelines, to be placed long term in custodial care.

Mr. Chairman, we are proud to report that we have been successful in meeting our program's goals. This vision of care integration, which was put in place in 1984, has succeeded in keeping over 90 percent of our nursing home-certifiable population in their own homes. That means that over the last 12 years, millions of dollars in state and Federal Medicaid funds were not spent on custodial care. It means that hundreds of seniors without the traditional support of nuclear families have been able to remain financially and physically independent. It also means that hundreds of families have been spared the pain of watching their loved ones placed in institutions for the remainder of their days.

This has been accomplished through the cost-effective application of services such as adult day care, respite care, emergency response, homemaker services, and personal care assistants, all of this coordinated by trained geriatric social workers. And importantly, it has reduced health care costs and improved quality and appropriateness of care.

I would like to share one brief case study, which happens to involve one of SCAN's members. A 73-year-old man became the prime care giver for a wife who developed Alzheimer's disease and for his mother, who was left half-paralyzed by a stroke. On the verge of emotional and physical burnout and severe financial distress in helping to pay for all of this care, they all enrolled in SCAN. SCAN pays $625 a month toward 24-hour, 7-day a week care for his mother and also provided for medical equipment and

railings for her bed. Thus, she was able to stay out of an institution.

SCAN also provided for a large portion of adult day care services for his wife, where she received care from 8 to 5 on weekdays in a specialized program for Alzheimer patients. In addition, SCAN's no-premium program supplies the Van Winkles with an unlimited pharmacy benefit, among other non-Medicare covered benefits and services. There are hundreds of similar stories from Elderplan in Brooklyn, New York; Kaiser Permanente's program in Portland, Oregon. Mr. Chairman, this is a program well worth continuing.

As we work to expand our services, in SCAN's case throughout southern California, we face expiration of the program 20 months from now. We respectfully ask that you consider Congressional action which will ensure continuation of the program. Please consider directing the Secretary of Health and Human Services to develop regulations which grant permanent waiver authority for existing sites and which provide a mechanism for other entities to apply for Federal qualification as a Social HMO. Upon promulgation of the regulations, existing sites would be granted permanent waiver authority if they met the requirements set forth in the legislation. If the Secretary does not promulgate regulations by December 31, 1998, the existing sites would automatically be granted permanent status.

Having submitted more substantive written testimony, I will stop now. I would be happy to take any questions from the Subcommittee.

[The prepared statement follows:]

[The SCAN Health Plan: Analysis of Cost-Saving Potential for the California Medi-Cal Program is being held in the Committee's files.]

TESTIMONY OF SAM ERVIN
PRESIDENT AND CEO, SCAN HEALTH PLAN
before the
HOUSE WAYS & MEANS SUBCOMMITTEE ON HEALTH

April 18, 1996

I. INTRODUCTION

Mr. Chairman and distinguished Members of this Subcommittee, I am Sam Ervin, President & CEO of SCAN Health Plan, one of the original Social Health Maintenance Organization (Social HMO) demonstration sites. I appreciate the opportunity to testify today on behalf of all Social HMO sites and to share with you our perspectives on the value of this important demonstration program.

Mr. Chairman, I am here today not only to provide evidence of the Social HMO's value, but also to urge your serious consideration of making permanent the current waiver authority for the existing sites and to provide a mechanism enabling other organizations to develop similar innovative approaches to integrated care. It seems to me entirely appropriate that the Health Subcommittee is reexamining the Social HMO and PACE demonstrations at a time when health care systems consolidation and integration are at their zenith and when there is so much interest in the concept of Medical Savings Accounts. Medicare and Medicaid restructuring and the development of managed care options for the elderly in many ways have their very origins in the Social HMO demonstration. The Social HMO is among the most successful demonstration programs and has provided approximately 50,000 seniors the opportunity to enroll in a program that covers the provision of home and community-based long-term care services. Upwards of ten years of experience demonstrates that the Social HMOs have proven effective in improving quality and consumer satisfaction while reducing costs and has provided literally thousands of Medicare beneficiaries an alternative to nursing home placement.

I would like to focus my testimony today on four areas of support for the Social HMO program. These include (1) the future of the program; (2) the tremendous benefits these programs offer to senior citizens and their caregivers, and by implication, other chronically-ill populations; (3) the benefits to both consumers and the health system that can be derived from the establishment of integrated systems of care that coordinate the provision of and pool financing for primary, acute and long-term care services; and (4) the cost-savings potential of this model.

II. BACKGROUND

The Social HMO demonstration was authorized under the Deficit Reduction Act of 1984. This purpose of this demonstration was to develop innovative financing and delivery models for integrating acute and long-term care services, and in the process, reduce health care costs and improve quality and appropriateness of care. Since the program's inception, more than 50,000 seniors have been served. The program currently serves approximately 19,500 seniors through three of the four original Social HMO sites.

Four sites initially were selected by the Health Care Financing Administration (HCFA) to participate in this demonstration: Elderplan, Inc. in Brooklyn, New York; Kaiser Permanente Center for Health Research in Portland, Oregon; SCAN Health Plan of Long Beach, California; and HealthPartners (Seniors Plus) of Minneapolis, Minnesota. The original (1984) legislation provided for a three and a half year demonstration which subsequently was extended three times (1987, 1990, and 1993). Current waiver authority is due to expire December 31, 1997. Three of the four sites continue to operate. In addition, the Social HMO I sites were instrumental in gaining the approval of six additional "second generation" sites ("Social HMO II") which are scheduled to become operational next year under authority granted by OBRA 1990. These projects will test variations on the Social HMO I demonstration.

The architects of the Social HMO intended to eliminate many of the problems which continue to plague the traditional fee-for-service system such as fragmentation of service delivery and

financing, duplication of administrative requirements across settings and programs, and conflicting policy directives. These problems are especially pernicious for providers serving the dually eligible population since duplication and fragmentation exists not only across health care settings but between the Medicare and Medicaid programs. Through the consolidation of acute and long-term care service structures and the integration of public and private sector funding streams, the Social HMO designers intended to achieve five key goals:

- producing Medicare and Medicaid cost-savings -- which could be used to increase service capacity in a budget neutral fashion -- through operational efficiencies, the provision of more appropriate levels of care and the downward substitution of lower-cost services;

- integrating the full range of acute and community-based long-term care services and providers to expand the continuum, more closely parallelling the needs of our aging Medicare population;

- consolidating services and professionals to enhance coordination of services and to generate norms of practice in caring for the frail elderly which would be applied uniformly across the spectrum of providers/settings;

- enrolling a cross-section of well and frail elderly to create an insurance risk pool for spreading the costs of care and reducing the burden on any one individual; and

- pooling funding sources for the dually eligible to eliminate barriers to effective clinical decision making -- such as the 3 day prior hospitalization requirement for Medicare SNF eligibility -- and allow providers to allocate resources based on individual enrollee needs.

The Social HMO sites have effectively implemented many of these goals to date. The remainder of my testimony will enumerate our successes in the areas of consumer satisfaction, cost-savings potential, and health systems benefits.

III. BENEFITS OF THE SOCIAL HMO

A. Consumer Benefits

Close to 60% of the 85 plus population are disabled and likely to need some type of support or assistance with activities of daily living. For those living in the community, nearly 90% receive assistance from relatives and friends. The majority of unpaid caregivers are women relatives, typically wives, daughters or daughters-in-law. Family support systems are often weak or non-existent, however, leaving those in need of assistance with daily living activities with no one to turn to for assistance. The frail elderly living alone, which account for almost 30% of the over 65 population, and higher for those 85 plus, are particularly vulnerable for institutionalization since often they don't have access to adequate informal support. Where family caregivers are available, they experience exhaustion from their enormous responsibilities and desperately need respite to be able to continue.

The burden of providing continuous care for an elderly relative can take a tremendous physical, emotional and financial toll on informal caregivers. Three significant problems faced by informal caregivers include the fragmentation of our current health and long-term care systems, the absence of financial support for long-term care services and the paucity of assistance available to negotiate the complex web of services frequently needed by a person with multiple disabling conditions. Further, despite older consumers' strongly stated preferences to remain in the community and receive care at home, and because our current reimbursement system is biased toward institutional services, older consumers frequently are forced to enter nursing homes in order to receive care. This payment bias needlessly increases overall health systems costs.

Demographic trends suggest that these and other challenges facing health care consumers, providers and policymakers will continue to escalate as we enter the 21st century. The

continued geometric growth of the over 65 population in general, and the over 85 population in particular, will severely tax public and private sector resources. The over 85 population, which account for the highest utilization rates for services associated with multiple chronic disabling conditions, will increase by 150% between 1990 and 2030. A number of demographic trends impede the ability of family members to provide adequate support for their aging parents such as the decrease in family size and the diminished supply of labor to provide support functions; the increase in the number of women entering the work force; adult children's conflicting loyalties between aging parents and their own children; and greater mobility of the working population.

The Social HMO has helped thousands of older persons and their families resolve these dilemmas by providing comprehensive coordination of all health and related services. We are particularly proud that this program has kept thousands of older persons out of nursing homes through community-based services designed to maximize their functional abilities and independence. Since the Social HMO's inception, we collectively have served approximately 50,000 individuals, roughly 12% of whom were classified as "nursing home certifiable." Between 90 to 95% of these members have avoided institutionalization at a cost savings of literally millions of dollars to the Federal and state governments. Below are a few "success" stories associated with the Social HMO program.

Case Study 1

Romilda is an Elderplan member who experienced difficulties in getting to the doctors' office for follow-up treatment after undergoing total knee replacement surgery. To accommodate her needs, Romilda's physician volunteered to make house calls and Elderplan's home health nurse and physical therapist worked with her in her home until she regained use of the new knee. Following rehabilitation, Elderplan continued to coordinate Romilda's transportation to medical appointments and provide in-home personal care services 12 hours per week. This combination of services prevented her from entering a nursing home and helped her to maintain her independence.

Case Study 2

Gladys lived an extremely active life until age 86 when she was diagnosed with cancer. Although she initially recovered from cancer treatment, she became increasingly frail and forgetful and eventually was unable to continue living alone. Her granddaughter Lynn was considering leaving her job to care for Gladys when she discovered Kaiser Permanente's Social HMO. Kaiser initially provided adult day care services for Gladys twice weekly, provided homemaker services and installed an electronic response system, paying for 90% of related costs. Eventually, expanded care services were changed to adult day care five days per week at a foster home near Lynn's house and respite care to relieve Lynn of caretaking responsibilities periodically. Gladys was able to remain independent with Kaiser's support until she passed away, never being forced to leave Lynn's home and Lynn was able to maintain her employment.

Case Study 3

At age 73, Floyd became the primary caregiver for a wife who developed Alzheimer's Disease and a mother who was left half paralyzed by a stoke. Floyd was on the verge of emotional and physical burn out and severe financial distress in helping to pay for his wife and mother's care when he discovered the Social HMO and SCAN. The plan paid $625 per month towards a 24 hour per day, seven day per week live-in assistant for his mother, and also provided for medial equipment such as a wheel chair and railings for her bed. SCAN also paid for a large portion of adult day care services for his wife where she received care from 8 Am to 5 PM on weekdays by professional caregivers trained in the care of Alzheimer's patients. The support provided by SCAN prevented Floyd from having to institutionalize both his wife and mother.

B. Cost Savings Potential

Social HMO services are financed on a prepaid capitated basis. Benefits may be paid for in three ways: (1) Medicare only; (2) Medicare and private premiums; or (3) Medicare and

Medicaid contributions. Differences in funding streams affect the relative size of the contribution to care. For example, SCAN contributes approximately $625 per month toward the cost of home and community-based services to the first two subscriber groups, but up to $1,000 per month for the dually eligible since SCAN also receives a capitation payment from Medicaid for this population. The enhanced package of services received by enrollees are provided in a budget neutral fashion. Social HMOs are paid, on average, 100% of the average adjusted per capita cost (AAPCC) of serving beneficiaries in their counties. Actual payment amounts are adjusted to account for the functional status of individual beneficiaries, as discussed under our recommendations in Section IV of my testimony.

Neither the Social HMO nor HCFA has conducted a comprehensive study of the cost-savings potential of this model. There are a number of built-in mechanisms to reduce or minimize health care expenditures, however, which we believe have substantially reduced system costs. Further, the Kaiser Permanente Center for Health Research conducted a study focusing on nursing home use between 1986 and 1988 which revealed substantial savings under this model. Data collected by the Social HMO Consortium reveal that the average spending for long-term care services plus the service coordination function averaged $38 per member per month across all four sites in 1990. This amount was equivalent to about 11% of Medicare's per capita payment to plans that year. There are several ways in which the Social HMOs have been able to hold down costs. Part of the cost-savings are achieved through the structure of the benefit. The Social HMO benefit package does not include unlimited long-term care services, but caps annual expenditures at between $7,500 and $12,000, depending on the site. In addition, the model includes a 14 to 30 day limit on non-Medicare nursing home care per spell of illness, consistent with the nature of the nursing home benefit which is used as a supplement to the community-based service benefit to pay for short-term respite stays, convalescence after Medicare nursing home coverage expires, or to cover the first portion of a permanent admission.

Data reveal that this per spell of illness limit has not placed a severe burden on enrollees. Of all Social HMO members using the long-term care benefit during a four year study period, less than 25% were authorized for care that exceeded 85% of the cap. Further, authorization for care does not automatically translate into the use of services. We attribute the efficient use of the long-term care benefit to our highly effective care management system which continuously monitors the health status of those at risk for nursing home placement, coordinates informal support services with those of paid services and maximizes the use of the Medicare skilled benefit which is otherwise available to Social HMO members.

Data produced by the Kaiser Permanente study reveal the cost savings potential of this model. This study compared the experiences of members enrolled in Kaiser Permanente's standard Medicare HMO and the Social HMO. During the study period, the Social HMO offered 100 days of ICF or SNF coverage per benefit period as well as up to $1,000 per month in services delivered in their home or community-based settings. Member copays were 10% for institutional and home care services. The benefits were managed by a service coordination unit that worked closely with hospital discharge planners, nursing home staff and home health care nurses to ensure appropriate and coordinated use of services. A major goal of members, their families and service coordinators was to avoid unnecessary institutionalization and to maximize independent functioning of members. Regular HMO members (i.e., those not enrolled in the Social HMO) received only Medicare-covered nursing home and home health care benefit.

The Kaiser Permenante study revealed many positive effects from the Social HMO benefit structure and service system. For example:

- short-term nursing home benefits reduced barriers to nursing home use for recuperative, respite and rehabilitative stays;
- home care benefits reduced nursing home lengths of stay by supporting more effective transitions back to the community;
- Medicaid expenditures resulting from "spend-down" were reduced by over 50% and these savings offset the higher AAPCC rate paid to Social HMOs by almost half;

- members received access to a coordinated package of chronic care services and a supplemental long-term care benefit which significantly reduced the out-of-pocket costs they otherwise would have incurred without access to the long-term care benefit.

The Kaiser Permanente study showed that, compared to the regular HMO programs, Social HMO members were more likely to enter a nursing home but less likely to stay as many days. Social HMO members had 25% higher admission rates but they spent 29% fewer days in ICFs and 24% fewer days in nursing homes overall. These patterns suggest that the Social HMO long-term care management and benefit systems reduce barriers to nursing home entry for short-term and recuperative stays and helped members return home more often and sooner.

The study also revealed that Social HMO reduced Medicaid spending on nursing home care. Since less than 1% of these members were categorically eligible for Medicaid, almost all of the savings were due to delaying or avoiding Medicaid spend-down. Medicaid spending for ICF and SNF care for regular HMO members was about $212 per member per month compared to about $80 per month for Social HMO members. Over the 24 month study period, the Social HMO saved Medicaid an average of about $5.50 per member per month which is equal to about 2.2% of the average Medicare capitation rate during the study period. Accordingly, although Medicare pays Social HMOs an average of 5% more than standard HMOs (i.e., 100% of the AAPCC vs 95% of the AAPCC), almost half of this additional reimbursement is offset through Medicaid savings.

Social HMOs also have developed a number of innovative approaches to further extend the formal services financed through Medicare, Medicaid and private insurance. I'd like to highlight an example of one such approach undertaken by Elderplan called the "Member-to-Member" program which operates as a Service Credit Bank. This program was established to help extend the formal chronic care benefit offered by the Social HMO. In this program, member-volunteers provide informal supportive services to member-recipients. These services fall into the general categories of escort, shopping, transportation, respite, friendly visiting, telephone reassurance, hospital/nursing home visiting, minor home repairs and peer counseling.

Service Credit Banking is an exciting new approach to mutual aid. It is based upon volunteers earning and spending Service Credits. Service Credits are a local, tax-exempt, computerized currency that utilizes time as the medium of exchange. Service Credits enable an individual to convert personal time into additional purchasing power by providing service to others. With this model, it is possible to generate large amounts of service without payment in money and, therefore, to operate a social service barter system on a scale much larger than ever before. Since the program's inception in June 1987, the Member-to-Member program has provided over 56,500 hours of service to almost 3,000 service recipients through the voluntary efforts of 238 volunteers. To provide some sense of the economic value of these services, in 1995 alone, this volunteer program delivered $161,701 worth of preventive and supportive services at a cost of about $74,000.

C. Health System Benefits

Chronic care represents the fastest-growing and highest cost segment of the health care sector. Our system is quickly moving from a predominance of short-term, cure-oriented conditions to a predominance of conditions that require ongoing, multidimensional and coordinated care. Eighty percent of all deaths and 90 percent of all morbidity are due to chronic conditions. Health care costs for the chronically ill only can continue to grow as the over 85 age group increases and the incidence of heart disease, strokes, respiratory disease, dementia and other chronic conditions expand as well.

To effectively meet the needs of this population, and reign in health systems costs, our health care system must recognize the critical importance of the linkage between acute and long-term care services. National studies as well as data collected by the Social HMOs reveal that almost all long-term care needs originate from acute care illness. Accordingly, efforts to

reduce the explosion of costs to the Federal and state governments and consumers for long-term care services must begin with the establishment of strong linkages between the acute and long-term care service sectors.

Social HMOs, which operate under TEFRA risk contracts, offer Medicare beneficiaries a voluntary choice. Those selecting the Social HMO option receive an enhanced package of Medicare services. In addition to all Medicare Part A and B services, coverage includes pharmacy benefits, hearing aides, eyeglasses, and up to $1,000 per month and home and community-based long-term care services. This enhanced package of services received by enrollees are provided in a budget neutral fashion. The home and community-based services benefits are critical to helping subscribers avoid institutionalization and maximizing their independent functioning. Among the services offered are the following:

Case Management: Geriatric resource managers review each senior's medical needs and determine the long-term benefit package best suited to the individual. Progress is monitored on a regular, ongoing basis. Individuals who become "nursing home certifiable" (NHC) and, therefore, eligible for the community-based long-term care benefit, receive quarterly assessments to determine their ongoing need for long-term care services.

Personal Care Assistance: Personal care aides attend to many basic health needs related to activities of daily living (ADLs) such as bathing, toileting and dressing, to help seniors remain in the community and as independent as possible. These services are made available around-the-clock, if necessary.

Homemaker Services: These services include coverage of home chores such as laundry, cleaning, cooking and shopping, to further enhance an individual's ability to remain independent and in their own homes.

Respite care: This benefit is intended to help relieve the burden of caregivers -- generally spouses and family members --who provide an average of 92 hours a week of their time for their fragile loved ones. Respite care may involve adult day care, overnight or weekend stays at hospitals or nursing homes or other relief.

Transportation for Medical Visits: Wheel chair, van and taxi services are provided to seniors to help assure access to health care services, such as physician office visits.

Adult Day Care: This service provides for a professionally staffed facility where seniors can remain safe and participate in social and medical activities during business hours, evenings or weekends.

Nursing Home Care: The Social HMO benefit provides for short-term nursing home stays of 14-30 days per spell of illness for additional rehabilitation or respite care which supports a home care plan.

Personal Emergency Response Systems: The Social HMO provides members a wireless electronic monitor which is worn around the neck and can be activated in the case of an emergency such as a fall. Members and their families gain a sense of security provided by this around-the-clock medical and emergency assistance benefit.

The Social HMO demonstrations have revealed a number of important linkages between these two systems and opportunities for cost-savings potential. One of the most important linkages relates to the identification of potentially disabling conditions and the development of treatment regimens to prevent or delay disabilities. Data from the Social HMO reveal that 60 to 70 percent of referrals to community-based LTC services come from the acute care system, including hospital discharge planners, utilization review staff, physician offices, etc. In many cases, individuals being referred only need short-term or mid-term rehabilitation service, not long-term custodial care. It is critical that acute and long-term care providers work together to identify patients' needs and develop appropriate treatment protocols and monitoring systems.

Social HMO data reveal that less than half of their enrollees assessed as nursing home certifiable (NHC) at any time remain consistently in this category for more than one year and

many become fully independent following rehabilitation. Further, the Social HMOs have identified several factors which predict whether a patient is likely to remain nursing home certifiable and eligible for long-term care services over the long-run, or to regain functional ability and discontinue long-term care service utilization. For example, predictors of moving from the NHC category include recent hospitalization, female gender, heart conditions and recent fracture or injury. Predictors of remaining NHC include higher age, becoming NHC soon after enrollment, having higher numbers of ADL impairments and higher income. The Social HMOs continuously monitor the health status of those who are at risk of becoming NHC or who are assessed as NHC to assure appropriate interventions. For those who are at risk, preventive measures are implemented to reduce the likelihood of progressive disability. For those who are certified as NHC, quarterly reassessments are performed to evaluate the effectiveness of the treatment regimens. Once an individual has regained functional independence, the long-term care benefit is discontinued and these resources can be directed to individuals in the system in need of these services.

Social HMOs include the type of effective geriatric assessment system which enables providers to (1) identify those at risk for disability and costly long-term care services; (2) develop appropriate interventions before the disabilities progress beyond the point of rehabilitation; and (3) establish a monitoring system for reassessing individuals' ongoing needs for services. A study published last year in The New England Journal of Medicine revealed that such assessments can delay the development of disability and reduce permanent nursing home stays among elderly persons living at home. This study examined the impact of an annual in-home comprehensive geriatric assessments and follow-up for individuals 75 and older. After three years of intervention, 22 percent of the survivors in the control group required assistance in performing the basic activities of daily living while only 12% of the survivors in the intervention group required such assistance. In addition, there were only one-sixth as many nursing home days for the intervention group. About 10 percent of those in the control group were permanently admitted to a nursing home compared to 4% of the intervention group. The study suggests that the prevention of decline in functional status was at least partially responsible for the reduction in nursing home admissions.

Although The New England Journal study did not include an analysis of the cost-savings potential of the geriatric assessment intervention program, certain assumptions can be made from the data provided. For example, during the second and third years of the study, there were significantly more physician visits among the intervention group than the control group. The cost of intervention for each year of disability-free life gained was about $6,000. This is approximately one sixth of the average cost of a year in a nursing home.

IV. SHMO CONSORTIUM RECOMMENDATIONS

As I indicated at the outset of my testimony, the waiver authority under which the Social HMOs operate will expire at the end of next year if no further action is taken. On behalf of the existing sites and members, we urgently request your intervention in granting permanent waiver authority to existing sites and making this valuable program available to other sponsors and subscribers. While the waiver authority is not due to expire until 1997, immediate action is imperative to protect the almost 20,000 senior citizens currently receiving Social HMO benefits. If the authority is not granted this year, the existing sites will have no choice but to begin to plan phasing down of operations in order to provide for an orderly transition from the Social HMO to an alternate health plan.

Immediate action also is needed to protect the integrity of the Social HMO II sites whose waiver authority also is due to expire in December of 1997. As you know, six additional sites are scheduled to begin operations this year under authority granted by OBRA 1990. Both HCFA and the sites have invested considerable time and resources in developing the framework for the next generation of this model. Without the extension, these sites would be fully operational for one year at most. I think you would agree that a one year demonstration would not provide HCFA a reliable basis for evaluation sites' abilities to achieve the second generation demonstration goals. We believe the organizational and financial commitment required warrants a minimum demonstration period of three to five years.

To accommodate both current and future subscribers and sponsors, we respectfully request that:

- Congress direct the Secretary of Health and Human Services to develop regulations which grant permanent waiver authority for existing sites and which provide a mechanism for other entities to apply for Federal qualification as a Social HMO;

- Congress provide legislative authority to continue the Social HMO I and II programs until such time as the Secretary of HHS has promulgated such regulations;

- Upon promulgation of regulations, existing sites shall be granted permanent waiver authority if they meet the standards set forth in the legislation (and described below). If the Secretary does not promulgate regulations by December 31, 1998, the existing sites shall automatically be granted permanent status.

We also request that Congress direct the Secretary to immediately make several modifications to the current waiver authority, as enumerated below, to allow current sites to operate more consistently with all TEFRA HMOs. Below is a description of our proposed modifications as well as recommendations regarding the standards organizations would be required to meet for qualification as a Social HMO.

Modifications to Current Waiver Authority

The Social HMO waivers currently provide for the following:

- payment at 100% of the AAPCC;

- the option to queue applicants according to disability;

- waiver of the 50/50 requirement that limits enrollment of the Medicare and Medicaid populations to 50% and requires that 50% of the membership be composed of commercially insured beneficiaries;

- waiver of the 3-day prior hospitalization requirement for SNF coverage.

We recommend and request several immediate changes to our waiver authority to allow the current demonstrations to operate in a manner more consistent with all TEFRA HMOs and to permit Social HMOs to be more competitive with TEFRA plans:

- eliminate any enrollment ceiling;

- eliminate the existing prohibition against enrolling nursing home residents;

- make regulations regarding marketing and evidence of coverage consistent with other plans.

Medicare Standards for Social HMOs

Social HMOs currently provide an enhanced package of primary, acute and home and community-based long-term care services to Medicare beneficiaries. We recommend that plans applying for Federal certification as a Social HMO under an expanded Medicare managed care program comply with several standards distinct from standard Medicare HMO risk contracts to ensure consistency with the current program. These standards pertain to benefits, case management functions and payment rules.

Benefit Standards

In addition to the Medicare benefits required under MedicarePlus, Social HMOs would offer the following benefits:

- Coverage of prescription drugs, eyeglasses and hearing aides.

- Home and community-based service benefits of at least $7,500 per member per year (exclusive of member copayments). Services would include personal care, homemakers, respite, medical transportation and adult day health care. Eligibility for services would be defined by the Secretary and include those who meet nursing facility admission standards and others at high risk for adverse long-term care outcomes.

- A minimum of 14 days per spell of illness $7,500 per lifetime of nursing facility care for stays that do not meet Medicare skilled criteria. (New spells of illness are defined as those beginning after 60 days of continuous community residence.

Case Management Standards

As indicated earlier in my testimony, the case management function has been critical to the success of the Social HMOs, from a cost-savings, quality and consumer satisfaction perspective. We recommend, therefore, that to qualify as a Social HMO, sites be required to provide comprehensive post-acute and long-term care case management services, including the following:

- initial and periodic screening of the enrolled population through a self-report health status form designed to identify members who meet nursing home admission standards, or who are otherwise at risk due to medical or functional difficulties;

- referral mechanisms that identify newly disabled and at risk members in acute care settings and through self-referral;

- comprehensive functional and social assessments;

- care planning, service authorization, and monitoring systems that ensure attention to member and family preferences and participation in decisions;

- linkages with acute care providers in hospitals, nursing homes, home health, physicians' offices and other settings to ensure timely sharing of appropriate clinical information, assignment of responsibility and coordination of care plans and covered benefits;

- a quality assurance system that integrates quality assurance activities for acute and long-term care services.

Payment Standards

We recommend that Social HMOs continue to receive reimbursement according to the current payment methodology. There are two important differences in the way Social HMOs and TEFRA HMOs are reimbursed. First, Social HMOs receive 100% of the AAPCC instead of 95% to account for the additional chronic care benefits provided. Second, while the only risk-adjustor used by the TEFRA plans to reflect health status is an institutional rate cell for those placed in nursing homes, the 1984 waiver language for Social HMOs specified payment at a higher rate for community-based residents who are "at risk of institutionalization."

Between 1985 and 1994, the AAPCC institutional cells were applied to both nursing home residents and "at risk" community residents. In 1995, a new formula was implemented based on updated research. This formula pays somewhat higher rates for those at risk of institutionalization than nursing home residents. Both the old and new formulas adjust the payment cells for members not meeting high risk criteria to keep the whole formula budget neutral. Accordingly, while Social HMOs are paid 100% of the AAPCC, on average, their actual reimbursement depends on the mix of well and frail or high-risk enrollees.

Mr. Chairman, I have tried to impart to you and Members of the Subcommittee the compelling nature of this HCFA program success which has proved to be a tremendous win/win for seniors and government, both federal and state. It is hard to paint a compelling picture in words about a faceless senior citizen whose dignity and dwindling independence has been buoyed by the application of the Social HMO program. But the essential morals and messages of the story are easy to tell:

- The Social HMO is a program that really works by allocating monies in the most cost efficient and beneficiary effective manner possible;
- The cost savings to the Medicare and Medicaid programs are just beginning to be quantified and understood;
- It is the type of government sponsored program which offers seniors significant choice in controlling their lives, offers health program planners the most cost effective approach to date in dealing with the fast growing frail population, and offers support and encouragement to families as they carry out their care giver roles; and
- Provides a care paradigm applicable to other costly home-bound and medically needy populations.

Mr. Chairman, this program is one that warrants you attention and support. We sincerely hope that you will consider the SHMO Consortium recommendations outline in Section IV of this testimony and help to make this cost effective care program available to thousands more seniors in the years to come.

Chairman THOMAS. Thank you, Mr. Ervin.

We have saved the best until last. Although we have heard some second-hand examples of case studies, we now have Ms. Rosalie DiPietro, who is a subscriber to Elderplan, and she is going to give us a firsthand statement about the program.

Ms. DiPietro.

STATEMENT OF ROSALIE DIPIETRO, SUBSCRIBER, MEMBER SERVICES, ELDERPLAN, INC., BROOKLYN, NEW YORK

Ms. DIPIETRO. Good morning. Thank you for inviting me to participate in today's hearing. I appreciate that you want to hear directly from a consumer about what this Social HMO means for Medicare beneficiaries. I am very concerned at the possibility that I could lose my health insurance coverage through Elderplan and have to find a whole new plan. This is why I agreed to come to Washington today.

From my personal experience, I think the Social HMO is excellent. I have had very good health care when I needed it and no paperwork. Most important, I have peace of mind about my doctors, hospital care and being able to manage my expenses, because I know that I will not be faced with deductibles or large copayments.

I have lived in Brooklyn, New York, all of my life. I own my own home, which I share with my daughter and her husband. I have six grandchildren and two great-grandchildren. I have been a widow for 43 years. I went to work after my husband died because I wanted to give my three young children a better living, what my husband would have wanted for them. I was employed at the bank for 30 years, and I held a second job in the evening for 20 years because I wanted to be sure that my grandchildren would have the best.

After working hard for many years, I retired at the age of 62. At the time, I had health insurance from my employer. I used it for several years, but I was not satisfied. There were many copayments, and I never knew how much I would have to spend if I became ill. How could I manage my expenses this way?

I decided to enroll in Elderplan in 1988. That was 8 years ago, and I have been very satisfied. I know what my health care will cost me, and I do not have to worry about anything. I keep up my Medicare part A and B, and I do not mind small copayments I pay for some services. For example, today, I am using glasses that I got from Elderplan. They are not fancy. They do the job, and for me, this is what I want.

For most of the time that I have belonged to Elderplan, I was very healthy. I went to the doctor once a year for a checkup, had my annual mammogram, and that was about it. And this fall, I really needed Elderplan. And if I had not received the right medical care and help while I was recuperating, I might not have been able to come here today to be part of this Congressional hearing.

My problems began 1 day last September when I was carrying a basket of laundry downstairs to the basement to do the wash. I fell and hurt my foot. At first, I just thought it was bruised. When the swelling did not go down, I called my doctor. He sent me for x rays and showed me a break. I was taken to the orthopedist immediately. I went home with my foot in a cast for 6 weeks. When

the time came, the cast was removed. Then, I used a special shoe and stocking until everything was healed. I did not have to spend a penny.

That was just the beginning. Just a few weeks after the cast came off, I broke my hip. One afternoon, I was walking along the sidewalk to see my neighbor, and a young dog came running out of his house and knocked me down. I knew something was wrong, because I could not walk. I really needed my health insurance this time. Elderplan was terrific. I received all of the health care and services that I needed. The doctors and hospital staff were excellent. They could not have taken better care of me if I had paid hundreds of dollars in premiums every month.

When I went home, an aide came to help me during the day for about 2 weeks. Later, when I was ready, I got a walker and then a cane. A physical therapist came to my house to show me how to move in the right way. All of this was arranged and paid for by Elderplan. Elderplan has meant a lot to my family, too. My children feel that I was well taken care of. If it had not been for the help I received at home when I broke my hip, my daughter would have had to take off from work. There would not have been any choices for us. I have peace of mind and a financial safety net because Elderplan took care of everything.

Elderplan has been very good to my brother-in-law and sister-in-law, who have been members for years. I see how other people are taken care of when they have heart surgery and other problems, so I know how much a good health plan like Elderplan can do. Now that I am pretty much back to my full activities, I like spending time with my family, and I scour my kitchen every Friday no matter what. Many of the things that keep me busy are connected to Elderplan. Elderplan sponsors quite a few programs about staying healthy. For example, I am in the walking club organized by Elderplan. Twelve of us walk together for about an hour once a week. Also, I am part of the Elderplan volunteer program called Member-to-Member. I usually spend 1 day a week in the office, unless I am taking care of my great-grandchildren. I go to health education programs that Elderplan has for members and the community at no cost to us. I have taken part in meetings, fitness and one on improving your memory, and for the past 2 years, I have been a subscriber representative to the Elderplan Board of Directors, which meets four times a year.

I can tell you that it gave me a great feeling at the meeting 2 weeks ago that we approved adding more benefits to Elderplan so Medicare beneficiaries like me will have many more choices and more control over their health care. Members suggested making changes, and Elderplan listened. One of the biggest changes will be having a budget of $100 a year for every member to use for trips to the doctor or other care. Right now, members who have a medical need can get free transportation from Elderplan. There will be more choices when it comes to selecting eyeglasses, hearing aids and dentures, and women who belong to Elderplan will be able to see their gynecologist and have their annual mammograms without getting referrals in advance from their primary care physicians. These improvements will be terrific.

Now, I never like to tell people what to do. I can only say what I like. I am very happy with Elderplan and very satisfied with the way I have been treated. I definitely believe that Elderplan should continue, because a lot of people will be in trouble without Elderplan and other Social HMOs.

Chairman THOMAS. Thank you very much, Ms. DiPietro.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. I thank the panel for your testimony. It was very interesting.

Ms. DiPietro, what premium do you pay——

Ms. DIPIETRO. Nothing.

Mrs. JOHNSON [continuing]. Per month?

Ms. DIPIETRO. Nothing; Medicare—they take my A and B, and that is it.

Mrs. JOHNSON. I see.

And can anyone else on the panel, maybe Dr. McCann, can you tell me what someone not eligible for Medicaid would pay in premium for the Elderplan program?

Ms. DIPIETRO. It is zero premium.

Ms. RAPHAEL. Yes, it is a zero premium health plan.

Mrs. JOHNSON. Pardon?

Ms. RAPHAEL. It is a zero premium health plan. Members need to maintain Medicare A and B. They do not pay an additional Elderplan premium.

Mrs. JOHNSON. It is a zero premium health plan, and you get a capitated reimbursement from Medicare of 100 percent of the Medicare capitated amount?

Ms. HANSEN. Our capitated amount from Medicare, targeting the frail elderly population that is already certified to be in a nursing home. I think Dr. Vladeck mentioned 2.39 of 95 percent of the AAPCC. That is the Medicare side.

On the Medicaid side, if someone is Medicaid-eligible, the state would pay anywhere from 5 percent to 15 percent, generally, lower than its Medicaid rate for a traditional fee-for-service system expenditures for this same population. From a standpoint of the consumer, if he or she is covered by both Medicare and Medicaid, there is no premium. If a person is middle income, they would pay whatever the same share the Medicaid person would have paid. And there are beginning experiments with long-term care insurers who are willing to start looking at paying some of that premium for someone who will be middle income.

Mr. ERVIN. For the Social HMOs, by the way, the premium at Kaiser is $156 a member month, and at the other two, Elderplan and SCAN, it is zero.

Mrs. JOHNSON. If the Elderplan's cost is zero, are you saying it is zero for those who also do not meet the Medicaid qualifications?

Mr. ERVIN. That is right.

Mrs. JOHNSON. And the reimbursement is 100 percent of the Medicare HMO rate?

Mr. ERVIN. Yes, each Social HMO receives 100 percent of the AAPCC.

Mrs. JOHNSON. That is very interesting. If the law should expire, what would prevent you from continuing in the form of an HMO, offering your services to Medicare recipients for a zero premium?

Mr. ERVIN. There are several waivers that the Social HMOs have which enabled us to exist. We were a small, community-based nonprofit organization which clearly could not meet the 50/50 rule; did not meet the Federal qualification rule and several other provisions. So we would not, for example, be able to continue. We have recently at SCAN, for example, started a commercial plan, which we hoped to build up to be large enough that we can apply to be a regular risk contractor side-by-side with the Social HMO. It would provide a certain level of insurance should the Social HMO ever come to an end. We hope that does not happen because of the incredible benefits that we are able to offer. And Elderplan is in a similar position, where they could not meet the requirements of a risk contractor currently.

Mrs. JOHNSON. Could they organize themselves simply as a Medigap insurance policy, offering all of the things that Medicare does not offer that you offer, the lower copayments and so on? What prevents that?

Mr. ERVIN. The thing that makes these benefits possible——

Chairman THOMAS. Mr. Ervin, would you talk directly into the mike?

Mr. ERVIN. Yes; I am sorry.

The thing that makes the benefits possible is the managed care system, putting all of the benefits into one managed system of care in an integrated fashion. In an indemnity model, it would cost far more to provide the same benefits.

Mrs. JOHNSON. Mr. Ervin, it is possible under current law to organize yourself as a managed care system and then offer yourself through the Medigap policy process. This is outside of the HMO risk contract. This is a completely different avenue. And if your law expires, what would be the impediments to organizing yourself as a managed care plan and offering a Medigap insurance policy for a zero premium? Is it that you could not have access to the capitated payment?

Mr. ERVIN. Yes, that would definitely be a major obstacle. It is the capitated payment that allows us to organize all of the strata of care that are required for the whole population that we serve, and in a managed care setting, you can accomplish that, and the capitation really is the financing mechanism that makes it possible.

Mrs. JOHNSON. Why have you found it difficult to compete with the TEFRA plans in your area?

Mr. ERVIN. I am sorry, Congresswoman, I missed the question.

Mrs. JOHNSON. Why have you found it difficult to compete with the TEFRA plans in southern California?

Mr. ERVIN. Well, in southern California, you probably know that it is certainly one of the two most competitive markets in the country. There are about 30 Medicare HMOs there. They are far larger than we are, almost all of them, and they have far greater money to spend on marketing, and it is a costly and labor-intensive effort as well, because we enroll generally one person at a time. We talk to them; we educate them. And it takes an educational process for them to understand the value of these added benefits, especially having them available if they do not need them right now. So this is not an easy thing to develop, plus, we have started very small, and we had an enrollment limit of 7,500 members until 1993, when

that was lifted, and then, it was raised to a possible limit of 12,000, which has not been imposed in our case.

Mrs. JOHNSON. The government put the limit on?

Mr. ERVIN. I am sorry?

Mrs. JOHNSON. The government established the limit?

Mr. ERVIN. The 1993 legislation gave the Secretary the right to impose a limit of no less than 12,000. Previous to that time, it had been 7,500.

Mrs. JOHNSON. Are you still operating under a limit?

Mr. ERVIN. At this time, two of the sites have been told that they are under a limit, as far as I know, of 12,000. We have not received such.

Mrs. JOHNSON. Does the limit in and of itself make it difficult to compete?

Mr. ERVIN. Yes, it does. It certainly limits your ambition in developing a network and in geographic expansion, and, therefore, in what your business plan for growth and expansion is.

Mrs. JOHNSON. Do you have any comment to HCFA's evaluation that the SHMOs have tended to serve the healthier clients?

Mr. ERVIN. Twelve percent of our population are nursing home certifiable. That has obviously changed over the years. There was a queuing mechanism in place for the Social HMOs to help prevent too great an adverse selection, which could have made it a very risky proposition and possibly driven us out of business early on. At this point, with 12 percent nursing home certifiable, definitely, we do not have a favorable selection compared to other risk contract HMOs.

Mrs. JOHNSON. Ms. Hansen, what about your population?

Ms. HANSEN. Our population probably is distinguished from the SHMOs. Our population is 100 percent targeted toward the 12 percent that he just mentioned, whereas the SHMO programs are really the blend of the well and a smaller proportion of the frail. And so that is the reason for the different types of programs that are here. When I mentioned the rates earlier, they are rate adjusted for that core population that is 100 state-certified to be eligible to be in a nursing home.

Chairman THOMAS. Before I turn it over to my colleague from California, Mr. Ervin, if, in fact, you were a regular HMO, and this program went permanent, and you could increase your amount from 95 percent of AAPCC to 100 percent, and you could remove the 50/50 rule and some of the other provisions, would not this be relatively attractive to a number of HMOs?

Mr. ERVIN. We believe it would.

Chairman THOMAS. Yes, I think it would, too. It would, significantly change the marketplace. Thank you.

The gentleman from California?

Mr. STARK. Thank you, Mr. Chairman.

I want to welcome Ms. Hansen here and welcome her to the East Bay of the San Francisco Bay area. I hope you do well.

You mentioned that you have both Medicaid and Medicare, and you do not charge premiums above that. What percentage of your budget comes from Medicaid—Medical, as we call it in California?

Ms. HANSEN. As is true for most of the sites, it is approximately 70 percent of the budget.

Mr. STARK. How about you, Dr. McCann? What percentage of your budget?

Dr. MCCANN. Very similar.

Mr. STARK. About 70 percent?

Dr. MCCANN. Yes.

Mr. STARK. I am not sure as much what will happen in New York as I worry about California, but if there was a 30-percent reduction in Medicaid, 20 or 30 percent, somewhere in that area, on a block grant basis, and assuming that that were spread evenly, which is not necessarily a fair assumption, but what would you guys do with your two programs?

Ms. Hansen?

Ms. HANSEN. For California, our rate is adjusted already at 15 percent below Medicaid average cost for that population. So already, there has been a 15-percent reduction. I think that all of us operating in the delivery systems are very keenly aware of that, and frankly, we continue to look for ways to have efficient delivery without compromising care. It still is one of those things that we realize is going to be a cut point where obviously, it will adversely affect.

Mr. STARK. I guess what I am asking, though, is if you had a 30-percent reduction in 70 percent of your volume, that means you have got about a 20-percent overall budget cut.

Ms. HANSEN. Right.

Mr. STARK. Can you operate with that?

Ms. HANSEN. I think that would severely curtail, certainly, our ability to provide services. And many of us are looking at how we can encourage a better mix of populations to service more of the private-pay population also to be a part of this.

Mr. STARK. Doctor?

Dr. MCCANN. Our rate in New York is set at 90 percent of the average Medicaid nursing home rate, and we also have not had a rate increase for 3 years. So another 30 percent cut would really be a problem for us.

Mr. STARK. Ms. Hansen, the idea of bringing in private pay is what we used to call cost-shifting. In other words, what you would like to do then is if you could get higher paying patients, they would, in theory subsidize the lower income patients, which is fine. That is, in effect, what you are hoping to do to offset any proposed cut in Medical; is that right?

Ms. HANSEN. Well, historically, what we have done is charge the private pay the same as the Medicaid. But I think also increasing the number of enrollees, frankly, the size——

Mr. STARK. If Medicaid went down, and private pay stayed the same, then if you increased the number of private pay, you could conceivably cover some of that reduction. Is what you are saying?

Ms. HANSEN. There would be, I think, possibly some ability to do that, but there would still be the issue of compromised ability to provide services if the cuts ended up being extremely severe, no matter what.

Mr. STARK. Mr. Ervin, one of the criticisms—I gather it is generic and not of your particular plan—is that physicians are not given greater time per patient in a SHMO when it is arguable that those patients need more time because of their condition. Did you adjust

the amount of time you are willing to pay a physician for various procedures, or is that an unjust or unfair criticism?

Mr. ERVIN. Congressman, I was not aware of that criticism. Perhaps I missed it someplace. We contract with—each of the Social HMOs is different. Kaiser has its group model; Elderplan contracts with medical groups, and so does SCAN Health Plan. We contract at the current time with about 15 different medical groups, and we work with them to understand our benefits. They set the policies and procedures by which their physicians operate, and we monitor them.

Mr. STARK. So if they do not like what you are paying, they could not bid on the job; is that in effect what——

Mr. ERVIN. That is correct. There is always a negotiation. And that always takes into account the kinds of patients that we will be sending them. And we work with them with our nursing staff, our quality assurance staff. We actually end up advocating considerably on behalf of our patients with medical groups as well as with hospitals if we find that they are not spending the kind of time and giving the care that is needed.

Mr. STARK. Fair enough.

Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Dr. McCann, earlier this week, we had a hearing on the GME, Graduate Medical Education System, and I wanted to hear if you had any ideas on how to restructure GME on geriatric care and geriatric medicine.

Dr. MCCANN. I can tell you that in our particular site, we do a lot of education. I am also on the faculty at the University of Rochester as an assistant professor of medicine, and we have medical students coming through our program; we have medical residents who do block rotations through our program, and we also have geriatric fellows who do a longitudinal experience through our program. So, we believe it is extremely important to introduce people to this type of care, to the most managed care that you can really have and a totally capitated system and let them know that you can practice great medicine in a system like this, just the kind that you thought you were going to practice when you went into medical school. I think it is extremely important, too, and certainly one of my high priorities in terms of medical education in our particular program.

Mr. CHRISTENSEN. One of the problems, though, that came out in the testimony from Governor Lamm was that under the Graduate Medical Education, we do not need the number of foreign medical graduates who are currently coming into the system. Is there a high concentration of foreign medical graduates in the geriatric care area, or would you agree with Governor Lamm that we have way too many in the system today?

Dr. MCCANN. I think that as far as people interested in working in geriatrics, there is a paucity of people. And as far as internal medicine graduates or people who go on to do a fellowship in geriatrics, we are not even close to meeting the need as far as the amount of geriatricians in our country. And it has not been a real

sexy area for people to want to go into when the other choices were ophthalmology and orthopedic surgery. But certainly, the people that we do attract tend to be very like-thinking and really find a program like this very conducive to the way they like to practice medicine.

Mr. CHRISTENSEN. Thanks, Doctor.

Dr. MCCANN. You are welcome.

Chairman THOMAS. We may find out that necessity is the mother of sensibility in terms of the kind of occupation that will be before us.

I want to thank the panel very much. The Committee will stand in recess until we get this vote in, probably about 10 to 15 minutes, and we will be back for the second panel. Thank you very much once again.

[Recess.]

Chairman THOMAS. The Subcommittee will reconvene, and we have a panel consisting of Dr. Leutz, associate research professor, Heller School, Brandeis University; Dr. Wiener, senior fellow at the Brookings; and Richard Bringewatt, president and chief executive officer for the National Chronic Care Consortium in Bloomington, Minnesota, with a slightly different profile than the other who has been presented.

Dr. Leutz, if you will proceed and inform the Subcommittee in any way you see fit. Any written testimony that you have will be made a part of the record.

STATEMENT OF WALTER LEUTZ, PH.D., ASSOCIATE RESEARCH PROFESSOR, INSTITUTE FOR HEALTH POLICY, FLORENCE HELLER GRADUATE SCHOOL, BRANDEIS UNIVERSITY, WALTHAM, MASSACHUSETTS

Mr. LEUTZ. Thank you, Mr. Chairman and Members of the Committee for this chance to talk today about the Social HMO. I have worked with this project for 15 years, so I have a real interest and a close knowledge of it. I am currently the chair of the Social HMO Consortium, which is an association of the sites and Brandeis University to do public policy and research about the project, but I speak today for myself from a research and policy perspective.

I could summarize my written testimony around two points. First a policy that the Social HMO is the only health care model that links Medicare with a privately financed long-term care benefit; I will elaborate on that. The second is a research point. A great deal has been learned from this project about how to integrate acute and long-term care. But there are still plenty of opportunities for learning.

On the financing point, there is a private risk-pooling mechanism that has not really been emphasized in the testimony. Most Medicare beneficiaries are neither rich nor poor. The poor have some access to long-term care benefits through Medicaid and programs like the PACE program, and people who are wealthy can either self-insure for long-term care or buy an expensive long-term care insurance policy. But the vast majority of Medicare beneficiaries really do not have those two options, and this program is an option for them to buy some protection against the costs of long-term care.

The other point that is unique about the Social HMO is that it is a program that serves all Medicare beneficiaries. It is not just a program focused on those with chronic disabilities and long-term disabilities. We have found that that is an important point, because many of the people who become disabled, like the member of Elderplan who spoke this morning, are disabled for a short term. What the Social HMO can do is pick up those people with short-term disabilities and help them to recover. And those individuals are not appropriately served in a PACE model, which separates people with permanent disabilities and focuses on their care.

The point about research is that we have learned a great deal about integrating acute and long-term care, and I think the work that we have done really confirms the importance of tying long-term care benefits to a Medicare set of benefits in a managed care model. The case management units in the SHMO programs, for example, receive two-thirds of their referrals of people who are newly disabled from the acute care system—from hospital discharge planners, from physicians' offices, home health agencies, nursing homes. We have found that one-third of the members who are discharged from hospitals are found to be frail within 2 months of their discharge, and again, they are picked up through the internal referral system.

We have found, when looking at the utilization of Medicare skilled benefits, the home health and nursing home benefits, and the Social HMO long-term care benefits that are available on the basis of disability, that there is a one-third overlap in eligibility for and use of those two benefits. That is, people are receiving those two types of benefits at the same time, and what the Social HMO does is make decisions on which benefits are used and how those services are coordinated into internal management decisions.

Another thing we have learned is that there are some savings in this model. There was a study done at Kaiser Permanente that compared the Medicaid costs for regular HMO members and Social HMO members who were not on Medicaid at the start of the study and found that they were significantly lower, $132 per member over the course of the study, for the Social HMO members. They used fewer nursing home days and had later Medicaid spend-downs and fewer Medicaid spend-downs.

There is still much more to learn in this project. More could be learned about the current sites through additional research about the long-term patterns of disability and relationships between service utilization and disability. The new Social HMO sites are testing a geriatric model and a chronic disease management model. Not mentioned yet today is that under this authority, there are end-stage renal disease managed care organizations being tested. An RFP went out last month for them, and this is an opportunity to learn how to bring managed care to this population.

So, I would make two recommendations. I agree with many of the others who have testified here that there is ample cause and good mechanisms to make this a part of the Medicare Program, but absent are the waivers for the current sites, and the new sites should be extended to complete the test of the model.

[The prepared statement follows:]

LEARNING FROM THE SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION: 1985-1996

Testimony to the Health Subcommittee
Ways and Means Committee

April 18, 1996

by Walter Leutz, PhD
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Introduction

My name is Walter Leutz. I am an Associate Research Professor at the Institute for Health Policy at Brandeis University's Florence Heller Graduate School. I am also the Director of the Social HMO Consortium, which is an informal partnership of Brandeis and the Social HMO demonstration sites. Although I have long been associated with the Social HMO sites, I speak here today for myself and not the Consortium.

The purpose of the Social HMO Consortium is to perform research and improve policies concerning integrated acute and long-term health care systems. Although my colleagues and I have been an advocates of the Social HMO concept, in our work together we have tried to be objective, to be concerned about public and beneficiary interests, and to share our experience in the public domain. Over the years we have published more than 25 journal articles, 12 public reports, and one book on the Social HMO. A recent bibliography is attached.

Overview of the Social HMO Model

From a research and policy perspective, there are four distinctive things about the three Social HMOs that are now in their 11th year of operations under Congressional authority:

1. Social HMOs add community long-term care (LTC) to a Medicare HMO. By community LTC, I mean care beyond where Medicare definitions of skilled care leave off. The current sites' benefits cover up to $1,000 per month for personal and social care in the home and in adult day health centers. Short-term nursing facility stays are also included. Over the first ten years of the project, about 8,000 of the 40,000 Medicare beneficiaries who have been members have used the Social HMO's LTC benefits (Altman, et al., 1993; Consortium, 1996).

2. Social HMOs finance expanded benefits by enrolling a cross-section of Medicare beneficiaries. In contrast to PACE, which concentrates on Medicaid eligibles who meet nursing home eligibility criteria, the great majority of Social HMO members are private-pay and not disabled. The representative membership and private premiums create a private risk pool for financing long-term care and other supplemental benefits. Over the first ten years of operations, more than $60 million worth of community LTC benefits and case management have been provided - an average of more than $5,500 per year for members who have used these benefits (Consortium, 1996).

3. Social HMOs integrate the delivery of acute care and LTC. Social HMOs send their new members a health status screening form to identify individuals with disabilities and other risk factors. The forms are screened by nurse and social worker case managers. They connect members who have medical risks to physicians, and they go on to develop and oversee care plans for members needing community LTC. The case managers work closely with hospital discharge planners, nursing home staff, home health nurses, physicians' offices, and families to identify members who are newly disabled, who are transitioning across settings, and who need ongoing care (Abrahams, Capitman, Leutz, & Macko, 1989; Abrahams, Greenberg, Gruenberg, & Lamb, 1988; Leutz, Abrahams, Greenlick, Kane, & Prottas, 1988; Yordi, 1991a).

Although health status screening is an important way to find members who need LTC, integration with medical care is even more important. Two-thirds of the referrals to case managers come from the acute care system (Altman, et al., 1993). Nearly one-third of the members leaving the hospital are frail enough to meet community LTC eligibility criteria within 60 days of discharge (Leutz, Greenlick, & Capitman, 1994). More than one-third of members who are eligible for Medicare home health are also eligible for and receiving community LTC at the same time (Karon, Capitman, & Leutz, 1990).

These data show the close relationships of acute care and LTC. These relationships provide opportunities to reduce Medicare spending by substituting more appropriate and affordable community LTC. The integrated delivery system also raises providers' consciousness about addressing chronic illness and disability (Abrahams, Macko, & Grais, 1992). Finally, in contrast to PACE, which connects with community referral sources to find frail members, the Social HMO has internal referral systems. This allows Social HMOs to help with short-term disabilities and transitions across settings of care for a much broader group of beneficiaries.

4. Medicare pays Social HMOs 100% of estimated fee-for-service (FFS) expenditures. Paying 100% of the adjusted average per capita costs (AAPCC) gives sponsors the incentive to offer community LTC (as well as prescription drugs, eyeglasses, and hearing aids) and makes it more affordable for beneficiaries to choose this high-option plan (Leutz, & Hallfors, 1993; Leutz, et al., 1985). The Social HMO payment formula has special rate cells that pay higher for members with disabilities who reside in the community and correspondingly less for other community residents (Gruenberg, Silva, & Leutz, 1993). This protects sponsors against the extra costs of enrolling more than fair their share of beneficiaries with disabilities, and it protects Medicare against favorable selection.

Paying 100% of AAPCC may look like a cost compared to the 95% paid to TEFRA risk plans, but it is not a cost compared to FFS. If the underlying growth rate in Medicare expenditures are controlled, so are Social HMO expenditures. It does not make sense to require every Medicare program option to save money if there are other good reasons to support that program. TEFRA HMOs have not offered LTC benefits like those found in Social HMOs, and they are not likely to without the protections of disability-based payment formulas and relatively higher payment rates.

HCFA evaluation studies

The Health Care Financing Administration (HCFA) supported an outside evaluation of the Social HMO Demonstration over the period 1985-1989. Regretably, due to methodological problems with the basic approach to the final evaluation studies, there are no definitive conclusions on Social HMO impacts on Medicare costs and member health outcomes compared to FFS (Leutz, & Greenlick, 1995). Major findings from earlier studies included:

1. No selection bias: Social HMO sites enrolled memberships similar to Medicare beneficiaries in their communities in terms of disability and health status, in part due to a case mix quota system (HCFA, 1988; Newcomer, Harrington, & Friedlob, 1990b).

2. Choice: Beneficiaries joined the Social HMO because of its richer benefits for drugs, community long-term care, dental care, and eyeglasses (Newcomer, Harrington, & Friedlob, 1990a).

3. Satisfaction: Social HMO members were generally just as satisfied as beneficiaries in FFS or other HMOs (Newcomer, Preston, & Harrington, 1991).

4. Informal support: The Social HMO strengthened the informal support system of Social HMO members compared to beneficiaries in FFS (Yordi, 1991b).

Other research

Several other research findings based on studies by the sites and Brandeis are worth noting.

1. Medicaid savings: Kaiser Permanente Social HMO members had significantly fewer days of nursing home care, later Medicaid spend-downs, and lower Medicaid costs than Kaiser TEFRA members, after controlling for age and gender (Boose, 1993).

2. End of life savings: Kaiser Permanente Social HMO members in their last year of life had fewer days of nursing home care and were more likely to die at home than Kaiser TEFRA members, after controlling for age and gender (Brody,).

3. Low-cost and manageable community LTC benefits: Numerous community care demonstrations and national health reform proposals have examined how to deliver an affordable benefit to cover community LTC (Leutz, Capitman, MacAdam, & Abrahams, 1992). The Social HMO sites have shown definitively that community LTC is an insurable, affordable, and manageable risk in the context of a Medicare HMO supplement (Altman, et al., 1993; Greenlick, Nonnenkamp, Gruenberg, Leutz, & Lamb, 1988; Leutz, et al., 1994; Leutz, Greenlick, Ervin, Feldman, & Malone, 1991). The Social HMO thus shows a way for managed care organizations to fill a gaping hole in the private insurance coverage available to Medicare beneficiaries.

4. Private LTC benefits for the middle class: Citing reimbursement shortfalls, Health Partners closed the Twin Cities Social HMO site in 1994. Out of concern for its vulnerable members, Health Partners has studied experiences their experiences in the year after the closing. Preliminary results show that LTC services were reduced and stress was increased for these members, particularly for those who did not qualify for public LTC benefits (Fischer, 1996). This shows that the Social HMO was providing benefits that were difficult to replace in the private market.

Policy issues

Taking a step backward, the experience to date with Social HMOs, PACE, and other integrated health care approaches raise several questions for future policy at the federal, state, and provider level. On each of these issues, the Social HMO is testing unique, powerful, and potentially valuable approaches to service delivery and financing.

1. Geriatric care or community LTC? A second generation of Social HMO sites will soon test a model of care that expands geriatric evaluation and management services for Social HMO members with chronic illnesses (Harrington, Lynch, Newcomer, & Miller, 1993). This will require more far-reaching changes in sites' acute care systems than did the first generation model of integrating community LTC with existing acute care systems. It remains to be seen whether expanding benefits to geriatric services (the second-generatin Social HMO model) will produce better outcomes than expanded community LTC (the first-generation model), but both models are certainly worth testing (Leutz, Greenlick, Ervin, Feldman, & Ripley, 1995).

2. Integrated Medicare and Medicaid financing or expanded private LTC financing? The PACE initiative, as well as a number of state initiatives, seek to achieve savings and improve outcomes by integrating Medicare and Medicaid financing and services (Kane, Illston, & Miller, 1992; Wiener, & Skaggs, 1995). The Social HMO is the only major initiative that integrates Medicare with expanded private financing of LTC. Because it reaches the private market, the Social HMO is the only current managed care approach that has the potential to provide an affordable choice for millions of Medicare beneficiaries to insure for prescription drugs and community LTC.

3. Integrated acute and LTC through generic or specialty programs? Several Medicare demonstrations (e.g., PACE, Medicare Alzheimers, EverCare, Community Nursing Organization) (Vladeck, Miller, & Clauser, 1993), as well as a number of state Medicaid and provider initiatives (Kane, et al., 1996; Saucier, & Mitchell, 1995) all seek to integrate acute and

LTC for either a subset of the population or a subset of services. Such specialty programs have the advantage of concentrating on populations and services that they know well. However, they operate with eligibility and service network barriers that limit the number of beneficiaries they can serve and how they can serve them. The Social HMO is the only model that stands ready to enroll all Medicare beneficiaries and provide the full range of acute and LTC services. It thus has the potential to serve beneficiaries with all types of chronic illnesses, all levels and durations of disability, and in all settings. As the Kaiser Permanente Interregional Committee on Aging has affirmed, the model of care can and should be extended beyond the Medicare and Medicaid populations to citizens of all ages (Nonnenkamp, 1996).

Recommendations

The Social HMO sites are now in their 11th year of operations, and their Medicare waivers are set to expire on December 31, 1997. This schedule will require current sites to begin closing down and disenrolling members at the end of 1996. Pursuant to Congress's 1990 expansion of Social HMO authority, seven new sites are scheduled to begin operations this summer. Additionally, as directed by Congress in its 1993 waiver extension, in February 1996 HCFA issued an RFP for sponsors to demonstrate a capitated managed care program for End Stage Renal Disease (ESRD) beneficiaries. The ESRD site(s) may be ready to begin operations next year.

Both the current Social HMO sites and these new demonstration efforts deserve the continuing support of Congress. Two actions make sense: (1) making the Social HMO a Medicare option and (2) extending the waivers to allow further research on the model.

1. Develop a program to allow any qualifying managed care organization to become a Social HMO. Such Social HMOs would be paid at a slightly higher rate than regular HMOs using a disability-based payment formula providing they met minimum standards concerning benefits (LTC, prescription drugs, and other supplements), case management, and enrollment. There has been ample testing of the essential Social HMO operational protocols to feel confident of success, and time can be built in to refine other mechanisms. The Social HMO Consortium developed a proposal (but did not submit anything to the House yet) that would accomplish these ends by making the Social HMO one of several managed care options available to Medicare beneficiaries.

2. Extend the waivers for four years to support futher research. The 1997 waiver end date will not allow a test of the second-generation Social HMO and ESRD initiatives, and it will not allow time for the first-round sites to transition to new operational authority. More research should be conducted on both the new sites and the existing sites, which have not been studied in the last six years. A four-year extension through December 31, 2001 would cover all needs. HCFA has the authority to extend these waivers, but extension can be assured and greatly expedited with a Congressional mandate. This continuation of waivers needs to happen soon and should be enacted independently of making developing the Social HMO program within Medicare.

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Chairman THOMAS. Thank you, Dr. Leutz.
Dr. Wiener.

STATEMENT OF JOSHUA M. WIENER, PH.D., SENIOR FELLOW, ECONOMIC STUDIES PROGRAM, BROOKINGS INSTITUTION

Mr. WIENER. Thank you, Mr. Chairman.

Over the last few years, there has been a new interest in the integration of acute and long-term care services and financing. This derives from the observation that persons with disabilities do not come with just a need for acute care or just a need for long-term care, but they come with a need for both sets of services. Yet, we have a situation where the financing system is fragmented; where the delivery system is fragmented; and where the system as a whole is more costly than it likely needs to be.

There has been a hope that by integrating acute and long-term care services we will be able to provide both better quality care and to save some money as well. While there are a variety of models for the integration of acute and long-term care services, most of them depend on the application of managed care principles, including capitation.

We have a wide variety of models of integration, some of which have been discussed here today. Medicare HMOs, while not serving long-term care generally, do provide skilled nursing facility care and home health. We have Social HMOs and the On Lok/PACE program. A program not mentioned so far today is the Arizona Long-Term Care System, and a variety of other state demonstrations are underway as well.

As Congress considers what to do with the integration of acute and long-term care services, there are a variety of policy considerations that need to be taken into account. The first is do managed care organizations understand low-income elderly populations? Do they understand long-term care? To date, managed care organizations have little experience with the elderly and virtually no experience with the low-income elderly, the younger disabled population or with long-term care. Clearly, this is an area where they could learn, but they are not there yet.

Second, is managed care good for long-term care? Advocates for long-term care are not unanimous in their belief that this is the direction that we ought to go. In a capitated system dominated by doctors, some people worry that the acute care sector will end up with the lion's share of the resources, and that they will, in fact, end up stealing from the long-term care budget in order to finance acute care. There is also a worry that in a system dominated by doctors that the care will be medicalized; you will have a medical rather than a social model. There is also a worry that the current movement for consumer-directed care will be subverted by the move toward managed care. After all, many would argue that the essence of managed care is to shift power away from the individual client and their chosen provider to other third parties: The HMO, the insurance company, or some other like source.

Another question is what model of integration should be promoted. We have a wide variety of models in terms of the delivery system. Under most of the Social HMOs, we have a "hand-off" model that tries to ease the transitions across the acute and long-

term care sectors. The On Lok/PACE model tends to be more of a geriatric model that builds on team providers, geriatricians, and aides who really try to change the way in which both the long-term care providers and the acute care providers do business.

Another question is how will quality and access be assured? It is well-known that the fee-for-service system tends to produce overutilization, but under capitated systems, there is always the danger of underutilization. The question is when does efficiency fade into underservice, and how will either the managed care organization, the state Medicaid agency, or the Health Care Financing Administration know? The reality is that no one has the personnel, the data systems or the technology to monitor those questions very well.

Another question is how should these managed care organizations be paid? We have had a considerable amount of discussion about the problems with the AAPCC not adequately adjusting for risk. Between 1980 and 1984, I worked for the Health Care Financing Administration, and one of the first meetings I attended in 1980 was on how to improve the AAPCC. Sixteen years later, the AAPCC is exactly the same.

Who gets the savings? A lot of the expanded benefits that are provided by both the PACE program and the SHMO are funded by savings from the acute care sector paid by the Medicare reimbursement. Eventually, Medicare will claim those savings as part of budget deficit reduction. So the question is, will there be money left over for these expanded benefits?

How much freedom of action will states have? Currently, states have a significant amount of flexibility in managed care but not that much. Certainly, in terms of the dual-eligible population, states do not have the flexibility in dealing with the Medicare Program.

So, in conclusion, one of the great triumphs of the 20th century has been the great conquest of acute illnesses. We now have the rise of chronic illnesses, which is very important. And the question before us is, how to extend managed care and how to deal with those chronic illnesses so that we can adequately serve them.

Thank you.

[The prepared statement follows:]

STATEMENT OF JOSHUA M. WIENER, PH.D.,
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MANAGED CARE AND LONG-TERM CARE:
THE INTEGRATION OF FINANCING AND SERVICES

Persons with disabilities currently receive care in a splintered and uncoordinated financing and delivery system (Evashwick, 1987, National Chronic Care Consortium, 1991). Financing for acute care is largely the province of Medicare and the federal government, while long-term care is dominated by Medicaid and state governments. Because of the bifurcation of financial responsibilities, there is a strong incentive for the federal government to shift costs to the states and vice versa. At the very least, there is indifference about initiatives that would save money for the other level of government.

In terms of service delivery, fragmentation exists both within and between the acute and long-term care systems. A major consequence of this fragmentation may be that total costs are higher than they would be in an integrated system (Finch et al., 1992). For example, some elderly patients may remain unnecessarily in acute care hospitals because appropriate nursing home or home care services are not immediately available, appropriate follow-up physician care cannot be arranged, or financing is not available.

Because of the growing awareness of the inadequacies of the current system, there is increasing policy interest in finding ways to bring the acute and long-term care sectors together into a single integrated system. Almost all of these initiatives depend on managed care. Under these models, capitated organizations have financial incentives to avoid both the functional decline that can result from unmet needs and the unnecessary costs associated with providing services in needlessly expensive settings. At least in theory, this coordinated approach would produce acute care savings because lower-cost outpatient and home-based services could be substituted for more costly inpatient services when appropriate (Rivlin and Wiener, with Hanley and Spence, 1988; National Chronic Care Consortium, 1991; Leutz, Greenlick, and Capitman, 1994). These acute care savings, in turn, could be used to fund more comprehensive long-term care benefits or could be captured by third-parties as savings.

DEMONSTRATIONS AND OTHER INITIATIVES

A substantial number of demonstration projects are underway to test various approaches to integrating acute and long-term care services. The best known of these demonstrations are the Social Health Maintenance Organizations (Social HMOs), On Lok and its Program of All-inclusive Care for the Elderly (PACE) replications, and the Arizona Long-Term Care System (ALTCS) program. Several other initiatives are under way which either seek to enroll Medicaid eligibles with disabilities in health maintenance organizations for their acute care services or for both their acute and long-term care services (Wiener and Skaggs, 1995). Although not directly involved in long-term care, conventional HMOs participating in the Medicare program are required to provide the full range of benefits, including home health and skilled nursing facility services.

Medicare Health Maintenance Organizations (HMOs)

Under rules established by the Tax Equity and Fiscal Responsibility Act of 1982, Medicare beneficiaries may enroll in HMOs (McMillan, 1993). Congress is currently debating various changes to these rules. Medicare beneficiaries who enroll in HMOs give up their free choice of providers and agree to use the providers approved by the HMO. These organizations provide or arrange for Medicare-covered services in exchange for a capitated payment which based on 95 percent of the estimated costs of serving an enrollee in the fee-for-service system.

Social Health Maintenance Organizations (Social HMOs or S/HMOs)

Social HMOs extend the traditional HMO concept by adding a modest amount of long-term care benefits (Leutz, Greenlick, and Capitman, 1994; Harrington and Newcomer, 199; Greenberg et al., 1988; Rivlin and Wiener, 1988; and, Leutz, Greenberg, and Abrahams, 1985). A coordinated case management system authorizes long-term care benefits for those who meet the established eligibility criteria. Social HMOs are intended to serve a cross-section of the elderly population, including both functionally impaired and unimpaired

persons. In fact, the overwhelming majority of enrollees are not disabled. While all enrollees are Medicare eligible, relatively few Medicaid beneficiaries are enrolled. Enrollees pay premiums to cover the extra benefits. Originally a four-site initiative, Congress has authorized a "second generation" of demonstrations.

On Lok/Program of All-inclusive Care for the Elderly (PACE)

In 1983 On Lok Senior Health Services obtained federal waivers allowing it to receive monthly capitation payments from Medicare, Medicaid, and (in a few cases) individuals to provide a comprehensive range of acute and long-term care services (Ansak, 1990; Zawadski and Eng, 1988). PACE is a an effort to replicate the On Lok model in 10 sites throughout the country (Kane, Illston, and Miller, 1992; Irvin et al., 1993). Enrollment is limited to persons who are so disabled that they meet nursing home admission criteria. Because expenditures per person are so high, very few persons can afford to pay an actuarially fair insurance premium. As a result, almost all enrollees are Medicaid eligible. PACE sites operate as geriatrics-oriented, staff model HMOs, with primary care physicians as employees of the organization. Finally, the approach makes heavy use of adult day health care, which is integrated with primary care.

Arizona Long-Term Care System (ALTCS)

The Arizona Health Care Cost Containment system (AHCCCS) is a statewide demonstration project which finances medical services for the Medicaid-eligible population through prepaid contracts with providers. Beginning in 1989, the ALTCS program incorporated Medicaid long-term care services into the AHCCCS program (Northrup, 1994; McCall, Korb and Bauer, 1994; McCall et al., 1993; and, Irvin et al., 1993). Participation in the program is limited to individuals who are certified to be at risk of institutionalization. ALTCS covers acute care services, as well as care in nursing facilities, intermediate care facilities for the mentally retarded, and home and community-based services. Under the ALTCS model, the state contracts with one entity in each county to assume responsibility for covered services to elderly and physically disabled eligibles. In the overwhelming majority of cases, the contractor for elderly people and persons with physical disabilities is the county government.

WHAT HAVE WE LEARNED?

Research on Medicare HMOs, Social HMOs, On Lok/PACE, and ALTCS provide evidence regarding enrollment, satisfaction, quality of care, and utilization and costs. With the exception of the ALTCS program, these demonstration projects generally depend on voluntary enrollment, which provides both a market test of different plans and a check on quality of care. In most areas of the country, these capitated approaches, which require enrollees to give up freedom-of-choice of providers, have had a difficult time enrolling the elderly and disabled populations (McMillan, 1993; Harrington and Newcomer, 1991; Finch et al., 1992; Leutz et al., 1993; Kane, Illston, and Miller, 1992; Branch, Coulam, and Zimmerman, 1995). As more older persons become familiar with managed care, this resistance appears to be diminishing, at least for the Medicare HMO program.

Evidence from conventional HMOs and the Social HMOs suggests that Medicare enrollees tend to be healthier and less disabled than persons remaining in the fee-for-service system (Brown et al., 1993; Riley, Rabey, and Kasper, 1989; Newcomer et al, 1995; and, Manton et al., 1994). Some researchers and administrators associated with the Social HMOs strongly challenge these findings as methodologically flawed (Leutz, Greenlick, and Capitman, 1994). Although the On Lok/PACE enrollees are clearly very disabled, they appear to be less disabled in the activities of daily living than nursing home patients and may have other characteristics that distinguish them from persons who are institutionalized (On Lok, 1993). Medicare HMOs and Social HMOs tend to have fairly high disenrollment, but Medicare makes it extremely easy to disenroll (Brown et al., 1993; and, Harrington, Newcomer, and Preston, 1993).

An argument in favor of integrated systems is that quality of care and consumer satisfaction will be improved because artificial barriers between care providers will be eliminated. Overall, evidence concerning Medicare and Social HMOs suggests generally high levels of consumer satisfaction among enrollees (U.S. Department of Health and Human Services, Office of the Inspector General, 1995; Brown et al., 1993; Newcomer; Weinstock, and Harrington, 1989). Consumers were most satisfied with covered benefits and the out-of-pocket costs. However, compared to persons receiving fee-for-service care, consumers were generally less happy with the care provided. A notable exception to this generalization is the "impaired" group within the Social HMO, who were more satisfied than the comparison group on almost all dimensions of care.

Formal studies of quality of care have shown mixed results. Although evaluations of Medicare HMOs generally show that they produce outcomes roughly comparable to the fee-for-service sector, enrollees receive less care (Brown et al., 1993; Greenwald and Henke, 1992; Carlisle et al., 1992; and, Yelin, Shearn, and Epstein, 1988). Of concern is that some studies find outcomes for persons with disabilities and persons with chronic illness to be worse in HMOs than in the fee-for-service sector (Shaughnessy, 1994). Within the Social HMOs, at least some disabled groups had higher mortality rates than persons receiving fee-for-service care (Manton et al., 1993), although, again, these results have been challenged by the Social HMOs on methodological grounds (Leutz, Greenlick, and Capitman, 1994). In a evaluation of nursing home care, quality of care was lower in Arizona under the ALTCS program compared to New Mexico, but it is difficult to know the cause of the differences (Balaban, McCall, and Paringer, 1994).

To policymakers, one of the major attractions of the integration of acute and long-term care services is the potential for cost savings in acute care that could be used to finance long-term care services or to reduce overall expenditures. In evaluating this issue, it is difficult to separate the effects of capitation from the effects of integrating acute and long-term care services. Evidence concerning Medicare HMOs, Social HMOs and On Lok/PACE show that acute care utilization can be reduced in capitated care settings, but it is less clear that integrating acute and long-term care services generates additional savings (Brown et al., 1993; Finch et al., 1992; Harrington and Newcomer, 1991; On Lok, Inc., 1995; On Lok, Inc., 1993). Social HMOs did not appear to do substantially better than conventional HMOs in reducing acute care expenditures. The early evidence from On Lok/PACE is more encouraging, but the data are very preliminary, do not adjust for casemix, and involve a relatively small sample. Complicating the evaluation of cost savings are the inadequacies of the Medicare and Medicaid payment methodologies which do not adjust adequately for risk (National Chronic Care Consortium, 1993; Kane, Illston, and Miller, 1992; Leutz, et al., 1993; and, Brown et al., 1993). As a result, for conventional HMOs the evidence suggests that Medicare is overpaying the plans, and thus losing money (Brown, 1993).

The ALTCS program appears to save money, largely because of how it provides services to the population with mental retardation and developmental disabilities (McCall et al., 1993). For older people and persons with physical disabilities, savings are smaller and derived largely from providing services to fewer people than would have received them in a traditional Medicaid program. It is unclear whether the savings come from acute or long-term care services. In an early assessment of the home and community-based services provided under ALTCS, the program appeared to successfully target persons at high risk of institutionalization and was cost-effective in its provision of noninstitutional long-term care services (Weissert, 1992).

POLICY CONSIDERATIONS

As states and the federal government explore ways to reform its system of financing and paying for acute and long-term care services for persons with disabilities, at least seven issues should figure in the calculus:

Do Managed Care Organizations Understand Low-Income Elderly and Long-Term Care?

To date, managed care organizations have mostly focused on providing acute care to the nonelderly population. Nationally, only about 10 percent of the elderly Medicare beneficiaries are enrolled in HMOs (HCFA, 1995). In addition, the vast majority of states have focused their Medicaid managed care programs on children and nondisabled adults; few states have actively attempted to enroll the elderly or persons with disabilities in managed care programs (Rowland et al., 1995). Only a scattered number of health maintenance organizations provide long-term care services. As a result, few managed care organizations have any experience with low-income elderly and virtually none have any experience with long-term care. Thus, it may take time before a substantial number of providers become knowledgeable about caring for this population.

Will Managed Care be Good for Long-Term Care?

A persistent concern of long-term care advocates is that the integration of acute and long-term care services will have negative consequences for the provision of long-term care services (Wiener and Illston, 1994; Schlesinger and Mechanic, 1993; and, Batavia, 1993). One concern is that fiscal pressures within integrated systems will end up shortchanging long-term care. Within the Social HMOs, there is some evidence that chronic care benefits were reduced because of rising acute care costs and market resistance to higher premiums (Harrington and Newcomer, 1991). Another concern is that long-term care will become overmedicalized in integrated settings and that services will become less consumer-directed. After all, many would argue that the essence of managed care is that the balance of power shifts from the individual client and his chosen provider to HMOs, insurance companies, or other administrative entities. On this issue, there are virtually no data in the published literature, although managed care supporters deny that this has been a problem in the demonstrations (Leutz, Greenlick, and Capitman, 1994).

What Model of Integration of Acute and Long-Term Care Services Should be Promoted?

Proposals to "integrate" acute and long-term care services are receiving increasing attention as a way to save money and provide better care. Conceptually, financial integration is relatively straightforward, referring to the pooling of funds from Medicare, Medicaid, insurance, and consumers.

On the other hand, there is little consensus about what constitutes "integration" in the delivery system. One view conceives of integration as improving the transitions and referrals back and forth between the acute and long-term care services (Leutz et al., 1995). The alternate view conceives of integration as dramatically changing how acute and long-term care providers provide services and puts multidisciplinary teams trained in geriatrics at the center of the care process (Harrington, Lynch, and Newcomer, 1993). The shape of the delivery system will depend on which model is promoted, if any.

How Will Quality of Care and Access to Services be Assured?

A major issue with all managed care initiatives is how to make sure that the drive to reduce utilization does not result in underservice to beneficiaries. This is a particular concern when managed care organizations enroll disabled individuals, who are likely to have high needs for both acute and long-term care services. Unfortunately, at this time, the states and the federal government lack the technology, personnel, and data systems to monitor the quality of care in managed care organizations. As limited as their general capability to monitor quality of acute care, there is no experience in assessing quality of long-term care in managed care settings.

How Should Managed Care Organizations be Paid?

With the exception of the ALTCS, almost all managed care providers of integrated acute and long-term care are paid a rate based on a percentage (usually 90 to 100 percent) of

what it is estimated the enrollee would have cost if he had remained in the fee-for-service system. The model for this reimbursement methodology--Medicare's Adjusted Average Per Capita Cost (AAPCC)--does a poor job predicting an individual's use of services (U.S. General Accounting Office, 1994; National Chronic Care Consortium, 1993; Kane, Illston, and Miller, 1992; Leutz et al., 1993; and Brown et al., 1993). The payment rate varies with the individual's geographic location, age, gender, reason for entitlement (age or disability), institutional status (residing in a nursing home or not), and whether they are Medicaid eligible. In spite of these adjustments, Medicare spends approximately 5.7 percent more for persons who enroll in HMOs than it would have spent on fee-for-service care (Brown et al., 1993). Thus, Medicare is currently losing money on its HMO program. The increase in costs to HCFA is due primarily to favorable selection in the Medicare HMOs, which leads to a healthier than average enrollment within each payment category. Because of lack of confidence in the reimbursement methodology, providers fear that they will not be adequately reimbursed, while policymakers worry that the government is spending more than is necessary.

In addition, capitated Medicaid rates, which generally follow the Medicare model of a percentage of the costs that would have been incurred in the fee-for-service system, are difficult to calculate because they must be relative to some comparison group. States are uncertain whether the appropriate comparison group for rate calculation is with nursing home residents, nursing home eligible or certifiable clients, community-care clients or some blend of these. The fact that some beneficiaries become Medicaid-eligible only after they have been admitted to a nursing home and impoverished themselves further complicates the computation of Medicaid payment rates for integrated systems.

Who Gets the Savings?

In general, integrating acute and long-term care services has a goal of reducing hospital and physician utilization by increasing the use of home and community-based services and sometimes nursing home care. Thus, cost savings usually accrue to the acute, rather than long-term care side of service delivery. As a result, Medicare rather than Medicaid may claim the savings. In addition, if the proposals to control Medicare expenditures are enacted, then Congress will extract the savings that managed care organizations may be able to obtain. In addition, as noted above, limited research raises questions as to whether the addition of long-term care services produces additional acute care savings.

How Much Freedom of Action Will States Have?

Under current law, most projects that integrate acute and long-term care financing require waivers of Medicare and Medicaid regulations. For example, to operate a Social HMO, administrators must obtain waivers of regulations regarding open enrollment, covered services, payment methodologies and levels, and the limitation on the percentage of HMO enrollment that can be Medicare or Medicaid beneficiaries. But these waivers are only available for research purposes and the process for receiving waivers is cumbersome, time consuming, and approval is not guaranteed. Moreover, because these waivers are for research demonstration purposes, the waivers are time-limited and tied to specific populations.

Under changes being considered by Congress, States will have much greater freedom of action to fashion their Medicaid managed care programs, but they will not have any control over the Medicare program. Since Medicare reimburses most of the acute care expenditures of elderly Medicaid beneficiaries, Medicaid agencies will either have to obtain Medicare waivers or work around the Medicare program. Because Medicaid pays only the deductibles, coinsurance, and uncovered services (mostly prescription drugs), the State may not have a great deal of leverage over the HMO's provision of acute care services. In addition, given the relatively small role of Medicaid in acute care for the elderly, it may be difficult to mandate that the elderly enroll in HMOs.

RECOMMENDATIONS

Although integrating acute and long-term care carries risks, such as overmedicalizing long-term care and loss of funds transferred to acute care from long-term care, the overlap of long-term care and acute care needs of persons with disabilities makes the integration of the financing and delivery of these two disparate systems a worthwhile goal. However, integration faces numerous technical, political, and attitudinal barriers. To a large extent, policymakers and providers are just beginning to learn how to create a seamless financing and delivery system for persons with disabilities. Indeed, the ideal model may not yet exist.

While comprehensive health care reform, including greatly expanded funding for long-term care, would help the cause of integration, such initiatives are unlikely for the foreseeable future. Despite these limitations, there are at least three broad initiatives that would further the integration of acute and long-term care financing and delivery:

Expand Research and Demonstrations on Integration

Although progress has been made over the last decade, not much is known about how to integrate the financing and delivery of long-term care. Thus, a major priority for the Health Care Financing Administration, foundations and philanthropic organizations should be to fund research and demonstrations (including their evaluation) of new ways of integrating acute and long-term care services.

Research and demonstrations should focus on three issues. First, high priority should be given to analyzing ways of improving the Medicare reimbursement rate formula--the Adjusted Average Per Capita Cost (AAPCC)--to better account for the costs of caring for the disabled elderly population. Since efforts to revise the AAPCC have been ongoing for the last 15 years without a great deal of success, accomplishing this task will not be easy.

Second, HCFA, foundations and philanthropic organizations should encourage innovative projects that foster the integration of acute and long-term care. In evaluating these initiatives (and they must be systematically evaluated to be useful), key questions should include: What do acute care providers do differently in integrated systems than they do in unintegrated systems? What do long-term care providers do differently in integrated systems that they do not do in unintegrated systems? Do integrated systems cost less than unintegrated systems? Is quality of care better or worse in integrated than unintegrated systems? Are outcomes better in integrated systems than unintegrated systems?

Finally, research should continue on ways of "bundling" post-acute Medicare skilled nursing facility and home health payments with hospital DRG and other payments. With the rest of the health care system moving rapidly toward managed care, it seems unlikely that the elderly population will be able to resist capitation forever. However, for the near term, older people have been reluctant to enroll in HMOs, forcing proponents of integration to look at what might be done in the fee-for-service sector.

Support Geriatric Education

Most doctors as well as other health professionals know little about the health care needs of the chronically disabled population and almost nothing about long-term care. While there is dispute about the necessity of depending on board-certified geriatricians, there is widespread consensus among those concerned with the elderly population that more geriatricians and geriatric education would likely increase the sensitivity of health professionals to the special needs of the chronically disabled. Although drawing large numbers of persons into the field will require a major restructuring of the medical profession, additional federal financial support for training programs would help.

Make Social HMOs and On Lok/PACE a Regular Part of Medicare and Medicaid

Finally, the Medicare and Medicaid programs should be altered to allow states and providers that want to experiment with the integration of acute and long-term care services to do so without having to obtain research waivers. Under current law, organizations seeking to integrate acute and long-term care services generally require Medicare "222" and Medicaid "1115" waivers, the research and demonstration waiver authorities under the two programs. Waivers are restricted to time-limited periods and to specific projects.

This is a controversial recommendation because Social HMOs were not without their problems and the On/Lok PACE demonstrations have yet to be evaluated. While these shortcomings are undeniable, the basic principles of these two demonstrations--providing comprehensive care to older people in a capitated environment--are basically sound. This recommendation is not made with the intent of propagating the "one true model," but rather in the spirit of "letting a hundred flowers bloom." The purpose of the recommendation is to move the integration of acute and long-term care beyond "greenhouse boutiques" and into the mainstream of care for the elderly population (Personal Communication from R. Bringewatt to J. Skaggs, 1994).

While there are several minor changes to Medicare and Medicaid statute and regulations that would be necessary (e.g., requirements for statewide implementation and uniformity in terms of amount, duration and scope of services), there are two important changes that should be made to Medicare and Medicaid and one commonly proposed change that should be rejected at this time. First, organizations that wish to replicate Social HMOs or On Lok/PACE or that want to try new methods to integrate acute and long-term care services need an adjustment to the Medicare AAPCC in order to account for the costs of caring for severely disabled persons in the community. Without this adjustment, there would be a perverse incentive for organizations to admit persons to nursing homes in order to obtain the higher Medicare reimbursement rate that is available for the institutionalized population.

Another change that should be enacted is the elimination of the Medicare requirement that Medicare and Medicaid beneficiaries comprise no more than half of the membership in any participating HMO; a similar Medicaid requirement limits the proportion to 75 percent. This requirement was initially enacted to guard against poor quality HMOs that would only enroll Medicare and Medicaid beneficiaries. Since the financial incentives under capitated arrangements are to undersupply services, quality of care in HMOs remains an issue. However, organizations that do not specialize in the elderly populations are less likely to change their delivery systems to accommodate persons with disabilities.

Finally, in response to the original Social HMO concerns about adverse selection due to enriched benefits, HCFA permitted waivers of the requirement for open enrollment without regard to medical status. In the demonstration, the sites were permitted to close enrollment to the impaired population if enrollment exceeded estimates of the proportion of the elderly populations residing in the community who were functionally impaired. Although allowing queuing would make life easier for new organizations, it should not be permitted. Closing enrollment based on health status is inconsistent with the fundamental tenet of equity, which requires open enrollment for all individuals regardless of health status. Moreover, if the technology becomes available to make improvements in the reimbursement methodology, plans would be more likely to receive adequate payment if they enrolled a disproportionate number of disabled individuals, thus tempering concerns about adverse selection..

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Chairman THOMAS. Mr. Bringewatt.

STATEMENT OF RICHARD J. BRINGEWATT, PRESIDENT, NATIONAL CHRONIC CARE CONSORTIUM, BLOOMINGTON, MINNESOTA

Mr. BRINGEWATT. Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to testify today on behalf of the National Chronic Care Consortium. The National Chronic Care Consortium represents 27 of the nation's leading health networks and functions as an operational laboratory for integrating primary, acute and long-term care for people with serious and disabling chronic conditions such as heart disease and Alzheimer's. These people represent the highest cost and fastest growing care segment of health care spending.

Today, I would like to make three points. First, Medicare problems only can be fixed by a better understanding of the problems faced by chronically ill people. Let me give you an example related to the care of Mrs. Jones, an 88-year-old woman with Alzheimer's. Mrs. Jones was living alone in her apartment when she developed Alzheimer's. Her children were concerned that their mother was falling, but the present Medicare and Medicaid system does not generalize a process for identifying risk. Further, existing payment strategies are designed to react to events, not to prevent them.

So, Mrs. Jones eventually fell and broke her hip. Then, the entire continuum of care became available to her, until Mrs. Jones was transferred to a nursing home for rehabilitation. Then, Medicare stopped paying part A benefits, because she was not making progress with her rehabilitation. Her coverage was shifted to Medicaid, enabling her to continue to receive nursing home care. But after several weeks, she developed a urinary tract infection because she was eating poorly and became dehydrated.

The payment system favored transferring her back to the hospital for IV fluids, antibiotics and feeding tube placement. After 3 days in the hospital, she returned to the nursing home for a feeding tube and continued to collect Medicare part A coverage for the full 100-day benefit as long as she kept the feeding tube. To continue receiving payment, the nursing home did not resume regular feeding until day 101. Does this sound like humane or cost-effective care?

Second, Medicare long-term demonstrations have provided us very valuable information about meeting the needs of the chronically ill. Just three quick examples. These demonstrations first tell us that containment of Medicare costs requires long-term care to become more integral to integrated health networks. People in need of long-term care also have extensive medical needs. Keeping long-term care out of integrated health networks does a disservice to the payer and to clients as well.

Second, the current wave to consolidate assets and authority for hospitals and physician groups may increase efficiency, but it will never improve health care for the chronically ill or save money unless these mergers also integrate the ongoing management of care across the spectrum of services used by disabled people.

My final point is to reduce spending and contain long-term costs, we must develop policies that reduce the accumulation of costs

across settings and over time and recognize the interdependence between Medicare and Medicaid. Policies governing acute care and long-term care must be made more consistent. Spending Medicare funds to prevent, delay or minimize disability can significantly reduce the accumulation of long-term care costs under Medicaid. Spending Medicaid funds to reduce adverse medical conditions can reduce acute care expenditures under Medicare.

Third, we must move beyond demonstrations. We can ill afford to conduct endless demonstrations and wait 5 to 10 years for evaluation results. How can we ask an organization to fundamentally change standard operating procedures for a subset of patients representing less than 5 percent of the system's overall costs? How can we convince sponsors to make a substantial investment if they cannot apply demonstration learnings to their ongoing business?

In conclusion, I simply want to make three recommendations. First, the NCCC urges the Subcommittee to grant permanent waiver authority to the Social HMO I and II sites and establish PACE as a permanent Medicare Program. Second, we recommend enabling other mainstream provider networks to establish variations on integration and managed care financing for chronically impaired people under permanent waiver of identified requlations that impede effective integration. And third, we recommend that authority and financial responsibility for Medicare and Medicaid be invested either with the Federal or state government. In the interim, all unnecessary inconsistencies in the administration of Medicare and Medicaid must be eliminated.

Mr. Chair, we are in a major crisis, as you well know. Medicare and Medicaid costs are out of control. We have to move demonstration out of the greenhouse and into the real world. We must take the learning we have accrued and get on with the business of containing costs through better care. This requires a fundamental reengineering of how we finance, administer and deliver care for the chronically impaired elderly.

Thank you, Mr. Chair and Members of the Committee.

[The prepared statement follows:]

STATEMENT OF RICHARD J. BRINGEWATT
PRESIDENT, NATIONAL CHRONIC CARE CONSORTIUM
before
WAYS & MEANS SUBCOMMITTEE ON HEALTH

APRIL 18, 1996

I. INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to testify today on behalf of the National Chronic Care Consortium (NCCC) regarding long-term care and managed care options for Medicare beneficiaries. NCCC is a national nonprofit organization representing 27 of the nation's leading health networks, all of whom serve the Medicare and Medicaid populations. Our mission is to establish new methods of integrating care for persons with serious and disabling chronic conditions, such as heart disease, Alzheimer's and stroke. We appreciate the Subcommittee's interest in the Social HMO and PACE programs as examples of how Medicare could be restructured to expand managed care options for our nation's seniors. Several Consortium members operate PACE and Social HMO programs within their systems and over half have Medicare risk contracts. In addition, NCCC members are participating in other long-term care managed care programs such as the Alzheimer's Medicare Demonstration Program and the Community Nursing Organization Demonstration and several have submitted proposals to be demonstration sites for the Minnesota Long-Term Care Options Program (LTCOP). The Consortium itself has a contract with the state of Minnesota to develop a Technical Assistance and Education Program for LTCOP. This extensive experience with managed long-term care programs affords the NCCC an inside view of the advantages and constraints inherent in these models.

I would like to focus my testimony on three critical issues related to long-term care options including: (1) the rationale for developing integrated financing and delivery models providing primary, acute and long-term care services for the elderly and chronically-ill populations; (2) the lessons we have learned from existing demonstration programs such as the Social HMO, PACE and LTCOP; and (3) the rationale for moving beyond the demonstration mode for Medicare and Medicaid demonstration programs and into mainstream delivery systems. I will conclude my testimony with NCCC's recommendations for moving beyond the status quo.

NCCC strongly supports Congressional efforts to expand Medicare options for integrating primary, acute and long-term care services through managed care and integrated delivery system approaches. We believe that sufficient evidence from private sector initiatives and public demonstrations exists regarding the cost-containing potential of integrated delivery and managed care approaches to warrant deployment of these models and other variations into mainstream programs. NCCC strongly urges the Subcommittee to make permanent the waiver authority for the existing Social HMO sites and to establish a new managed care option under the Medicare program which provides for the expansion of Social HMO and PACE programs and includes enough flexibility for sponsoring entities to continue evolving these models. The Consortium strongly urges Members of Congress to enact legislation which establishes mainstream provider initiatives compatible with principles for serving the chronically-ill. We recommend that such legislation (1) consolidate administrative and oversight requirements for integrated provider networks that serve a common high-risk population; (2) establish incentives for risk-based capitated financing for provider-based networks building upon risk-based payment methodologies which adjust for health status; and (3) direct the Secretary of HHS to conduct research to determine the aggregate costs targeted, high-cost chronic conditions and to establish outcome indicators for chronic conditions that measure quality over time, place and profession.

II. A CASE FOR HEALTH SYSTEMS INTEGRATION

The prevailing view in the United States is that our nation no longer can afford its current health care system. The government, business and the general public increasingly are burdened by unmanageable expenditures and by concerns that high priced care is not resulting in desired health care outcomes. The past few years have witnessed tremendous consolidation in the health care marketplace among providers and payors in the form of joint ventures, mergers and other affiliation models. In most cases, integration efforts have focused on the merger of assets and the consolidation of governance among hospitals, physicians, and managed care plans. Participating provider organizations have sought to achieve a competitive advantage in obtaining contracts with third party payors and expanding and stabilizing their share of the health care market. They hope to achieve new levels of efficiency through reduction in hospital capacity, decreased expenditures for subspecialties and medical technology and greater use of primary care. While nursing homes and other long-term care services have, for the most part, been exempt from network integration, newly aligned networks are beginning to establish exclusive vendor relationships with targeted long-term care providers and to use managed care financing methods. A number of states such as Arizona, California and Minnesota also have begun to move toward application of managed care principles in the purchase of long-term care. These efforts have resulted in long-term care providers exploring network affiliations of their own that mirror developments in the acute care sector.

These integration efforts *have* significantly changed the nature of authority and the distribution of health care dollars among existing health care institutions. They *have not* significantly changed the nature of the relationship among purchasers, payors and providers serving people with serious chronic conditions. We continue to treat problems in response to acute events and to manage care within the walls of provider institutions and the confines of established health care professions. The effectiveness of cost containment initiatives and care for millions of

Americans afflicted with chronic disease and disability will require that we extend the concepts of integration beyond the consolidation of assets and authority to the integration of care, information and systems. Chronic conditions such as heart disease, stroke, arthritis, and Alzheimer's Disease represent the highest-cost and fastest growing expenditure categories in the health care system. Approximately 80% of all deaths and 90% of all morbidity is related to chronic disease. The proportion of health care dollars devoted to chronic illness will continue to escalate into the next century with the aging of the population since chronic diseases disproportionately affect the elderly.

Cost containment and quality of life for persons with serious and persistent chronic conditions are both significantly dependent upon the full array of primary, acute, transitional and long-term care providers working together to prevent, delay or minimize disability progression and its associated costs. Hospitals, nursing homes, physicians and community-based long-term care providers are becoming increasing interdependent in serving a common chronically-impaired population. Effective management of chronic illness requires an interdisciplinary approach which recognizes the multidimensional and progressive nature of chronic disease and disability. It requires that we move beyond containing costs within isolated health care sectors such as hospitals and nursing homes and establish administrative, clinical and financial incentives for managing aggregate costs across time and settings. It requires that we empower the individual and their family caregivers to more fully and effectively optimize their own health and well being.

While the managed care approach is intended to reduce costs by carefully directing patients to the most appropriate and lowest cost targets, current regulations substantially impede providers' ability to do so. Care for the same person frequently is provided by multiple organizations with little or no incentive to work together to meet common goals regarding patient outcomes and cost-containment. Impediments to integration are rooted in statutes and regulations which require duplication across health care settings and often contain conflicting financial incentives as patients move across health care settings and/or payment sources (i.e., Medicare and Medicaid). Fully integrated service networks manage care across all settings in the service of a common care plan which seeks to optimize patient outcomes through collective action. Administrative, financial and information systems must be integrated to support a common approach to care for people with chronic conditions. For integration to occur under managed care plans, all providers serving the same patients must share in the financial risks and rewards associated with providing care, with all providers working toward common cost and quality goals across the network. Incentives among providers within a given network must be aligned for a network to be integrated. When new capacities exist for serving this population, new approaches to deregulation can be applied.

III. BARRIERS TO INTEGRATION

The challenge of constraining Medicare and Medicaid costs requires more than tinkering at the margins. It requires that we recognize the critical interdependence between the Medicare and Medicaid programs, with respect to serving both the dually eligible population and individual Medicare or Medicaid beneficiaries. Excess Medicare and Medicaid costs currently are incurred in two ways. First, aggregate program costs can be increased by reimbursement policies that focus on producing short-term savings for each health care segment (e.g., hospitals, nursing homes) instead of long-term savings across the system. While significant attention has been devoted to controlling short-term costs within individual provider settings, such as hospitals and nursing homes, scant attention has been paid to reducing aggregate costs for chronic condition across time, place and profession.

Second, we must consolidate and restructure administrative systems to produce health care services more efficiently. Policies governing acute and long-term care programs must be made more consistent through strategies such as standardized goals, objectives, service definitions, standards and reporting requirements for programs serving the chronically-ill. Since most providers serve both the Medicare and Medicaid populations, the establishment of compatible regulatory requirements would substantially increase the efficiency of provider operations.

A. Administrative Policies

Health care administrative policies and procedures are based primarily on the acute care model with its episodic orientation. Separate policy authorities exist for major segments of chronic care financing and separate administrative authorities exist for each Federal program. Regulations governing eligibility criteria, coverage rules, payment policies and evaluation methods differ across program categories such as Medicare and Medicaid. Requirements regarding patient assessments, care planning, data collection and record keeping are separately defined by clinics, hospitals, nursing homes and community-based service settings resulting in high costs and care fragmentation.

The administration of health care financing also must be standardized across providers and payors. Administration should be shifted from cost accounting systems focused on different payors and providers to a system which integrates financing administration for the network of providers offering services to common patients. All network providers serving a common population should be given incentives to collect a standard set of core data on client characteristics, health status, service use, costs and quality outcomes. While different providers and payors require information that is unique to their own settings, it is critical that integrated delivery systems define information the same way among providers where information is common to all. For example, assessment protocols for measuring

functional and cognitive status should be the same whether collected by a nurse or social worker in a nursing home or home care setting. In addition, financial management systems must begin linking cost data with outcomes data across providers and payors for purposes of assessing the cost-effectiveness of various treatment protocols and establishing outcome measures for evaluating performance.

B. Financing Policies

Our current health care financing system is replete with disincentives to cost-effective service delivery. Most cost-containment strategies, including those involving capitated, managed care financing, focus on short-term cost savings within existing provider structures with separate contracts and risk arrangements. There is little or no incentive for providers to collaborate in cost-savings across the continuum of care. Even managed care organizations, such as HMOs, engage in a certain amount of cost-shifting within the system. For example, many HMOs limit their financial risk by passing it on to the providers with whom they contract on a fee-for-service or discounted cost contract basis. In contracts, under managed care plans, all too often individual providers work under separate contracts and work within their own settings to maximize billing opportunities.

Instead of identifying strategies to *suppress* annual costs for specific health care sectors (e.g., hospitals, nursing homes, etc.) through artificial means such as spending caps and routine cost limits, we should develop solutions that *eliminate* expenditures by preventing, delaying or minimizing the progression of chronic illness. Cost avoidance will generate far greater savings over the long-run than cost reductions.

For example, Medicaid policies prohibiting reimbursement of physician visits to nursing homes more than once every 30 days result in cost-shifting to the Medicare program and actually may increase Medicaid costs over the long-run. When nursing home patients need to be transferred to hospitals to receive medical care, both programs incur administrative costs related to discharges and admission/re-admission in addition to the costs of medical care delivered in the hospital. Likewise, it may be more cost-effective in the long-run to increase Medicare acute care spending for certain services that could prevent, delay or minimize chronic disease and disabilities as a strategy for avoiding or reducing Medicaid long-term care expenditures in the long-run.

Health care financing policies must be modified to be less prescriptive of process and more focused on outcomes. Financial incentives should be established to encourage providers to collectively contain costs, prevent disability progression and emphasize consumer satisfaction across time, place and profession. Provider based systems should be established where provider networks are paid under shared risk arrangements for achieving common cost and outcome targets. Authority, responsibility, and accountability for the ongoing management of care should be delegated to provider-based networks of care rather than micro-managed by health plans functioning as third party payors.

C. Barriers to Serving the Dually Eligible

Efforts to control costs for elderly beneficiaries receiving benefits under both Medicare and Medicaid long have been confounded by the duplicative and conflicting regulations governing each of these programs. Differences in program requirements not only require providers and payors to maintain parallel administrative systems at an exorbitant cost, but the differences in clinical and financial rules actually create conflicting incentives which make it all but impossible to establish an efficient financing system. Below is a summary of the key differences between Medicare and Medicaid rules and examples of the conflicts that often arise and administrative inefficiencies inherent in developing service programs for the dually eligible population.

Membership Requirements

One of the most significant barriers to integration consistently cited by providers, purchasers and payors alike are membership requirements that Medicare and Medicaid risk contracts include both commercial and publicly financed residents. Medicare restricts enrollment of public beneficiaries to no more than 50% of the plan total and Medicaid restricts this number to no more than 75%. The remainder of beneficiaries must be enrolled from the commercially insured population. This requirement for commercial enrollees originally was implemented to assure quality of care for Medicare and Medicaid beneficiaries. Public officials believed that the commercial sector would demand high standards which, in turn, would protect those financed under public programs.

This requirement raises several important issues for consumers, providers, payors and state agencies. First, NCCC believes that the 50/50 rule is an inappropriate mechanism for assuring that Medicare and Medicaid beneficiaries receive appropriate care. This strategy shifts the burden for quality assurance from the Federal and state governments to the commercially insured who are expected to advocate on behalf of the elderly and poor. Clearly, the Medicare and Medicaid programs have sufficient quality controls to provide HCFA the necessary tools for monitoring. Moreover, in many cases, there is now sufficient managed care penetration in the commercial population to lift the 50/50 burden from providers with special interest in serving the low-income and elderly populations.

Second, it forces providers to divert their primary attention from serving the elderly to serving the population at large. In addition to developing specialized programs of care and marketing programs for the elderly, providers must also develop clinical and marketing programs for the general population. From the state's perspective, it

diminishes the size of the pool of potential providers and contractors with whom the state can contract. Although states may have a wide network of contracts for serving the Medicaid population on a risk basis, these contractors can not provide Medicare services to the dually eligible unless at least 50% of their plans' enrollees are commercially insured -- even though Medicaid rules require that only 25% of enrollees come from the commercial pool. This forces states to develop multiple contracts for serving the same population, and prevents them from being able to adequately and efficiently coordinate the delivery of services to the dually eligible by using the same providers for a defined population.

Enrollment Options

Under 1115 waiver programs, states are permitted to mandate the enrollment of the Medicaid population in managed care plans if they offer enrollees more than one choice of plans. In large states with heavy managed care populations, this "freedom of choice" requirement generally is not a problem. In small states, however, this requirement can virtually doom a state's ability to mandate enrollment. Because HMOs do not perceive significant enrollment opportunities in rural regions, small states have experienced difficulty in attracting managed care organizations.

The Medicare prohibition against mandatory enrollment and "locking-in" for more than 30 days Medicare beneficiaries who voluntarily enroll also disadvantages states. Since states may not require the dually eligible to obtain their Medicare benefits through a managed care plan, opportunities to coordinate and manage the care of this population through a single network operating under joint risk contracts are severely diminished. States have argued that this prohibition reduces the incentive to produce Medicaid savings since these savings are passed on to Medicare. In effect, states pay double for services: once for the Medicaid capitation payment, and a second time for Medicare premiums, deductibles and cost-sharing requirements. To maintain states' interest in the establishment of managed care programs for the dually eligible, states should be permitted to require subscribers to pay the difference between Medicare fee-for-service costs and the costs of providing the care through a capitated payment arrangement or provide opportunity for a lock-in for a limited period of time, e.g., one year.

Covered Benefits

Differences in Medicare and Medicaid requirements regarding covered services and benefit levels can complicate the provision of care to the dually eligible for both states and providers. States can dictate what Medicaid benefits a health plan must offer, but they have no control over Medicare benefits. Each individual health plan can determine which optional Medicare benefits to offer in addition to those required by Federal law. Further, health plans are required to offer supplemental benefits if Medicare payments in a given community exceed the plan's cost of providing the standard benefit package. This variation prohibits the establishment of uniform state-wide programs and diminishes opportunities for minimizing costs through administrative efficiencies.

The provision of care for the dually eligible also creates challenges for provider networks that offer services in multiple locations within a state or in more than one state. Networks must effectively develop multiple "products" or benefit packages to account for variations in benefit requirements across counties -- due to different Medicare payment levels -- and across states -- due to differences in Medicaid coverage requirements.

Differences in benefit requirements between Medicare and Medicaid programs further complicate care to the dually eligible due to conflicting financial incentives that lead to cost-shifting. For example, since Medicare is biased toward acute care, hospitals have the incentive to discharge patients as quickly as possible to LTC settings to maximize their DRG rate. Since Medicaid is biased towards long-term care, nursing home residents often must be transferred to an acute care setting to receive payments for services such as physician care.

Finally, differences in requirements for accessing certain benefits, such as Medicare's three-day-prior hospital requirement prevent providers and purchasers from providing the most efficient combination of services at the best time to meet patients needs. For example, under the Medicare fee-for-service program, home and community-based service eligibility is conditioned upon prior receipt of a higher level of care. Second, most HCBS waiver programs only allow Medicaid to pay for community-based services if the person is at risk of institutionalization. This prohibits providers from offering services early enough in the disability process to prevent further decline and ultimately leads to higher health care costs per capita and in the aggregate.

NCCC recommends that Congress address these problems by vesting authority for the Medicare and Medicaid programs for the over 65 with either the Federal or state governments in favor of the current structure of parallel authority between the two. Vesting authority with a single governing entity would pave the way for establishing uniform standards of care for the chronically ill and consolidating under a uniform system administrative structures, oversight requirements, reporting procedures and payment rules. It would substantially reduce duplication and eliminate conflicting incentives that frequently lead to cost-shifting from one program to the other. Further, delegation of authority for the Medicare and Medicaid programs for those over 65 to either the Federal or state

governments not only would diminish the challenges of caring for the dually eligible populations, but also, it would also create incentives for establishing a uniform policy for caring for the chronically ill in general.

Payment Methodology

States experience several problems based on differences in Medicare and Medicaid payment methodologies. Medicare payment rates are established by the Federal government based on a formula that takes into account utilization rates and prices in the fee-for-service sector. A payment rate is established for each county based on the "average adjusted per capita cost" of caring for the population and plans are paid 95% of this amount. States have no ability to negotiate rates with Medicare risk contract plans. Further, states are not permitted to receive direct payments from Medicare which would enable them to merge Medicare and Medicaid dollars into a single pool and establish a single, blended capitation payment for each plan enrollee. Under the Medicaid program, states have the ability to set capitation rates and providers can negotiate these rates with the state. States clearly would have greater flexibility in providing services under a pooled capitation rate. It also would enable them to address to some degree the county-by-county variance in Medicare AAPCC rates which makes it impossible to establish standardized benefit packages across the state.

IV. DEMONSTRATIONS FOR INTEGRATING PRIMARY, ACUTE & LTC SERVICES

Over the past 15 years, the public sector has undertaken a number of demonstration programs designed to eliminate legislative and regulatory barriers to the integration of primary, acute and long-term care services. These programs have been directed at improving access to services, enhancing quality of care, and reducing public expenditures for health care services. For purposes of this testimony, I will focus on three particular demonstration programs, including the Social HMO, PACE, and the Minnesota Long-Term Care Options Project (LTCOP). Each of these programs diverge from the Medicare HMO program established under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Federal government's first attempt at making managed care options available to Medicare beneficiaries. Each of these programs operate under TEFRA-like contracts, but extend TEFRA benefits to include some level of coverage for long-term care services. Each of these programs offer important lessons which will inform the ongoing development of managed care approaches and integrated delivery networks.

Social HMO and PACE Demonstrations

The Social HMO and PACE demonstrations have been operational the longest of the three demonstration programs. Upwards of 10 years experience with Social HMO and PACE programs provides extremely fertile grounds for better understanding how to predict and control chronic care risk and reduce costs through the integration of primary, acute and long-term care financing and delivery structures and aggressive care management techniques.

Both models represent prepaid, capitated health plans which provide elderly beneficiaries an enhanced package of primary and acute care services and varying amounts of long-term care benefits. For example, in addition to all Medicare Part A and B benefits, beneficiaries receive coverage for prescription drugs, eyeglasses, and hearing aides. Standard Medicare risk contracts cover all Part A and B services and Medicare copays and deductibles, but are only required to offer additional benefits if the cost of a health plan's benefit package costs less than 95% of the AAPCC based on the average community rate for the area. The Social HMO also includes up to $1,000 per month in home and community-based service benefits and PACE offers unlimited coverage of long-term care services. TEFRA contracts only cover short-term skilled nursing facility and home health care services for rehabilitation services related to acute care episodes. Providers also have more flexibility to allocate resources based on individual patient needs -- as opposed to restrictive payment guidelines -- under the demonstration programs than TEFRA contracts. For example, enrollees can be admitted directly to nursing homes without a prior three day hospital stay.

Social HMO and PACE Services are financed through pooled funding from Medicare, Medicaid and private premiums. Between two-thirds and three-quarters of PACE dollars are contributed by Medicaid and most of the remainder by Medicare. Only two sites (The Bronx and Rochester) have a relatively high percentage of Medicare only clients where subscribers pay a monthly premium equivalent to the Medicaid capitation payment. Alternatively, Social HMO funding is provided almost entirely by Medicare. Less than 5% of Social HMO patients are dually eligible and two of the three operational sites have eliminated private premium contributions.

Despite these similarities, the Social HMO and PACE models differ significantly in the populations they serve and the focus of their integration efforts. The Social HMO is an insurance model targeted toward a cross section of well and frail elderly. Although Social HMOs are permitted to queue to prevent adverse selection, only one site uses this technique. Currently, between 10% and 15% of Social HMO beneficiaries are disabled. The PACE program is a risk-management model directed exclusively at the frail elderly. Applicants to the PACE program

must be assessed "nursing home certifiable" to qualify for coverage. On average, members are disabled in between 1.8 to 3.4 out of 5 activities of daily living

The difference in the populations served has led each of these models to focus on a different aspect of integration and a different area of health service delivery. The Social HMO has expanded LTC insurance opportunities for the general population of Medicare beneficiaries. Because the Social HMO's long-term care risk is limited through an annual benefit cap, these demonstrations have placed greater emphasis on issues of rehabilitation prior to the time an individual qualifies for nursing home care. The capped chronic care benefit of up to $1,000 per month is intended to supplement the Medicare skilled benefit through coverage of convalescence after Medicare nursing home coverage expires, payment for short respite stays to provide relief for family caregivers and to pay for the initial portion of a permanent nursing home admission. Social HMOs would have stronger incentives to manage the interrelated costs of primary, acute and long-term care benefits if they were fully at risk for all of these benefits.

The PACE program targets a smaller niche of the Medicare market, those who are extremely frail as well as dully eligible for Medicare and Medicaid services. About 90% of PACE enrollees are dually eligible. Since PACE is fully at risk for all primary, acute and long-term care services for a frail population, this program has been forced to more extensively restructure and more fully integrate all patient care services, but only after the subscriber has become severely disabled. This is accomplished through an interdisciplinary team approach to care provided under an adult day care center model. PACE enrollees visit day care centers up to 6 days per week where they receive a wide range of primary care, rehabilitation and medical services on frequent basis.

Another important advantage of the Social HMO and PACE models over the TEFRA model relates to the payment structure for disabled enrollees. Both models include stronger financial incentives to care for the severely chronically ill, unlike traditional risk contracts. TEFRA risk contractors are only rewarded financially for subscribers who are sufficiently ill or impaired to warrant institutionalization. Payment for the institutionalized can be significantly higher than for community-dwelling subscribers. The Social HMO and PACE programs include a risk-adjustment for *community-dwelling* seniors who are frail as well. Plans receive almost 2.4 times the premium level for frail elderly, regardless of where they are living.

The Social HMO and PACE programs have demonstrated the importance of linkages between the acute and long-term care systems. Both have produced strong evidence, for example, of the critical importance of care management as a tool for preventing the onset or progression of disabilities and for controlling costs. PACE subscribers' plans of care are monitored continuously thorough day care staff to determine the need for a change in proposed treatment plans. The care coordination resulting from regular communication with subscribers helps to anticipate health problems, avoid flair-ups of chronic illness and prevent acute illness. While PACE has not been formally evaluated, sites report a 15% savings compared to the traditional fee-for-service sector.

The Social HMOs perform quarterly assessments of the nursing home certifiable population to determine ongoing need for services. This care management function is extremely important to helping control costs since Social HMO beneficiaries only remain eligible for long-term care services while they are nursing home certifiable. Less than half of those qualified as nursing home certifiable at any time remain in this category consistently for more than one year and many fully recover following rehabilitation. Thus, the long-term care benefit can be discontinued for those who regain functional ability and these dollars can be redirected to those in need, thus helping to maintain stable costs and premiums. Social HMOs also have identified several factors which predict the likelihood of someone remaining nursing home certifiable vs regaining functional ability. This information is used to monitor subscribers' health status and develop appropriate interventions.

Notwithstanding the initial progress towards integration and cost-containment made by these demonstration models, there are a number of constraints that will need to be addressed in further generations. One of the most significant barriers to effective management of chronic illness and the consequential cost-savings potential relates to each model's targeted population. The Social HMOs have a limited incentive to aggressively manage LTC benefits since they are not at financial risk for these services. PACE has the financial incentive to manage all services, but opportunities to reduce expenditures associated with chronic illness are limited by the nursing home certifiable eligibility requirement. This represents a significant limitation relative to overall system cost containment since the majority of long-term care episodes originate from acute illness.

The Social HMO and PACE models also could be significantly enhanced through consolidation of administrative and oversight requirements. While both models permit providers considerably greater flexibility in clinical decisions regarding service allocation by virtue of waiver authority, many of the administrative barriers to integration cited above continue to plague these programs. For example, providers must enter separate contracts with Medicare and Medicaid and are subject to parallel and often duplicative oversight requirements related to data collection and documentation. NCCC also believes that the PACE program could be enhanced through relaxation of prescriptive protocols governing service delivery. For example, barriers to entry include unwillingness of

prospective subscribers to attend the adult day care program the expected four to five times weekly, and the importance of family support to provide coverage outside of the day care setting. Greater exploration of housing options such as assisted living and supportive senior housing arrangements could help eliminate these barriers.

Finally, it is important to highlight a problem experienced by the Social HMOs with respect to a conflict between marketing and risk-management. Social HMOs have had to invest precious resources resolving marketing issues that could have been targeted more effectively on systems development. Social HMOs have found it difficult to compete with the TEFRA plans in their area due to the higher costs associated with the long-term care benefit. Since they can't be price-competitive, they must highlight the long-term care benefit as a justification for their higher costs and to demonstrate superiority over their TEFRA counterparts. Yet, by highlighting this benefit, Social HMOs risk substantial adverse selection since they will attract those who most need this benefit. If they minimize or "de-market" this benefit to prevent adverse selection, they undermine their own ability to compete with TEFRA risk contracts based on price. Almost all of the Social HMOs experienced difficulty meeting their enrollment targets early on which led to higher than projected administrative costs per capita and lower revenues.

The marketing/risk management conflict has affected Social HMO sponsors' ability to get the degree of "buy-in" across the entire system which is critical to developing a fully integrated system of care. Social HMOs do not have sufficient market share to leverage providers to change their practice patterns. For example, some programs have experienced resistance from physicians in requiring that a separate set of clinical protocols be employed for a subset of patients comprising less than 5% of the systems' total patient population (i.e., Social HMO subscribers).

These marketing challenges have diminished the Social HMO's ability to effectively integrate the provision of primary, acute and long-term care services to date. Two of the three existing sites have eliminated the private premium originally charged in order to be more competitive with TEFRA HMOs. The elimination of the Medicare premium may increase the Social HMOs' competitive position with seniors, particularly if it is clarified that these entities no longer are subject to an enrollment cap.

NCCC recommends that Congress enact legislation which makes permanent the waiver authority granted to existing Social HMO demonstrations and enables other provider networks to establish like programs. We also strongly recommend that legislative authority be established to provide for the establishment of additional Social HMO and PACE programs. However, it is critical that this authority be sufficiently broad to enable provider-based networks to continue evolving these important models as opposed to simply expanding the same models under existing protocols.

Minnesota Long Term Care Options Program

The Minnesota Long-Term Care Options Program (LTCOP) was developed to facilitate the integration of primary, acute and long-term care services for persons over age 65 who are dually eligible for Medicare and Medicaid benefits. After two years of intensive efforts, the state received a unique package of waivers which will enable them to combine the purchase of both Medicare and Medicaid services under a single contract and permit the state to contract with smaller entities which previously were prevented from contracting with Medicare on a risk basis.

A major goal of this demonstration is to eliminate the extensive duplication of effort and conflicting financial incentives which typically characterize programs for the dually eligible.
The LTCOP program will combine services and funding from several sources, including Medicare, the prepaid medicaid managed care program (PMAP) and the Elderly Waiver program. Minnesota already has been enrolling elderly medicaid beneficiaries in managed care programs for a number of years, but PMAP does not cover extended long-term care benefits. PMAP does cover hospitalization, physician visits, rehabilitation therapies, home care services, medical supplies and equipment, dental, prescription drugs and Medicare copayments and deductibles. Under the LTCOP program, enrollees also will be entitled to all Medicare Part A and B benefits, home and community-based services covered under the Elderly Waiver program, and the 180 days of nursing facility care for those who enroll while living in the community. Additional nursing home expenditures will be funded under the traditional nursing home benefit, outside of the managed health care capitation rate.

The LTCOP program differs from the Social HMO and PACE programs in several ways. First, it will initially be implemented in seven counties with a view toward state-wide expansion over time. Unlike the Social HMO and PACE, the number of participating sites is not restricted under law so the number of beneficiaries served could be substantially higher. Second, pursuant to Minnesota's 1993 health care reform legislation, services will be delivered primarily through integrated service networks (ISNs) and community integrated service networks (CISNs). These organizations will be responsible for providing the full range of primary, acute and long-term care services for a pre-determined, capitated premium. To qualify as a LTCOP contractor, providers will be required to meet a higher "standard" of integration such as developing integrated information systems which assure the flow of pertinent clinical and logistical information across points of service from hospitals to home health care agencies.

NCCC believes the use of the ISN and CISN models will result in much greater mainstreaming of this program even during the demonstration phase.

Third, although it is targeted toward the dually eligible program like PACE, enrollees do not have to be nursing home certifiable to qualify for LTCOP. Well-elderly also will be enrolled and, like the Social HMO providers, will have the opportunity to take precautions against chronic illness either before the onset of disabilities or earlier in the process. This has tremendous cost-savings potential. Fourth, the LTCOP program has further refined the risk-adjustment process used by the Social HMO and PACE programs by developing four different payment levels that account for different levels of disability. For example, for community-dwelling subscribers who are not nursing home certifiable, plans will be paid 95% of the non-institutional Medicare AAPCC, the non-institutional PMAP rate and a nursing facility add-on to account for up to 180 days of nursing home care. For individuals receiving nursing home care for at least six months who return to the community for at least one year, plans will receive Medicare payments based on the PACE risk adjustor (i.e., 2.39 times 95% of the AAPCC); the institutional PMAP rate; and twice the average monthly Elderly Waiver Payment. Unlike TEFRA HMOs which only reimburse higher amounts for the institutionalized, this payment methodology creates significant financial incentives to care for a severely chronically ill population.

The fourth difference between PACE and Social HMO programs and LTCOP may be among the most significant from the states' perspective because it significantly simplifies program administration, diminishes opportunities for cost-shifting between Medicare and Medicaid, and provides an opportunity for states to implement a fully coordinated state-wide long-term care strategy as distinct from the current county-by-county approach. The LTCOP is the first state-based managed care program for the dually eligible elderly which enables the state to consolidate the administration and oversight of both programs under a single umbrella. It includes several unique features. The state will negotiate a single contract with HMOs and CISNs for capitated risk-based Medicare and Medicaid services under an agreement with HCFA, instead of multiple contracts for various providers under each program. In addition, there will be a single, instead of dual, enrollment process for the dually eligible. The state will incorporate quality assurance functions for Medicare services into its existing PMAP (Medicaid) managed care quality assurance process instead of being required to establish a separate system. Finally, the overall continuing care of each enrollee will be coordinated by a case manager who will have access to all of a health plan's medical information and health resources.

The LTCOP program clearly has the potential to demonstrate the impact of a more fully coordinated system of care on cost and quality. To date, no formal mechanism has existed for documenting the costs of parallel administrative and oversight requirements for Medicare, Medicaid and state-based long-term care programs. Further, LTCOP will help assess the impact of more fully integrated systems on quality of care and health care outcomes. Improvements in these areas could have tremendous implications for consumer satisfaction and cost-containment. Like the other demonstrations, however, LTCOP has a few limitations worth noting. First, the waivers do not allow health plans to require subscribers to receive Medicare services from health plan providers within the capitation payment. Subscribers are free to continue receiving Medicare services outside the plan. This makes it difficult for the health plan to assure coordination between plan providers and Medicare providers which can lead to inefficiencies. Demonstration guidelines, however, would not require plans to cover the copayments and deductibles for Medicare services provided outside the plan since enrollees are locked-in for Medicaid services. This provides a strong incentive for enrollees to obtain their Medicare benefits within the managed care system.

A second limitation of the LTCOP program is that it only serves the dually eligible which prevents Medicare-only patients from accessing the many advantages offered by this coordinated system of care. Given that the dually eligible represent the greatest challenges, both in terms of regulatory barriers to integration and the high costs of care, NCCC believes that this population is an appropriate place to start. The lessons learned under this program will be more easily translatable to the Medicare population since services are funded primarily from one source.

V. THE CASE FOR MOVING BEYOND DEMONSTRATION STATUS

Demonstrations provide a valuable opportunity for testing concepts in a controlled environment prior to implementation on a wide-scale basis. NCCC believes, however, that sufficient experimentation with the integration of primary, acute and long-term care services has occurred to warrant moving beyond demonstration models and toward mainstream programs that could be implemented on a wide-spread basis within a clear regulatory framework to assure ongoing quality and cost controls. There are a number of limitations related to demonstration programs that impede the development of integrated programs for the elderly and chronically impaired. The rapid growth of the elderly population, the advancement of chronic conditions as the fastest-growing segment of the health care market, and the acceleration of costs associated with these two trends argue strongly for moving beyond a demonstration model. A number of serious limitations of the demonstration model aptly make this case.

First, demonstrations are implemented in an artificial environment, freezing in place certain research designs and prohibiting modifications to these protocols as learning occurs. The evolving dynamics in health care require a reengineering approach to change implemented in mainstream environments under flexible arrangements rather than a research and demonstration strategy. Second, size creates significant limitations on the demonstration approach. There are only 3 Social HMO sites currently operational with six more scheduled for implementation later this year. Over 10 years, only 50,000 seniors have been served. Demonstration authority for the PACE program is limited to 11 sites which serve between 170 and 350 members each.

Size creates several problems. It impedes rapid learning since so few sites are testing and refining concepts and minimizes the cost savings potential and efficiencies that only can be gained through economies of scale. It also creates internal challenges to organizations and discourages providers from fully embracing the goals of the program. It limits providers' ability to penetrate the market and test the competitive advantage of this model over others. Consider the difficulty of convincing physicians and other clinicians in a large health care system to use one set of protocols for regular HMO patients that comprise over 95% of the systems' patient load and a different set of protocols for a patient population that may in fact represent 5% or less of all subscribers. Consider convincing administrators to implement a separate management information system which aggregates clinical, cost and quality data for a patient population that represents a small percentage of the system's total revenue. Consider convincing the chief financial officer to enter a risk-sharing arrangement for a population that is at risk of consuming significantly higher than average resources when this risk will be spread across less than five percent of the entire patient population.

Third, demonstration status can discourage providers, payors and state governments from establishing programs. Demonstrations require considerable time and investment of resources, yet the "pay-off" and return on investment is uncertain unless sponsors receive some assurances that they will have the opportunity to mainstream the programs in which they are investing. PACE sites need to make a significant investment before even applying for Federal waivers since they must become operational under state-based Medicaid capitation systems first. Even after demonstrations are operational, demonstration status continues to absorb significant amounts of administrative, financial and clinical resources since sites must continuously return to the Congress and Administration for extensions of waiver authority to remain operational. Valuable time is taken away from day-to-day operations, research and patient care while sites are collecting data and building a case for their ongoing existence.

Demonstration status also has discouraged consumers from enrolling in programs due to the uncertainty of the health plan's future. HMOs already have difficulty attracting seniors unless the senior's physician already is part of the health plan. Seniors are more reticent to "leave" their physicians behind than the younger population. Adding a second significant barrier -- the prospect of having to change plans and providers in the future if the demonstration is not continued -- exacerbates the marketing problem. This can be especially problematic for senior citizens and chronically impaired persons whose "insurability" may be marginal to begin with due to the high risk of needing extensive health care services.

The NCCC does not intent to suggest that selected concepts should not be tested under controlled conditions. Yet, unless the Federal government breathes more flexibility into mainstream operations with incentives for developing new and innovative approaches, the health care industry will not successfully respond to emerging demands as we enter the 21st Century. For these and other reasons, NCCC strongly urges the Committee to establish a permanent provider category under Medicare and Medicaid which promotes the establishment of integrated provider networks.

VI. NCCC RECOMMENDATIONS

NCCC recommends that Congress take the following actions to help promote the integration of primary, acute and long-term care services as a strategy for increasing consumers' access to needed health care services, improving health care outcomes, and reducing health care expenditures.

A. Comprehensive Initiatives

EXPANSION OF PROVIDER-BASED NETWORKS: Establish authority for provider-based networks as a new managed care option available to Medicare and Medicaid beneficiaries. Networks would be subject to a uniform set of requirements governing administrative, payment and oversight policies. Networks would be required to demonstrate capacity related to integration and risk-based financing criteria would build on the experience of the Social HMO and PACE projects in areas such as establishing risk-adjustment payment methods.

ADMINISTRATIVE REFORM: Direct the Secretary to consolidate administrative requirements for organizations providing services to a defined population through an integrated health care network. All Medicare and Medicaid services provided by a federally qualified provider network would be subject to a uniform set of administrative reporting procedures, performance standards and payment methods.

PAYMENT REFORM: Direct the Secretary to develop incentives for risk-based, capitated financing for provider-based networks which provides for the pooling of Medicare, Medicaid and private coverage including Medicare supplemental policies, private LTC insurance policies or subscriber premiums. Payment reform should build upon the risk-based payment methodology designated for Social HMOs and PACE programs. Incentives might include health status adjustments, blended capitation/actuarial use rates, risk corridors, risk and outlier pool arrangements and withhold and bonus arrangements.

CHRONIC CARE RESEARCH: Direct the Secretary to conduct research related to the costs of chronic illness to: (1) determine the aggregate costs of services for the chronically ill by documenting Medicare, Medicaid and private expenditures across settings for specific conditions and (2) establish outcome indicators for chronic conditions that measures quality over time, not at the point of discharge from each individual setting.

B. Targeted Initiatives

- Direct the Secretary to develop regulations which grant permanent waiver authority for existing Social HMO I and II sites.

- Provide for the establishment of additional provider-based integrated delivery networks as an expanded Medicare managed care option. Criteria should be sufficiently broad to permit the expansion of Social HMO and PACE sites as well as alternative integration strategies that continue to evolve the Social HMO and PACE models under permanent waiver authority.

- Explore opportunities to further enhance integration capabilities through collaborative efforts between provider networks and the newly established Veterans Integrated Service Network initiative.

- Eliminate 50/50 rule requiring Medicare HMOs to enroll at least 50% of subscribers from the commercially insured population.

- Establish a state-based dually eligible demonstration program to develop models for integrating primary, acute and long-term care services for the dually eligible which would permit states to integrate quality assurance systems, enrollment procedures and other administrative, financing and oversight requirements for the Medicare and Medicaid programs under a single umbrella.

- Provide either the Federal or state government with the financial responsibility and program authority for the Medicare and Medicaid programs for the elderly and disabled as a strategy for consolidating program administration, increasing operation efficiencies, and aligning financial incentives between programs

Chairman THOMAS. Thank you very much.

Mr. Bringewatt, my goal when I first involved myself in this area was to try to get the payment system to reflect a continuum of care based upon patient need. You have given us a couple of good examples of how it simply does not do that. You deal with the patient care based upon the payment system, and I went through this personally with my father, which got me focused in the area. It made no sense in terms of some of the things I had to do based upon his needs, and the answer I always got was well, if we do not do it that way, we do not get paid for it.

And so, my goal has been to create a need-based continuum of care that you draw on. I agree with you totally on that, and then, you went to a solution, which is to create a permanent waiver for particular programs. And my concern is to find out what it is that we are waiving that makes these programs work and get rid of it, because I think it is a problem for the entire system, and that I do not want to go to a permanent waiver for particularly defined programs; I want to change the system so folks can get in and out of it in providing for the various needs.

In listening to the discussions, and even, Dr. Wiener, in yours, and I want to know if this is a fair criticism because I simply do not know; we are talking about making comparisons in the costs for these programs to the traditional Medicare and Medicaid, and I am wondering if we are looking at the universe of costs when we compare, say, a SHMO, integrating long-term care into the normal acute program. Is there any money outside of the Medicare/Medicaid model we use for comparative purposes on costs that we are not considering which should be part of the pot if we are creating a completely integrated program between acute and chronic?

Just let me give you an example: We passed a health care bill—it is over in the Senate; it is being debated right now—in which we are allowing long-term care insurance costs to be deducted as part of health care costs above 7.5 percent of AGI on your income tax, on Schedule D. And we accepted a memo which would allow actual long-term care costs to be deducted. It seems to me when we are dealing with several billions of dollars of deductions off of income tax, that is probably not part of the pot we have considered historically available to pay for these programs. And one of the things this Committee has wrestled with is long-term care. Everybody talks about it out there; it is something we need to deal with; it is on the horizon; when in fact, it is here, and we are not really facing it. And what I see is the possibility of setting up a program which takes the current arrangement, increases it 5 percent from 95 to 100 percent, gets rid of some arcane rules as far as I am concerned that may have had some historical use for us, 50/50 or others, and we essentially begin to deal with the long-term care problem. To say that it may not be cost-effective because it does not stay within 100 percent of the expenses of Medicare and Medicaid is not fair because it requires that model be based upon the potential costs that this Congress will place on the American taxpayer in another context to deal with long-term care. Do you understand my direction? Are we not counting all of the money that should be in the pot to deal with the unique continuum of care provided by the SHMOs and for a defined group, the PACE program?

Mr. WIENER. Well, certainly for the SHMOs, there are private payments as well.

Chairman THOMAS. I am looking primarily on the government side in terms of expenses that we would accept. I understand the private payments. Are you with me? Do you understand what I am talking about?

Mr. WIENER. I am not entirely sure.

Chairman THOMAS. Does anybody understand what I am talking about? Take a shot at it.

Mr. BRINGEWATT. Well, let me try here. Obviously, Medicare and Medicaid represent the lion's share of dollars relating to people who have chronic diseases and disabilities on the acute and the long-term care side. However, there are other public programs that also provide care to the same population. They include social service block grant programs under Title 20; they include the Older Americans Act programs; and they include the Veterans Administration, where there is a significant dollar amount relating to similar populations.

Chairman THOMAS. And, I might add, all the legislation we have not yet passed to deal with long term care, which will certainly cost significant amounts of money, and especially when you can begin talking about programs that focus on defined groups, as PACE has done with the frail elderly, but as programs will do with end-stage renal disease and others which will give us a packaged program that if we examine all of the costs that would otherwise have been expended rather than just the Medicare and Medicaid 100 percent dollar amount, then, in fact, we would find savings larger than we think and more importantly programs that meet specific needs of patients so that the quality aspect, which we cannot always quantify, is nevertheless one that we believe strongly in.

Mr. WIENER. Mr. Chairman, I would certainly hope that we would find those savings, but I do not think that you can guarantee it. For example, if you have a nursing home-level person who is out in the community and receiving SSI and food stamps, once they enter the nursing home, basically they lose all of those SSI payments and food stamps, and it all shows up in the Medicaid budget. If we succeed in keeping that person out in the community, then we have to pay SSI; we have to pay food stamps; and whatever their medical and long-term care costs are. So it may net out that we save money, but it may net out that we do not.

Chairman THOMAS. And all I am saying is that we need to look at the larger picture whenever we talk about the costs that are necessary.

You also indicated, Dr. Wiener, that there was some concern about who controls the programs that the doctors are involved in. Is not one of the key aspects of both the SHMOs and certainly of PACE the idea of this team component, which is more and more emphasizing a kind of interdisciplinary geriatrics approach to dealing with the issues, and, certainly, various models will have different folks in control. But would the marketplace not tend to take care of that if you made permanent the concept, and instead of making it a permanent waiver, simply allow HMOs a higher percentage of the costs or all of the costs if they would fold in these costs? With programs that better met the needs of seniors through

an integrated geriatric program instead of—and I do not mean this pejoratively—a narrow, doctor-controlled program that did not look at the larger picture—there would be winners and losers. And I would much rather have the marketplace try to determine winners and losers than government trying to identify structures that may or may not work.

Mr. WIENER. Well, we can certainly—if we can open things up, we could see what the effects of the market are. As you know, only about 9 percent or 10 percent of the elderly have chosen to join HMOs, and we have only a small handful of programs that integrate acute and long-term care services. In terms of integration, the Social HMOs have focused on smoothing the transitions between acute and long-term care. But certainly the PACE model has done that. But again, we just do not have a whole lot of data. It may be that PACE and the SHMOs are able to take into account the needs and the desires of the individual clients. But it may also be that, driven by the need to save money, in a larger setting, they may decide that there are certain things that people cannot have. And at least at this point, there are not a lot of options out there for people.

Chairman THOMAS. Well, and the other cost that I am looking at is the last 6 months argument and the quality of life versus quantity and the expense that this society currently spends on the question of death and near dying. And finally, and Dr. Leutz, if you want to get in, I will let you in, the whole question of data collection has been frustrating us across the health care spectrum in terms of outcomes research not just for this particular area. Frankly, we are way behind the curve in utilizing the current data gathered in a way and manipulated in a way with complete security for privacy that would provide us with a whole lot more information than we should have. And so, one of the thrusts, I think, which is currently bipartisan that we are trying to move forward on is outcomes research and data collection.

Mr. LEUTZ. Mr. Chairman, I just wanted to respond to your question about putting this out on the market. It is important, I think, if this does go on the market that there be some minimum standards set about what a Social HMO is and what you do for this extra 5 percent. The proposal that we made has set out minimum benefits in terms of dollar amounts. Prescription drugs has always been and I would maintain should continue to be a part of the benefit package, and also, you might include standards around geriatric care; you might include standards around service integration; about screening the membership; having case management; doing chronic disease management and so forth. And there should be a minimum set of things that you do in order to be able to call yourself a Social HMO on the market, it seems to me.

Chairman THOMAS. Well, my concern there would be to define a particular product which would not allow for continued innovation, which I think we probably need, although obviously, a positive definition of who you are to me is far better than a waiver structure with a restriction on the amount of folks you can bring into the program. That seems to me relatively self-defeating; in fact, it defines a demonstration program and guarantees that you will re-

main a demonstration program. And I think what we are talking about is trying to break out of that.

The limits on the breakout in terms of what you can and cannot do are obviously something we could discuss as we move forward. I want to thank the panel very much, and especially for your written testimony. You never get to present as much material as you have in your written testimony, but it is very helpful to us, because this is an area, I think, that the Subcommittee will continue to want to increase our knowledge curve on.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. I do not know whether you have the experience to answer this question or not, but managed care plans have had some experience in Medicare, particularly in those areas where Medicare Select was allowed. They currently have the legal right to offer Medigap policies. The terms of the Medigap policies are that you participate in the managed care system. It would have the effect of their receiving the Medicare premium for payment for participation in the Medicare managed care plan.

Now, under a Medigap policy offered by Medicare Select plans, in other words, if any managed care plan wants to offer a Medigap policy covering exactly the services you want, it would have the effect of a capitated payment, plus whatever additional costs they thought they had to charge for the Medigap policy, and they would not be covered by the 50/50 rule for, I think, any of the impediments that block your development.

Now, is that true or untrue?

Mr. LEUTZ. Well, one impediment that has not been mentioned in terms of the payment system that a Social HMO gets, and it is also fundamental to the PACE plan, is a disability-based AAPCC. The payment is based upon Medicare fee-for-service equivalent, but within that is a different underwriting factor that pays higher for community residents who meet nursing home eligibility criteria.

Mrs. JOHNSON. So, in other words, if we wanted that development to move forward in the private sector, we would have to offer not just the Medicare premium but the higher disability-based premium?

Mr. WIENER. I think the key point is that under current law or practice, if you have a very severely disabled person, and they go to a nursing home, that is great for the HMO, because they get a significantly higher payment. If they keep that very same person out in the community, they get a dramatically lower reimbursement rate. What you have for the SHMOs and for On Lok/PACE is an ability to get that higher reimbursement while that person is in the community.

Mrs. JOHNSON. But if, under a Medicaid block grant structure, there would be no impediment to a state setting a rate for Medicaid eligible disabled for a Medigap premium, for a plan that would offer a managed care Medigap premium plan that would offer everything you are offering and for that Medicaid eligible disabled a higher premium. That would leave the Medicare-eligible disabled at a disadvantage, correct?

Mr. WIENER. There would be no impediment except the one that Representative Stark alluded to—which is that the gross amount

of money available to the state might be substantially less. But you would still have the problem on the Medicare side.

Mrs. JOHNSON. Now, in terms of the Medicaid issue, my impression is that there has been a demonstration project that has demonstrated that you can reduce the rate of growth of long-term care costs by more effectively targeting your reimbursement rate just the way we have been talking about, I think it is in New Jersey, but I am not sure. One of the states was able to merge their Medicaid and Medicare moneys.

Mr. WIENER. Arizona.

Mrs. JOHNSON. Was it Arizona?

Mr. WIENER. Well, I think Arizona is a very interesting case. But if you look very carefully, you will see that they get most of their savings by serving fewer people than would be served under a traditional program. The per-member, per-month cost in Arizona compared to a traditional program is basically the same. So they do get significant savings, but they come from serving fewer people.

Mrs. JOHNSON. Mr. Bringewatt?

Mr. BRINGEWATT. Yes; if I could make a couple of points. One, first of all, just in looking at the Medicare Select program by itself, in terms of the moneys that are available for long-term care, I think it is important for us to keep in mind that the dollars there really relate to acute care benefits and not long-term care benefits. And so, it is helpful to free a system up to spend those moneys, but it does not necessarily mean that there will be long-term care that comes as a result of that.

Mrs. JOHNSON. You misunderstood me.

Mr. BRINGEWATT. OK.

Mrs. JOHNSON. My assumption is that the managed care plan would offer a Medigap insurance policy that would add on these benefits and would charge a premium for that. But their savings, the benefit for them, would be that the Medicare participant would then participate in their managed care plan, which would be a good deal for them on the acute care side, and they would use this to encourage people to be in their managed care plan. And what the person would get back for it is an integrated care system which is broader than anything that Medicare offers. So, I am not suggesting that they would not be offering the same benefits. In fact, what interests me is that they would have the power to offer those same benefits, and they would have to charge some additional premium.

For a Medicaid disabled person who was not Medicaid-eligible, this would provide them with access. And I get the idea that the premium probably would be modest.

Mr. BRINGEWATT. I think—and maybe Mr. Leutz can speak to this—but in some ways, what you are describing would be a variation on the Social HMO program. You could offer an additional long-term care benefits that could be developed through an additional premium.

Mrs. JOHNSON. Right. My question is—and you can also think about this and get back to me—is there any reason why the Social HMO model could not be offered through the private sector, through managed care plans offering a Medigap policy to add on all of the other benefits of the Social HMO?

Mr. LEUTZ. Well, the one reason we talked about before was this disability-based payment to protect them on the Medicare side. But on the Medicaid side, in fact——

Mrs. JOHNSON. Excuse me; on the Medicare side.

Mr. LEUTZ. Yes?

Mrs. JOHNSON. The disabled might simply have a higher premium for the Medigap insurance.

Mr. LEUTZ. Well, they would get a higher Medicare payment to protect against the——

Mrs. JOHNSON. Well that would help, because it would function like a capitated payment.

Mr. LEUTZ. Yes, it would be—oh, I see, so you are talking about an indemnity insurer at this point.

Mrs. JOHNSON. No, the way the government relates to a managed care plan, the premium goes to the managed care plan.

Chairman THOMAS. Let me try it.

Mrs. JOHNSON. Yes.

Chairman THOMAS. Instead of getting 100 percent of the AAPCC, what we actually did in the Republican plan was to give all of the managed care 100 percent as an inducement to increase the opportunities. Instead of taking that 100 percent and the waiver from the 50/50 rule and the other requirements for your average Medicaid patient and then putting the long-term care component within the dollar savings that you get because of managed care, including prescription and vision, she is suggesting that you take your managed care program and have a Medigap policy available to those who can pay it which would add a long-term care component to the HMO plan.

Mr. LEUTZ. That seems to me essentially what the Social HMO models that are out there do right now.

Mrs. JOHNSON. You have the right to do that under current law.

Chairman THOMAS. So, it would be a self-selecting SHMO by the individual in terms of the package that they pick up from the HMO. Not everyone in the HMO would be in a SHMO, only those who have picked up the Medigap aspect of the long-term care, making it a SHMO for them.

Mrs. JOHNSON. See, that is exactly what I am saying. Now, it means that the managed care plan could offer this, cultivate that, develop. But you would not have to be tied by the 50/50 rule; you would not be limited by the waiver; you would not be a demonstration. You would just simply be an insurance plan. But you would take the benefit of what we have learned in SHMOs and even PACE.

Now, with PACE, you would need the state to guarantee you the disability level payment. But this is one of the things I want you to think about is how do we replicate this in the private market, because the private market is way ahead of us, and no matter how fast we legislate, they are probably going to be doing this in 6 months or a year, and we ought to think about how they are going to do it and whether we like the way they are going to do it.

Mr. LEUTZ. Just if I could—as I read what the private market has been doing under Medicare anyway, the tendency has been to offer in most markets less benefits and not richer benefits, that the fear is that plans will attract the sicker people; in this case, if you

offer disability-based services, more disabled people who are more expensive. So the question is, why would they do that if they can offer a stripped-down Medicare plan with minimum benefits and get plenty of people's money that way?

Mrs. JOHNSON. They cannot offer a stripped down Medicare plan. They can only offer Medicare benefits. I mean, the Medicare HMOs, that is all that is in the market now. The right of managed care plans to be in the market is fairly recent, and so, those plans are only now qualifying themselves. But as they develop their position in the market, there is absolutely no reason why they cannot offer a Social HMO as one of the Medigap policy benefits.

Mr. LEUTZ. That is right; there is no reason why they cannot.

Mr. WIENER. I think that is right. I think what it boils down to is the question that Walter raises, which medical underwriting, because nobody is going to offer a long-term care benefit if they cannot do extensive medical underwriting. And at least in the HMO program, that has not been allowed so far. I think that is one of the key issues. But I think you are basically right that if plans want to offer these kinds of benefits, they can now. It may not be optimal in terms of the Medicare reimbursement, but they could probably do it if they wanted to.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. And just add the one other component to it, in which you could, then, from a government point of view create an incentive on the multiplier factor like we do with PACE for those people who perhaps cannot find a product. All you have to do is get a profile of those people, the disabled or others, and you create multiplier factors based upon those individual patients so that you get a mix of benefit to the HMO on the dollar amount. That would be a more sophisticated AAPCC model far beyond that so you can get people on the basis of what it costs to pick them up and put them in the program, and the government pays on a more specific basis of what the needs are. And then, I think you will find a home for everybody who is out there.

The difficulty is, of course, the risk factor formula, which has been eluding everybody for 15 years or more, and that is an area along with data collection that we need to work on to be able to have a sophisticated ability to say this is how much we need to help this person in this program.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman. I appreciate the discussion we have just had, and I think there are tremendous problems associated with trying to do what the gentlelady suggests if you are trying to have the government supply the wherewithal or private plans to operate in that manner. It seems to me the administrative burden of individually figuring thousands and thousands of conditions of individuals would be mindboggling.

But anyway, be that as it may, let me get back to some easier questions for you. Dr. Wiener, you talked about the possibility that in these comprehensive, continuum-of-care plans, the bias of the medical community may intervene to allocate more of the resources toward acute care and not to long-term care. Have you any evidence in any of the plans that are out there now that that is occurring, or is that just——

Mr. WIENER. Well, we do not have a whole lot of evidence. There is some evidence—Walter may wish to dispute it—that over time, that as the Social HMOs entered a more competitive acute care marketplace and as the costs on the acute care side rose, that the long-term care benefit, was pared back so that they could keep the total premium down to a competitive level. So, that is one illustrative example, but we do not have a lot of evidence on that. But it is a worry. If you have a Social HMO model, the vast bulk of the expenditures are for acute care, and the long-term care is relatively small, and it just becomes easier to chip away at that to feed the much larger, much more dominant acute care system. It does not necessarily have to happen; it is just one of the risks that is out there.

Mr. MCCRERY. Dr. Leutz, do you have any comments about that?

Mr. LEUTZ. Well, one place that I think Josh is right that the current sites did cut back on their coverage of long-term nursing home care. But most of them increased their coverage of home and community-based services, because this was where they thought they were having the most effectiveness and this was the preference of members.

The fear, though, that is expressed is a fear that I hold, too, and I have been an advocate of having minimum or clear standards for eligibility so that people understand what their benefit is in long-term care and also clear standards for what it buys in terms of a set of services up to some kind of well-understood amount, a dollar amount like the current sites have if there is going to be a limit.

Mr. MCCRERY. And finally, Dr. Leutz, do you have anything to add on this whole question of whether this form of providing medical services, this continuum of care concept, provides us any long-term savings in the system? Dr. Wiener, for example, pointed out that as you keep people in a community setting rather than a nursing home setting, you continue to give them SSI benefits, food stamps, have you considered that whole question of net costs to the system?

Dr. LEUTZ. Well, I guess it depends on how large you define the system. Medicare has been set up—at least under the demonstration so far—not to make any savings. Medicare pays its fee for service equivalents. So then, the question is if there are savings on that, where do they go? And I think that there have been savings on the Medicare package of services. If you look at the utilization levels for hospital care, for example, they are much lower than fee-for-service. And those savings have now gone to the members who joined the plan in the form of a richer package of benefits; prescription drug benefits and the long-term care benefits are the primary ones.

There has also been some evidence of savings for Medicaid, in terms of reduced utilization of nursing homes by private-pay members, which has slowed spend-down.

Mr. WIENER. I think it is an important thing to underline that these demonstrations have not been set up to produce large savings. There may be large reductions in utilization; there may not be. But whatever savings you get from that are being recycled back into the program for other kinds of benefits. So if your eye is on the, the Medicare Trust Fund, you are not getting any particular

savings, and you would not get large savings by expanding the program.

Mr. MCCRERY. Yes. I agree with you that the trust fund is not being particularly affected one way or another by these demonstrations, but looking no larger than that, it seems to me that you do have potentially some Medicaid savings. But it really gets down to the question of does this method of providing care for elderly and disabled folks, provide us any net savings, and I will go so far as to say the private system or the public system, because we have heard conflicting testimony about preventive care and managed care, and whether, in the end, it provides us any savings at all. It may provide for a better quality of life in the last few months or something like that, but if you are talking dollars and cents, it does not really provide us any savings.

Any thoughts on that?

Mr. LEUTZ. I think that for many Social HMO members, there are some real potential savings. If it allows a member who comes in under private pay, for example, to remain at home and not have to enter a nursing home, which they would have had to pay for out of pocket, then that is a savings to them. Now, I cannot quantify those savings, but that is one type of savings that could occur to beneficiaries.

Mr. WIENER. I think the demonstrations clearly show that capitation works here as well as elsewhere. Whether you get substantial additional savings by integrating acute and long-term care, I think the jury is still out on that. But capitation does produce savings, by creating a system that allows substitution and by really turning the financial incentives on their head.

Mr. BRINGEWATT. An important issue in addressing cost savings, I think, is asking "savings relative to what," because we tend to look at cost savings in relation to specific provider types or kind of care as opposed to looking at cost savings relative to addressing a particular problem over an extended period of time. And at this point, we really do not know what the cost of care is for a number of conditions, because we do not collect or monitor care or cost of care in relation to problems. We monitor and manage cost in relation to providers. And until we make that shift in looking at cost in relation to problems from looking at cost in relation to providers, we are not going to have the kind of cumulative cost savings we need. A critical step in getting there is mainstreaming this kind of private sector approach that enables different provider networks to move dollars into different provider arrangements that, from a cumulative perspective, demonstrates cost savings so that they are not locked into managing costs within narrow, unrelated provider silos.

Mr. MCCRERY. Thank you.

Chairman THOMAS. I want to thank the panel, and I think we need to constantly remind ourselves that the yardstick that we use for saving is the fee-for-service model, and there are a number of changes that are going to be occurring in that area, and if we could plow back "savings" into more benefits within a continual slowing of the growth of what has been a 10.5-percent increase area, then I think you do get on a comparative basis cost savings and, I think,

from everyone I have talked to to a very great extent a qualitative improvement, and there is some value in that as well.

I want to thank the panel very much. We may have you back. The Subcommittee stands adjourned.

[Whereupon, at 1:12 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

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COMMITTEES:
AGRICULTURE, NUTRITION, AND FORESTRY
FINANCE
RULES

United States Senate
WASHINGTON, DC 20510-1601

April 18, 1996

Mr. Chairman,

I appreciate the opportunity to testify before you today on a bill that I introduced in the Senate in June of last year, S. 990, the PACE Provider Act of 1995. PACE, the Program of All-inclusive Care for the Elderly, is a cost-effective managed care system pioneered by On Lok Senior Health Services in San Francisco.

PACE programs provide a comprehensive package of primary acute and long-term care services. All services, including primary and specialty medical care, adult day care, home care, nursing, social work services, physical and occupational therapies, prescription drugs, hospital and nursing home care are coordinated and administered by PACE program staff.

Mr. Chairman, PACE programs are cost effective in that they are reimbursed on a capitated basis, at rates that provide payers savings relative to their expenditures in the traditional Medicare, Medicaid, and private pay systems.

The PACE Provider Act does not expand the number of individuals eligible for benefits in any way. Rather, it makes available to individuals already eligible for nursing home care, because of their poor health status, a preferable, and less costly alternative.

Specifically, the act would increase the number of PACE programs authorized from 40 in 1996; to 50 in 1997; and to an unlimited number in 1998.

Mr. Chairman, today, 11 PACE programs provide services to 2,200 individuals in eight States--California, Colorado, Massachusetts, New York, Oregon, South Carolina, Texas, and Wisconsin. At least 45 other organizations are actively working to develop PACE in many other States.

By expanding the availability of community-based long-term care services, On Lok's success of providing high quality care with an emphasis on preventive and supportive services, can be replicated throughout the country. PACE programs have substantially reduced utilization of high-cost inpatient services. In turn, dollars that would have been spent on hospital and nursing home services are used to expand the availability of community-based long-term care.

Mr. Chairman, analyses of costs for individuals enrolled in PACE show a 5-to 15-percent reduction in Medicare and Medicaid spending relative to a comparably frail population in the traditional Medicare and Medicaid systems.

States have voluntarily joined together with community organizations to develop PACE programs out of their commitment to developing viable alternatives to institutionalization. This is particularly relevant as the demand and responsibility for long-term care expands.

Mr. Chairman, as our population ages, we must continue to place a high priority on long-term care services. Giving our seniors alternatives to nursing home care and expanding the choices available, is not only cost effective, but will also improve the quality of life for older Americans.

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**STATEMENT OF DEBRA SYLVESTER,
COORDINATOR, SENIOR HEALTH SERVICES,
FALLON HEALTHCARE SYSTEM**

The Fallon Healthcare System is a vertically integrated system made up of a well-developed network of services and facilities offering different types and levels of health care. Within this network, Fallon can provide continuity of care and utilize alternatives to costly treatments.

The Fallon Healthcare System includes Fallon Community Health Plan (FCHP), a federally qualified HMO with over 178,000 members; the Saint Vincent Healthcare System with an acute hospital, a home health care provider, a nursing home system and a laboratory; and The Fallon Clinic, a large multi-specialty group model clinic. Fallon is a physician directed system in which primary care physicians coordinate care for their patients within a seamless delivery system. By bringing all of the elements of health care together, Fallon enables patients to move among the levels of care effectively and efficiently.

Fallon Community Health Plan, established in 1977, is recognized as a leader in providing high quality care at an affordable price. Approximately 1000 of the area's best doctors are affiliated with Fallon, with that number growing continually. FCHP continues to grow and expand into new areas with the most recent expansion into the Boston area adding even more physicians and hospitals from which to choose. In addition, Fallon introduced the Peace of Mind Program for HMO members enrolled through group plans. This program enables members to request specialty care at some of the most prestigious of Boston's hospitals.

Fallon continually works to ensure a network of the highest quality providers, following stringent credentialing procedures and closely monitoring the quality of care provided by all network providers. In 1994, FCHP received a full three year accreditation from the National Committee on Quality Assurance, one of only a small percentage of HMOs to do so. In addition to Fallon's achievements in the areas of quality and utilization management, Fallon is also proud of its 93% member satisfaction ratings for the commercial plan and 98.4% satisfaction ratings for our Senior Plan(s).

EXPERIENCE WITH THE MEDICARE POPULATION

Fallon has been a leader in managed care for the Medicare population since the Health Care Financing Administration (HCFA) initiated the Medicare risk contracting process. On April 1, 1980, FCHP became the first HMO nationally to enroll Medicare beneficiaries and accept reimbursement from HCFA on a prospective, per capita basis as a demonstration project. Since then, Fallon has maintained a risk contract with HCFA and has consistently offered a more comprehensive range of health care benefits than standard Medicare supplements, while maintaining competitive premiums.

Since 1980 Fallon has offered the Senior Plan, now called Senior Plan Preferred, which provides a full array of benefits including full prescription drug coverage. In 1994, Fallon introduced two new benefit plans from which Senior Plan members can choose in addition to the established plan. Senior Plan Saver's coverage is identical to Senior Plan Preferred's coverage but does not include drug coverage. Senior Plan 1000 also offers identical coverage except for a cap of $1000 on prescription drug coverage in each calendar year. Senior Plan Preferred and Senior Plan 1000 are offered to members enrolling through employer groups.

The Fallon Senior Plans are open to individuals who reside in the FCHP service area and are eligible for Medicare Parts A and B or Part B only. Individuals are entitled to join when they first become eligible or during a yearly open enrollment. There is no screening of applicants.

After fourteen years in Medicare risk contracting, the Fallon Senior Plans have grown to over 28,000 members. Fallon's experience as a leader and agent for innovation in senior health care makes it an ideal site for the SHMO II expansion. In particular, Fallon has made strides in member screening, use of Geriatric Nurse Practitioners and Social Workers, geriatric assessment, coordination of the care of nursing home patients, health maintenance programs for the well elderly, and participation in the Medicaid Managed Care Program. Since 1986,

Fallon has also been coordinating members' medical care with available community support services.

In 1994, Fallon became the only HMO to sponsor a PACE (Program of All Inclusive Care for the Elderly) replication. The Elder Service Plan is part of a statewide replication as one of six sites in Massachusetts serving the most frail and at risk seniors. Elder Service Plan at Fallon provides all-inclusive care for those age 55 and older who are eligible for nursing home care but prefer to remain in their own homes. All medical and long term care services needed are provided or arranged for by the ESP team of professionals. Services include but are not limited to primary care, in-home care, adult day health care, physical therapy, transportation podiatry, dentistry, and prescription drugs.

As the population ages, the need to supplement the basic Medicare benefit with additional supportive services and long-term care becomes increasingly urgent. Fallon believes that the SHMO model can address the needs of those seniors who are at risk but not yet nursing home eligible.

BACKGROUND OF SOCIAL HMO

The Social HMO demonstration was authorized under the Deficit Reduction Act of 1984. The purpose of the demonstration was to determine if investing in some long term care benefits for Medicare HMO enrollees could save money through coordination of care and the provision of services that might present more costly medical complications. Services provided include personal care aides, homemakers, medical transportation, adult day health care, respite care and case management in a community setting. In 1985 the first generation of Social HMO projects became operational at the following four sites: SCAN Health Plan in Long Beach, California; Group Health and Ebenezer Society established Seniors Plus in Minneapolis-St. Paul; Kaiser Permanente Northwest established Medicare Plus II in Portland, Oregon. In 1990, Congress authorized an extension of the demonstrations and established the second generation of social HMO projects, known as Social HMO II. These sites are Fallon Community Health Plan; CAC-United Healthcare Plans of Florida in Coral Gables, Florida; Contra Costa Health Plan, in Martinez California; Health Plans of Nevada, Inc. in Las Vegas, Nevada; Richland Memorial hospital in Columbia, South Carolina and Rocky Mountain HMO in Grand Junction, Colorado.

BENEFITS UNDER SOCIAL HMO's

The Social HMO program provides standard HMO benefits such as hospital, physician services, skilled nursing home, and home health services as well as extended long term care benefits not currently available or provided through traditional fee for service Medicare or Medicare risk contracts. Extended long term care benefits under Social HMO range from community-based care to nursing home care. Services include personal care aides, homemakers, medical transportation, adult day health services, respite care and case management in a community setting. The Social HMO II sites will continue to provide many of the expanded benefits offered in Social HMO I sites. It is expected that the Social HMO II sites will address the following areas. Expand chronic care case management with linkages to acute and long-term care; geriatric focused care delivery; redefine the long term care benefit package; refine the financing methodology to a risk-adjusted payment methodology; target special populations such as minorities and residents living in rural areas.

GERIATRIC FOCUSED CARE

The elderly population often have multiple interactive chronic conditions, which need to be addressed through specific approaches to geriatric care. Medicare risk contracting allows for more flexibility in care provision than is possible within the traditional Medicare program. However, risk contracting does have its limitations The reimbursement in risk contracting is based on costs incurred for acute care only. While innovation is possible, it simply cannot meet the long-term, multi-dimensional needs of the elderly. The dual themes of the SHMO II project - expanded benefits and more comprehensive geriatric care will enable a new level of effectiveness in caring for the elderly.

Because of the unique needs of this population, health care for the elderly requires integration of ambulatory, acute chronic, home care, prescription, and support services. Appropriate geriatric care also involves the following:

Care Management. Care management functions are critical in managing the complex health care needs of the elderly population. Under the SHMO program a case manager will screen assess, intervene and monitor the medical, psychological and social risk factors of members that are potentially at risk. The desired outcomes of case management would be decrease in hospital, and nursing home admissions, improved quality of life and disease specific outcomes.

Screening mechanisms that result in early detection. A high incidence of functional loss has been found among the aged and those with chronic disease (Jette and Branch, 1981). Research shows that functional decline in the elderly is reversible (Branch, 1984), and that improvement is more likely when loss is recent and not severe (Crimmins and Saito, 1993). Although functional dependency has been shown to predict increased care needs (Williams, et at, 1987), impairments often go undetected and untreated (Besdine, 1988, Lachs, 1990, Applegate, 1990). Routine screening can ensure that these and other geriatric care issues are addressed appropriately.

Intervention. Identification of functional loss and other geriatric problems is futile unless intervention is planned. For an elderly patient, the most appropriate intervention may, at times, be supportive services, or coordination of care by two or more providers. For those most at risk, ongoing involvement of the care provider is essential. Limitations in current coverage prevent routine availability of such services and coordination activities.

Integration. Service delivery to the elderly remains fragmented. Typically, each care delivery site is focused on volume and resource use under its own roof. An integrated system with total risk for the care of elderly enrollees will only succeed if it coordinates care across all delivery sites while taking the patients' future care requirements into account (Wolford, et al, 1993), which the SHMO will do.

Health Maintenance. Only by extending improved geriatric care approaches to all enrollees, including those without perceptible frailties, can this approach yield the greatest long-range results. Evidence suggest that the primary prevention can significantly reduce functional decline (Mor, 1989). Early identification and appropriate geriatric care will play a role in improving health status for the population enrolled, slowing decline, reducing the need to enter a hospital or use an emergency room, and improving outcomes.

The SHMO will provide for initial and routine patient screening and care coordination. Monitoring of the at-risk patient will be increased. Expanded benefits will allow for all-important follow-through when additional services are needed.

The structure and financing of the SHMO is the only model on the horizon today that make these care delivery goals attainable.

FINANCING

Under the TEFRA Risk agreement with HCFA Fallon accepts full responsibility for health care costs under both Medicare Part A (hospital) and Part B (physician). HCFA pays Fallon a capitated amount equal to 95% of the average area costs per Medicare beneficiary. Under the Social HMO model services are also financed on a prepaid capitated basis. However, the plans receive 100% of the average area cost per Medicare beneficiary. The additional 5% of the AAPCC is used for financing the additional expanded benefit package. Under the capitated payment system, managed care organizations have the flexibility under the Social HMO program to tailor benefits to the unique needs of each beneficiary.

CONSUMER BENEFITS OF SOCIAL-HMO's

Social HMO's, which operate under TEFRA risk contracts, such as in the case at Fallon can offer Medicare beneficiaries an enhanced package of Medicare services. In addition to all Medicare part A and B services, coverage includes pharmacy benefits, hearing aids, eyeglasses, and up to $1,000 per month in home and community long term care services. These benefits help members to avoid institutionalization and maximize independent functioning. Under the Social HMO model of care, early identification and interventions can prevent serious illness or disabilities.

Under Social HMO's consumers have comprehensive coordination of all health as well as related services. Consumer choice will be enhanced and consumers will be able to choose a richer package of long term care benefits currently not available under Medicare risk contracts.

RECOMMENDATIONS

The Social-HMO demonstration programs are effective mechanisms for integrating acute and long-term services, offering richer benefit packages not available under Medicare risk programs. Consumer choice is enhanced. There is potential with the second generation sites and continuation of the first generation demonstration to continue to explore cost savings measures in order to reduce health care expenditures as well as improved health outcomes. Authorization for both the first and second generation Social HMO's will expire on December 31, 1997. The Fallon Healthcare System, as well as the other Social HMO's sites, will not become operational until July 1996 or, in many cases, late 1996. Therefore, the Social HMO's II sites would not be operational for more than a year and then would have to begin a process of phasing down the program. An extension of the Social HMO demonstration will provide the necessary time to further determine the potential for providing higher quality integrated care and extended benefits, in the most cost effective manner.

We respectfully request that:

- Congress direct the Secretary of Health and Human Services to develop regulations which grant permanent waiver authority for existing sites and which provide a mechanism for other entities to apply for Federal qualifications as a social HMO;

- Congress provide legislative authority to continue the Social HMO I and II programs until the Secretary of Health and Human services promulgated such regulations;

We also recommend the following modifications to the current waiver authority

The Social HMO waivers currently provide for the following:

- Payment at 100% of the AAPCC;

- the option to queue applicants according to disability;



Oxford Health Plans

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Timothy B. Meyer
Director, Government Relations

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April 30, 1996

Ms. Elise Gemeinhardt
Professional Staff
Subcommittee on Health
Committee on Ways and Means
1136 Longworth House Office Building
Washington, DC 20515

Dear Elise:

Enclosed is Oxford's written testimony for the record regarding the Long Term Care of April 18th, 1996. As you will note Oxford is supportive of the PACE program but we do believe we have additional experiences which we should have the opportunity of bringing to the program. Therefore, we oppose any restriction to participation whether it be prohibiting for profit companies or limiting participation to community based provider organizations.

I look forward to working with you on these issues. Please don't hesitate to contact me if we can be of any assistance.

Sincerely,

Timothy B. Meyer

cc: Kate Sullivan
Enclosure

Overview

Oxford's Medicare Advantage program began in 1992, and currently has over 80,000 members in New York, New Jersey and Connecticut. Oxford's Medicare program is one of the fastest growing in the country, with more than 5,000 new beneficiaries enrolling each month. Oxford has been enrolling Medicaid Members since 1992, and we currently have over 130,000 Members in New York, New Jersey, Connecticut and Pennsylvania.

Support for Capitated Long Term Care

Oxford is very encouraged that the Ways and Means Committee is addressing the continuing need for managed long term care, and is very supportive of S.990. In our experience, the fragmentation of funding for long term care and acute care services inhibits our ability to effectively manage the care of the frail elderly. Needless to say, care follows funding, so that fragmented funding results in fragmented care. The classic example of this is the incentive for emergency room admissions from nursing homes. Clearly, if one party were responsible for both the long term as well as the acute services, emergency room admissions would be less frequent and more appropriate, making everybody, most importantly, the member happier. We see great potential in being able to truly manage the entire continuum of care for a frail elderly Member.

We have been truly impressed with the achievements of the PACE sites around the country. We have followed their progress, and their success has solidified our belief in the value of comprehensive care.

Participation of For-Profit Medicare HMOs

While Oxford is very supportive of S.990, we are concerned about the language in Section 2 of the bill that states that waivers will be granted "to public or non-profit community-based organizations." Our understanding is that this language would preclude for-profit corporations such as Oxford from receiving waivers to provide comprehensive care through the PACE model.

We would assert that the tax-status of a company does not indicate the standard of care it provides. Like non-profits, for-profits have an incentive to provide quality care to maintain their Membership bases. Interestingly, a recent study found that for-profit HMOs generally spend more of each premium dollar on actual health care services than do non-profits. Oxford's efforts at providing excellent care have resulted in high ratings in customer service satisfaction surveys, and having recently been cited as having the country's lowest number of Member complaints upheld by HCFA per thousand members.

Track records for quality and member satisfaction can be used as a measurement of the standard that management uses to run its company. These representations of quality of care will much more accurate than whether an organization in for-profit or non-profit. Oxford's commitment to quality is evidenced in the extensive Quality Management programs it has in place. The goals of Oxford's Quality Management Program are to improve and/or maintain high quality patient services through ongoing monitoring and assessment of: provider compliance with the delivery of care in accordance with recommended clinical treatment guidelines; Member satisfaction with Oxford's services and health care services; provider satisfaction with Oxford's services; mechanisms to ensure that Oxford's cost containment programs do not adversely affect the quality of care provided to the Membership; educational needs for Oxford's providers and Members to facilitate their involvement in quality improvement activities.

Medicare HMOs have unique core competencies that will be very important to the success of broadened managed long term care efforts. Below are several other attributes that for-profit Medicare HMOs can bring to a demonstration of capitated long term care.

Education and Outreach

While we cannot speak for all for-profit Medicare risk contractors, many have demonstrated a real commitment to the care of older adults, which has even taken them beyond the realm of covered benefits.

Through our Outreach department for example, Oxford connects members with needed social services, such as transportation, meals on wheels, adult protective services, and custodial home care. In addition, Oxford implements a Health Promotion Series that provides a series of health education lectures and training programs on topics such as healthy eating, diabetes, arthritis, exercise, and prostate health. Oxford also publishes a bi-monthly health and wellness newsletter specifically for our Medicare Members. Other

initiatives include a pilot study to measure the impact of nutritional education on the health of our Members through the nationally recognized Nutrition Screening Initiative; and a comprehensive flu immunization program to educate our Members and physicians about the importance of receiving flu vaccinations.

Oxford has also received a matching grant from The Robert Wood Johnson Foundation to run a service credit banking program which also can provide community based seniors with needed services. This program encourages our active Members to volunteer their time to help frail Members perform custodial care activities, such as light housekeeping and cooking. In exchange, Members receive a guarantee which states that they will be eligible for those services if they ever need them.

Disease Specific Programs

Oxford is currently developing a number of disease specific, Member-help-Member programs. We will start with COPD "Leaders in Learning" this summer. The frail elderly could benefit immensely from "Learning to Live with Lung Disease," where they might be visited by a community senior who also has lung disease, and taught relaxation techniques customized for the frail elderly. These specific programs demonstrate our commitment to serving the elderly as well as the innovative community based approaches that we take which could be beneficial to these managed long term care programs.

Network

While HMOs are often not direct providers of medical services, they generally have broad based, well-established networks of providers that can meet all of their Members' needs. Oxford maintains a network of top-quality hospitals and physicians. Oxford requires each physician to have board certification in his or her specialty (as recognized by the American Board of Specialties) or become board certified within five years of becoming eligible. Our corporate medical director of data analysis employs an extensive software system to manage our 33,000 physicians, hospitals and ancillary providers. Through its network development and medical management, Oxford has consistently been able to reduce overall health costs in each region it covers while maintaining quality.

Marketing

One important aspect of any comprehensive care site is attracting a sufficient number of participants. The literature shows that current non-profit capitated long term care programs such as the PACE sites and Social Health Maintenance Organizations (SHMOs) have had

significant problems building census due to the difficulties involved in marketing to the frail population.

The lack of a clear marketing strategy and an inability to reach the home-bound elderly have been census-building barriers for PACE sites.[1] Oxford, in contrast, has a strong marketing and sales organization that has led to an increase in Medicare membership of over 5,000 per month. Oxford's Medicare sales approach involves a motivated and compassionate sales force that often provides one-on-one sales calls in the home. These "house calls" are particularly essential when marketing to a frail, home-bound elderly population.

Inadequate initial marketing budgets and inexperience in marketing to Medicare beneficiaries were also cited as reasons for enrollment problems. Oxford has a strong reputation in its service area and significant resources dedicated to acquisition of members. In addition, Oxford has a well developed marketing program with which to target potential members for a long term care program. Oxford has a large, experienced staff dedicated to acquisition marketing. We are skilled in developing communications appropriate for elderly consumers. This is important because we are able to demystify complicated concepts and make sure that potential members know what they are buying.

One of our most successful marketing programs is our Ambassador program for Medicare Advantage. Our Ambassadors are Members who voluntarily communicate the advantages of Oxford within their own communities. We have found that our audience is more receptive to our messages when they come from people they know and trust. When peers from their community believe in Oxford and the benefits of managed care, community Members feel more secure in having Oxford as their healthcare provider.

Tracking Systems

Another important attribute of for-profit Medicare HMOs is the ability to use sophisticated information systems to track encounters and outcomes. This ability is critical to evaluating the effectiveness of any demonstration effort.

Oxford has developed an information system specifically to meet the needs of the Medicare population and the providers who serve them. This system includes software for physician profiling and hospital profiling, allowing Oxford to evaluate practice patterns and analyze

[1] Robert Kane, MD, Laurel Hixon Illston, MPH, and Nancy A. Miller, PhD, "Qualitative Analysis of the Program of All-Inclusive Care for the Elderly," *The Gerontologist*, 1992, Volume 32, Number 6, page 778.

quality outcomes and cost effectiveness. The physician profiling software adjusts for differences in casemix, severity, and comorbidity, and recognizes that primary care providers have responsibility and accountability not just for the care they provide directly but the care provided by specialists to whom they refer cases. The resulting data helps determine expected costs and utilization, and enhances communication between Oxford and our providers. Oxford's systems are capable of providing utilization data based on particular services and the amounts of the claims for those services. This can be used to evaluate disease patterns and treatment patterns of enrollees.

Capital Investments

As a for-profit health plan, Oxford has the financial means to make significant capital investments in programs and services deemed necessary to implement an effective comprehensive long term care program.

Oxford has already illustrated its commitment to using its financial resources to provide services to its members by building two Health Centers in undeserved sections of New York City. Both centers will provide primary care and will service our Medicare and Medicaid Members. Each center will have gerontologist on site, in addition to podiatry, radiology, dentistry, and other services. The center in South Bronx is expected to open in May, and the center in East New York in Brooklyn is expected to open in July. The two centers will provide care for about 13,000 Oxford government programs Members, over 5,000 of whom are expected to be Medicare Advantage Members, who did not previously have access to quality health care.

The financial flexibility that Oxford has to make this kind of investment is something that non-profit organizations often lack. With this access to capital, Oxford could ensure that a comprehensive long term care program would be adequately funded to provide all necessary care needs.

Financial Reserves

For-profit HMOs usually have the financial wherewithal, expertise and experience to adequately reserve against the risk of essentially providing long term care insurance. In contrast, non-profit organizations often have difficulty weathering unexpected costs. According to a study of PACE programs in the *Gerontologist*, "the shaky financial base of these independent organizations makes them barely able to sustain any delays in start-up, much less to survive the costs of catastrophic cases early in their operation." (Kane, pg.

778) Oxford's reserve policy is very conservative; we currently have $301 million in reserves which translates to 72 days of operations. In addition, Oxford has reinsurance coverage to cover excessive medical expenses for our members.

Risk Management Experience

Many Medicare HMOs have already demonstrated though management of their current membership the ability to manage risk effectively. With capitated payments from HCFA for over 80,000 Medicare Members, Oxford has experience in successfully managing health care of the elderly in a capitated environment. Our satisfaction surveys show that this can be done while continuing to keep members satisfied.

Conclusion

We at Oxford truly believe in the concept of capitating acute and long-term care for the elderly and providing a comprehensive plan of care coordinated by a single entity. We also believe that as an for-profit HMO we bring attributes that can enhance a managed long term care program significantly.

It would be a disservice to the recipients of integrated long term care to preclude any interested party from participating solely based on its organizational structure. Instead, guidelines should be set for provision of care, and each organization should then be evaluated individually to determine whether it can provide acceptable care. Quality of care should not determined by the profit status of an organization, but by the outcomes it achieves in caring for its members.

WRITTEN COMMENT OF

THOMAS E. BROWN, JR.
ASSISTANT TO THE PRESIDENT
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FOR
HEARING ON LONG TERM CARE OPTIONS
APRIL 18, 1996

Introduction

My name is Tom Brown, and I am the Assistant to the President for Special Projects at Richland memorial Hospital in Columbia, South Carolina. One of the projects that I am involved with at Richland Memorial is the Social HMO II demonstration. Several years ago I was instrumental in development of the hospital's PACE site.

Richland Memorial Hospital is unique in that it is currently the only health care provider or health plan which participates in both the PACE and Social HMO II demonstrations. These two innovative programs will offer older South Carolina Medicare beneficiaries choices for receiving their health and long term care and provide opportunities for improving the method of organizing, financing and delivering their care.
Both of these demonstration programs require additional legislative authority to continue to provide these new models of health care financing and delivery which are important to the Medicare beneficiaries and federal and state policy makers.

Common Program Elements

The Social HMO II and PACE models integrate acute, medical and long term care service delivery. Richland Memorial's PACE program, Palmetto SeniorCare (PSC), is a staff model HMO and the program provides most services internally with limited external contract providers. PSC staff assure that program participants' care is delivered effectively across all settings, i.e. medical, acute and long term care. The Social HMO II demonstration program will utilize an IPA model delivery system, supplemented by protocols, guidelines and management information systems, to integrate the care and services across all settings.

An important policy issue for South Carolina policy makers is the applicability of the PACE and Social HMO II models to the Medicare/Medicaid older population. The State's Medicaid agency, working with Richland Memorial, has developed strategies for including the dually eligible population in these projects. This policy decision has enabled the programs to offer more choices to beneficiaries and to meet a broader need for care and services.

Providing managed care options in rural areas, which have low AAPCC's, has been a policy challenge for the policy makers and program administrators. Richland Memorial's programs have demonstrated a willingness and ability to accommodate the models to serve this population of rural Medicare beneficiaries.

Refinements of the Social HMO II Demonstration

The Social HMO II demonstration has three significant research and policy interventions which will enhance the Medicare HMO program. One improvement - the addition of long term care benefits to Medicare - was included in the Social HMO I demonstration and will be refined in the Social HMO II demonstration. The change in this aspect of the

demonstration will be to make the long term care benefit available to enrollees who are beginning to become frail, but who are not yet "nursing home certifiable". This change will enhance the program's ability to offer home and community-based services which can prevent or delay the decline in a enrollee's health and functional status.

The Social HMO II geriatric care system will fully integrate the plan's medical, acute and long term care benefits and services. Early detection of health and functional problems through risk screening processes, preventive care and services, physician and care management protocols and guidelines and a coordinating management information system will facilitate implementation of this new approach. The plan will utilize care managers to coordinate the care and to facilitate enrollee's transitions between care settings.

Implementation of a risk-adjusted prospectively determined Medicare HMO reimbursement system is the third important research and policy Social HMO II intervention. This new reimbursement approach will annually determine an enrollee's future likelihood of using Medicare services in the next year. The Health Care Financing Administration has projected that this new approach will improve the current AAPCC system and will provide incentives for HMO's to enroll more frail Medicare beneficiaries.

Linkage of Medicare and Medicaid

Federal and state health care policy for Medicare and Medicaid must recognize the importance of each program to older persons who depend on these programs for their health care. Categorical funding for these programs has been an impediment to care management and coordination of benefits across all settings. The PACE and Social HMO II models integrate these financing systems through a capitated payment to the plan. This linkage gives the plan added flexibility to address the enrollee's health care needs.

Recommendations

Legislative authorization for the PACE and Social HMO demonstrations is needed. The PACE model has been replicated through Medicare and Medicaid waivers and additional sites are being developed. This approach was necessary initially, but the program must now become a permanent provider type within the Medicare program.

Recommendation: PACE should be shifted from a demonstration to a permanent program.

The Social HMO II demonstration provides an opportunity to introduce new elements into the Medicare HMO program. The current legislative authority for the demonstration expires on December 31, 1997. The authorization needs to be extended to enable the demonstration to be fully implemented and evaluated.

Recommendation: The Social HMO II demonstration should be extended to December 31, 2001.

Thank you Mr. Chairman and members of the Subcommittee for this opportunity to submit written comments about these important health care initiatives for Medicare beneficiaries.



April 17, 1996

Philip D. Moseley, Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, D.C. 20515

Dear Mr. Moseley:

RE: LONG TERM CARE OPTIONS (HEARING APRIL 18, 1996)

It is our understanding that the Subcommittee on Health of the Committee on Ways and Means will conduct a hearing on Long-Term Care Options on April 18, 1996. While the focus of the hearing will be the PACE and SHMO programs, this seemed like a good opportunity to make the Committee aware of a unique Long-Term Care Pilot Project that Rocky Mountain HMO is conducting in Colorado.

Rocky Mountain HMO, the Colorado Department of Health Care Policy and Finance, and the Mesa County Department of Social Services are developing a pilot project to integrate Medicaid acute and long-term care services in a health maintenance organization. The project is funded by a Robert Wood Johnson Foundation grant and will be conducted in a county in rural western Colorado. Rocky Mountain HMO will provide Medicaid acute and long-term care services under a capitated contract with the Department of Health Care Policy and Finance. The project is currently in the development phase with an anticipated start this fall.

By way of background, Rocky Mountain HMO is a nonprofit HMO that has provided services for Medicaid, Medicare, and private members for over 22 years. While our original membership was primarily in western Colorado, more recent expansions include urban areas and a statewide delivery network. Rocky Mountain HMO was selected as a SHMO in 1995.

Enclosed are some materials describing the Rocky Mountan HMO Medicaid Integrated Care Program. We believe this is a truely innovative project with significant potential benefit. We would certainly be willing to discuss this project in more detail with you or other appropriate staff or Committee members. Please don't hesitate to contact me at 1-800-843-0719 or (970) 244-7966.

Sincerely,

Michael J. Weber
Executive Director

MJW:kjm
Enclosures
c: Rep. Scott McInnis

2775 Crossroads Blvd., P.O. Box 10600, Grand Junction, Colorado 81502-5500 • (970) 244-7760 • Toll Free: 1-800-843-0719 • Fax: (970) 244-7880

MEDICAID INTEGRATED CARE PROGRAM

CONCEPTUAL DESIGN

The Medicaid Integrated Care Program was designed by Rocky Mountain Health Maintenance Organization, the Colorado Department of Health Care Policy, and the Mesa County Department of Social Services to provide integrated acute and long-term care to 8,000 Medicaid and Medicare/Medicaid clients in Mesa County, Colorado. The program is founded on an alliance of clients, families, doctors, other medical professionals, regulators, institutions, collateral caregivers and payors--all working together to create and maintain an integrated care delivery system which produces better client outcomes and lower costs.

Improved outcomes and reduced costs are achieved through careful planning, delivery and monitoring of all types and levels of care--preventive, primary, acute, home-based and institutional. The intent of the program is to assure that each client receives the right care at the right time in the right place.

OBJECTIVES OF THE MICP

- Easier client access to integrated services.
- Enhanced care coordination to eliminate gaps and duplications.
- Aligned incentives for all caregivers to encourage delivery of the most appropriate care in the proper setting.
- Innovative alternatives to traditional ways of providing care.
- Care giver collaboration to achieve better client outcomes.
- Increased home care leading to reduced nursing home residency.
- Emphasis on preventive care to reduce acute care episodes.

The program is highly client focused. Client needs are identified and assessed early. Care decisions are based on each client's particular needs. Cooperation and collaboration among caregivers result in improved client outcomes.

The program operates with common assumptions which are tested frequently to assure that all participants are reaching similar conclusions. The program employs system-wide incentives, with all caregivers sharing proportionately in financial outcomes. This allows care decisions to be based solely on client needs and the outcomes desired, never on individual provider profitability.

The program gathers and shares client information through electronic and supportive networking. Decisions are based on the collective intelligence concerning each client's condition and needs rather than on isolated observations or individual opinions which can vary from one provider to another.

Emerging knowledge about new care techniques, especially for the frail elderly, is compiled by medical specialists and disseminated throughout the system. Care for the elderly is clearly founded on proven geriatric principles.

CHALLENGES AND OPPORTUNITIES

Several challenges must be addressed in order to gain maximum benefit from the program:

- Regulations which impede innovation and result in reduced care and higher costs must be revised.
- Providers who resist risk-sharing must be persuaded to shift old paradigms.
- The system must provide meaningful outcome and financial data which prove the efficacy of the program.
- Physicians must become comfortable with a team approach to client care, with emphasis on the integration of acute, chronic and preventive care rather than solely on acute care.
- Communications systems must be established which provide physicians and other caregivers with up-to-the-minute information on individual client status.

DESIGNED CHANGES WITHIN THE MICP

From RULES to GUIDELINES

Rules create boundaries which inhibit innovation. Rules can be used to defend unacceptable performance. Guidelines, however, provide general expectations which allow caregivers to innovate in order to achieve desired outcomes. Guidelines, unlike rules, cannot be used as excuses for failure.

From COMPETITION to COLLABORATION

Competition, although the foundation of the business system, leads to winners and losers. In health care, the losers are often the clients. Integrated care emphasizes collaboration, not competition. Collaboration occurs when different parties no longer protect their own turf, but come together to create something different from and better than what existed before.

From PAPERWORK to PEOPLEWORK

Governments have inundated the system with paperwork. Nurses spend more time on paperwork then on providing patient care. There is no clear evidence that any of this paperwork has improved client well-being or outcomes. Unnecessary and wasteful paperwork must be abolished.

From ASSUMPTIONS to FACTS

Client care is often based on assumptions rather than facts. Caregivers must challenge assumptions, and discard those which are not supported by evidence. Care planning must be based on factual expectations as evidenced by research and valid information, not on antiquated beliefs or customs.

From CONTROL to TRUST

The inherent desire for governments to control has created a fragmented system which impedes progress, encourages fraud and abuse, and has done little to protect the client. The MICP emphasizes trust rather than control to accomplish its objectives. Participating providers are trusted to provide high quality care at reasonable prices, and not to game the system. Any provider who proves unworthy of this trust will be barred from participation in the program.

From UNAWARENESS to KNOWLEDGE

The most intelligent person is the one who understands that there is always more to learn. A continual search for new knowledge is a fundamental element of a good system. Members of a good system are never satisfied with what they now know, but are forever seeking to learn more. The MICP seeks to be a learning system. Participants within the system are continually updating their knowledge based on new and innovative approaches to providing care to the clients.

From the STATUS QUO to INNOVATION

Providers and caregivers in a dynamic healthcare system are never satisfied with the current state of affairs. Instead, they are continually searching for better ways to do what they do, and for better outcomes for their clients.

From PROFIT FIRST to PEOPLE FIRST

A business enterprise cannot survive without profitability. However, long-term profitability and long-term survival depend on meeting customers' needs. If a customer's needs are properly addressed, profit will follow. Providers who seek to reduce or withhold care in the interest of increased profits will not be tolerated.

From WE CAN'T to WE MUST

The current system has caused people to become defeatists. People are told that something can't be done, and they believe what they are told. This negativism must be abolished. Caregivers must instead be encouraged to work together to create new and better ways to serve their clients.

Earl Elicker, MSA
Integrated Care Program Design
Rocky Mountain HMO

MEDICAID INTEGRATED CARE PROGRAM

The Medicaid Integrated Care Program (MICP) will optimize the health, independence, and well being of those clients who have persistent and ongoing medical or functional problems. The program will primarily serve the frail elderly and the chronically disabled but can also assist any client who needs non-acute as well as acute care. The MICP addresses a wide variety of client needs (medical, functional, emotional, social, and cognitive) and develops care plans directed at fulfilling these needs. A primary objective of the program is to provide the right care at the right time in the right place. By assuring that proper care is provided as soon as it is needed, the MICP seeks to prevent unnecessary hospitalizations and emergency room visits, and to delay or eliminate the need for nursing home admission.

Within the MICP, the management of care is linked across time, place and profession. Efforts are made to detect and correct problems early--before they become difficult to remedy. The activities of all care givers - physicians, nurses, institutions, family, and others - are coordinated to assure that the care provided is necessary, adequate, timely, and consistent with other services the client may be receiving. In all cases, the program endeavors to help clients retain independence and functional capability, and to avoid unnecessary and unwanted institutionalization.

Historically, health care has focused primarily on acute care - seeking to cure disease or repair injuries. While an acute care emphasis continues to be vital, it does not adequately address the needs of people requiring longer term care. If a person's long-term care needs (proper nutrition, healthy living conditions, adequate exercise, health education, personal care, etc.) are not adequately addressed, the person may become ill or incapacitated, sometimes critically. When this happens, the person typically must seek an acute care solution.

The MICP integrates acute and non-acute services in order to serve a variety of patient needs. The program offers easy access to integrated care, formalized care coordination, patient-specific care plans, regular monitoring of progress, early detection procedures, and a team approach to managed care.

Easy Access

The program is accessed by a simple inquiry to the care coordination unit by the client, the family, a doctor, or any other concerned party. Clients are screened to determine needs, and those determined to be at-risk are assigned a care coordinator who assesses the client for deficits, prepares a plan of care, and initiates services. The care coordinator addresses all the needs of the client and plans all care. The client works directly with this one individual, not with a myriad of agencies.

Care Coordination

A designated care coordinator will be responsible for coordinating and monitoring all care--skilled and unskilled--provided to a client. The care coordinator works with the patient, the primary care physician, specialists, nurses, the family, and other care givers to assure that the client's needs--whether acute, sub-acute, or long-term--are being properly addressed.

The care coordinator begins the care process by investigating the client's circumstances, i.e., medications, physician directives, home environment, family support, transportation needs, and any other aspect of the patient's situation which are pertinent to developing a care plan for the client.

Care Plan

Based on each client's assessment, the care coordinator develops a care plan which details all of the services needed by the client to improve or stabilize function and health and, whenever possible, to sustain independence.

The care coordinator reviews the care plan with a Care Team (geriatrician, advanced practice nurse, pharmacist, etc.) and with the client's primary care physician to gain concurrence with the level and frequency of services planned. The Care Team assists the care coordinator in developing a schedule of expected outcomes against which actual outcomes are compared. The schedule of expected outcomes allows the care coordinator to monitor the progress of the client and to modify the care plan when actual outcomes do not meet expectations.

Once the care plan and the schedule of outcomes is finalized, it is presented to the client and the family for acceptance and implementation.

Monitoring of Progress

Following implementation of the care plan, the care coordinator regularly monitors the client's condition and adjusts the services being provided if outcomes do not meet expectations. The care coordinator receives feedback from all care givers regarding services provided, and keeps the primary care physician and other care givers fully informed of the client's progress. In this manner, the care coordinator, the client, the doctor, the family, and others providing care become a knowledgeable team working together to provide the best care to the client.

Early Detection Procedures

Integrated care is not only directed at coordinating all services needed by the client, it also seeks to identify and correct emerging conditions which, if not addressed, may become serious. A person who is not eating properly or who forgets or neglects to

take prescribed medications may end up in the hospital. A person who is not being helped with bathing or toileting may eventually require institutionalization. A person who becomes weakened by inactivity may become prone to falls and fractures. Integrated care seeks to prevent these critical episodes through early detection and correction of the underlying problems.

The care coordinator solicits pertinent information from all care givers, as well as directly from the client. Any change in the client's condition or circumstances which could eventually result in a critical episode is addressed immediately. For example, modifications may be made to the client's home to improve safety. Meal planning and preparation may be adjusted to improve nourishment. Exercise programs may be started to help the client increase strength and decrease the risk of falling.

A Team Approach

The MICP builds a team of care givers--doctor, nurse, social worker, care coordinator, other professionals, family members, and, of course, the client--all working together to help the client maintain independence, stay functional, avoid hospitalization, and prevent or delay the need for unwanted institutional commitment.

Through coordination of services, early attention to problems, monitoring of progress, and sharing of information the team can achieve the results which are most desired by the client.

Features of the Medicaid Integrated Care Program

- Client's have easy access to an integrated continuum of care, including prevention, acute care, specialized short-term care, transitional care, and long-term care services.

- Care planning is client specific and includes self-help assistance to enable clients to optimize functional independence and well being.

- Care is centrally managed and is fully coordinated with primary care physicians and others to achieve and maintain continuity of care. Care givers work together to avoid duplication of care and to fill gaps in required services.

- Emphasis is placed on:

  - Finding new methods to prevent hospital and nursing home admission.

  - Strengthening the role of primary care physicians in managing the full array of medical and social services.

- Increasing the use of home-based and assisted living services in lieu of institutionalization.

- Expanding the use of wellness education and similar activities to prevent or delay the onset of illness or disability.

- Developing an information network to improve decision making by providing all care givers with up-to-date information regarding all services being provided to each individual patient.

Earl Elicker
Integrated Care Program Design
April 1996

○

RECOMMENDATIONS REGARDING FUTURE DIRECTIONS IN THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

APRIL 30, 1996

Serial 104–47

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RECOMMENDATIONS REGARDING FUTURE DIRECTIONS IN THE MEDICARE PROGRAM

TUESDAY, APRIL 30, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:09 p.m., in room 1310, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 23, 1996
No. HL-18

CONTACT: (202) 225-3943

Thomas Announces Hearing On Recommendations Regarding Future Directions in the Medicare Program

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on recommendations regarding future directions in the Medicare program. **The hearing will take place on Tuesday, April 30, 1996, in room 1310 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include representatives of the Prospective Payment Assessment Commission (PROPAC), the Physician Payment Review Commission (PPRC), and the U.S. General Accounting Office (GAO). However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Two major factors have brought the issue of future directions for the Medicare program to the forefront for Congress. Foremost is the concern that rates of growth in Medicare spending continue to outstrip inflation in the general economy, and even more importantly, the recent indications that Medicare's Part A Trust Fund is deteriorating more rapidly than was anticipated in the April 1995 Report of the Board of Trustees. Secondly, the broader evolution of the American health care system toward integrated health care delivery systems has an important impact on the future of the Medicare program.

Each of the three organizations identified above have statutory responsibilities in providing non-partisan advice and assistance to the Congress. PROPAC and PPRC are required to report annually to the Congress their recommendations, within their respective spheres of responsibility, concerning the Medicare program. Both PROPAC and PPRC released public reports in March 1996 detailing a variety of recommendations concerning nearly every aspect of the Medicare program. Separately, GAO has completed and also has underway a range of studies relating to policies and operations of the Medicare program. The current work, recent reports, and recommendations of these organizations will provide the basis for their testimony at the hearing.

In announcing the hearing, Chairman Thomas stated: "Securing the future of the Medicare program is an essential objective of this Congress. The advice and recommendations of these witnesses provide an important opportunity to enter into a sensible and constructive dialogue in the Subcommittee on future directions of the Medicare program."

FOCUS OF THE HEARING:

The hearing will focus on the recommendations of the witnesses concerning future directions of the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, May 14, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. The Subcommittee will come to order.

Today is the Health Subcommittee's meeting to discuss Medicare policy and means we have to save the program. We will hear about the latest projections which confirm the worst fears about the Medicare Part A Trust Fund.

According to the Congressional Budget Office, Medicare is in worse shape than we thought based upon what we were told last year, and its balance is declining more rapidly every day.

The witnesses today will give the Subcommittee advice and guidance on how we can not only save Medicare, but also preserve the program for future generations.

The CBO testimony will confirm that Medicare will be bankrupt by fiscal year 2001, much earlier than projected by CBO and Medicare's board of trustees just last year. As you know, the trustees had projected a Medicare surplus in fiscal year 2002 of about $4.8 billion. The CBO report indicates that in that same year, 2002, the Medicare Trust Fund will be $86 billion in deficit. That is a $91 billion swing.

Everyone, especially, I think, the President, must heed this urgent new warning about Medicare's deepening crisis. As a result of this new report, the President's existing Medicare proposal, the old $124 billion offer, is out of date, as it is based on old, overly optimistic projections, and it simply will not achieve the kind of results necessary based upon CBO numbers.

The President is about to release to the Congress the 1996 report to the Medicare board of trustees. I believe and hope that the time has come for the President to show true bipartisan leadership when he releases the trustees' report. He should update his Medicare proposal, in my opinion, to reflect the latest information, and he should submit to the Congress a new plan that would save Medicare on the same day he releases the 1996 trustees' report.

We will also do our part. At this hearing today, we will hear from the Prospective Payment Assessment Commission and its new chair. We will hear from the Physician Payment Review Commission and the General Accounting Office. Each will provide the Subcommittee their views on recent proposals to save Medicare and will highlight new areas we should focus on to both reduce the cost of Medicare and reform the program to serve its beneficiaries better.

It should be noted that the ProPAC testimony also provides new projections on hospital Medicare margins for 1996. Despite concerns raised during the development of the Medicare Preservation Act of 1995 by the hospital industry and other detractors, the report shows that hospitals on the whole are, in fact, doing extraordinarily well in terms of their Medicare business.

Further, it is of particular interest that ProPAC and the GAO, as they did in testimony last year, again, identified home health and skilled nursing facilities services as two areas where spending is continuing to skyrocket. Clearly, these services are important to Medicare beneficiaries, but testimony today also points out specific concerns in these areas which I believe we must address.

The testimony on these services is supportive of the efforts in the Medicare Preservation Act of 1995 to rein in the cost of these services through reform and a prospective payment system. Any true

reform of Medicare will include expanding beneficiary choices of coverage under Medicare.

Interestingly, the New York Times reported yesterday that the American Association of Retired Persons is moving into something similar to the Good Housekeeping Seal of Approval. The AARP will be expanding managed care programs, and the rationale offered was that their members want more choices.

The testimony from both Commissions gives us useful guidance on how to expand these choices.

In that regard, it is important to state that concern over increased Medicare spending, although critical, is far from being all that is at stake. There are major changes occurring in the American health care system, particularly relating to the evolution toward integrated care delivery and financing systems. It is our responsibility, I believe, to extract the most promising developments from this evolutionary process and consider how they can be adapted to strengthen the mission and the purposes of the Medicare Program, with the ultimate goal of creating a better Medicare for beneficiaries.

The time has come, I think, to work together to save Medicare. I hope that the President does not agree that this is an election year and, therefore, you can't deal with Medicare, as his chief spokesman, Mike McCurry, indicated, as reported in the news media. I would hope the President would choose to lead this Nation by submitting a new plan without tax increases that addresses the financial concerns evidenced by the CBO report and that can achieve a strong bipartisan agreement in both the House and the Senate.

Before welcoming our first witness, a gentleman from Connecticut, Congressman Shays, I would recognize the Ranking Member on the Committee, the gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Before I comment, I wonder what happened to my portrait. The room looks better, I must say.

Thank you for holding this hearing. Let me point out that what the CBO testimony makes clear but was not clear in your remarks—CBO's estimate of total Medicare spending shows that their estimate has declined and that we are actually spending $35 billion less than they previously estimated over the next 10 years.

It is true that the part A trust fund is heading down, but the part B portion is doing far better than expected, and the total spending picture, if one wants to give the true picture to the American public, is getting better, not worse.

As I read the ProPAC and PPRC reports, it is a good thing the President did veto the Medicare budget bill. The two reports contain certification that many of the Republican proposals would have destroyed Medicare and not saved it. The plan that was put forth by the Republicans wasn't cost containment. It was cost shifting to the beneficiaries.

The reports we will hear lay out the terrible flaws in those budget proposals—medical savings accounts, excessive cuts in safety net hospitals, balanced billing on seniors, and a budget fail-safe provision that would have destroyed the choice of doctor and hospital.

As the GAO makes clear, Medicare does need to do better, but we don't need to destroy the fee-for-service system or turn Medicare from a benefit program into a voucher program where it is every senior struggling by himself to find quality care. The trust fund is in trouble, and it is obvious the first thing we should do is not take more money out of the trust funds.

In your House-passed version of Kennedy-Kassebaum, you take out $2.6 billion from the trust fund in Medicare antifraud money over the next 6 years and spend it on medical savings accounts and other tax breaks.

The Senate version of Kassebaum-Kennedy takes a total of $20 billion in Medicare savings over the next 10 years and spends it on non-Medicare items.

The week before last, Speaker Gingrich proposed to take another $36 billion out of the trust fund over 5 years to lower taxes for wealthy seniors. You can't save Medicare by spending the trust fund money on new tax breaks.

This Committee has yet to meet in the last 2 years to discuss how we are going to save Medicare. It is like sending the board of directors for a large insurance company, which Medicare is, on a sabbatical. If, indeed, we would pledge to take Medicare savings and commit them to the trust fund, I think this Committee could very quickly extend the life of that trust fund for another 4 or 5 years until we had the time to talk about the systemic changes that must come, perhaps, in the year 2010 or 2015.

I would repeat the offer, and I can speak for the caucus, to make $124 billion in Medicare savings and add 10 years to the life of the Medicare Part A Trust Fund without making the radical structural changes, which are criticized in the two Commission reports we will hear.

So, if you are serious, we can get to work. If you want to pay for tax cuts for the rich, Medicare will continue to stay in trouble.

Chairman THOMAS. With the usual bipartisan atmosphere, the Subcommittee begins.

It is a pleasure to have the gentleman from Connecticut, Chris Shays, with us. He has been involved not just from his Subcommittee on Human Resources, but from the Budget Committee position, working on how we meet the needs of all Americans, and especially seniors.

It is a pleasure to have you with us, Chris. If you have a written statement, it will be made a part of the record without objection, and you may proceed to inform us as you see fit.

STATEMENT OF HON. CHRISTOPHER SHAYS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. SHAYS. Thank you, Mr. Chairman. I want to thank you for the opportunity to testify before this Committee and to say as the Chairman on the Task Force on Medicare and Medicaid, which looks at the macronumbers, not the micronumbers, and also as the Chairman of the Human Resources and Intergovernmental Relations Subcommittee of the Government Reform Committee, which oversees HHS for waste, fraud, and abuse, I come to you with some very strong concerns.

First, I want to say that I hope that this Committee perseveres on its efforts to save Medicare from bankruptcy and give seniors choice at the same time. You were able to come up with a plan that didn't increase copayments, didn't increase the deductible and left the premium at the same, and gave American citizens the same choice you and I have as Members of Congress. I am wondering why it is all right for Members of Congress and other Federal employees to have choice in their health care program, but we don't think seniors deserve the same kind of choice we have. I hope you persevere in providing for that choice.

I am here to speak on seven hearings that my Subcommittee on Human Resources and Intergovernmental Relations had on four specific areas dealing with Medicare and Medicaid. The four areas were on: First, criminal enforcement; second, adjustment of reimbursement rates; third, automated claims review; and fourth, centralized claims processing.

I first want to state for the record, we look at Medicare and Medicaid from the standpoint of waste, fraud, and abuse. We do not have any legislative responsibility. That is your Committee's responsibility, and I come with all the realization that we can expose, but only you can come up with the solution, and I also acknowledge that your Committee has worked many years on these issues.

I want to first compliment this Committee on dealing with criminal enforcement and inserting it in the health care reform bill that passed this House. So one of the four areas that we were focused in on, this Committee has already addressed. So I want to take the next three.

Let me say to you, and this is with no disrespect to HCFA, I am not a Member of Congress who looks to lob stones into their house. I realize under Republicans and Democrats, this has been an agency that has had many challenges and troubles, but when we had one of our first hearings on June 15 last year, we asked the HCFA Administrator, Dr. Bruce Vladeck, why it appeared so difficult to exclude dishonest providers from Medicare and why it appears so easy for excluded providers to get right back into the Medicare payment line. He responded, and this part is the quote, "as an observer in the process," and that word just blew our minds. And then not a quote, but basically, he said there was little he could do to prevent the Inspector General, the Department of Justice, from agreeing to settlements that fail to impose the exclusive remedy.

I assure you, our dismay over that response was both strong and bipartisan. He is not an observer, but I sometimes feel that HCFA thinks they are.

Dealing first with the adjustment of reimbursement rates, HCFA is reluctant to use existing statutory authority to adjust prices in a timely fashion under "the inherent reasonableness authority." I think this Committee feels that he has the authority, therefore, he should act, but this is the kind of thing that we found, and it just blows our mind.

HCFA pays $144 to $211 for home blood glucose monitors, while the monitors can be purchased for $50 at a drug or grocery store. We are paying three to four times the rate that someone could pay retail in a grocery store, and the estimate that this costs us in

Medicare, admittedly in the terms of the total dollars, over a 3-year period is $10 million, but it is $10 million just down the tubes.

HCFA on the average pays 174 percent more than the Department of Veterans Affairs for oxygen concentrators. The HHS IG estimates that if Medicare were able to pay the same price as the VA, the savings would be $4.2 billion over 5 years.

I will point out to you that the response is that when HHS does it that they are including greater services than Veterans Affairs, but the difference is too stunning, an ultimate savings of $4.2 billion over 5 years. And then just the perennial kind of problem of why a hospital bed which costs $1,000 sometimes ultimately costs Medicare $7,000 just in terms of the rental process.

We believe that HHS should be allowed to have an interim price, not go through this year of bringing forth the change in regulations, allow for there to be comment from the medical community and the providers, then to respond, and then 2 to 3 years later, we have a change in price. I mean, my God, if we are the ones paying the price, why don't we pay, and if nobody is willing to deliver at that price, then we don't get it and then we have to increase the price, but if we can buy it for less, why are we spending so much more in the case of the oxygenators, up to $4.2 billion over a 5-year period?

On the automated claims review system, this autoadjudicated prepayment screen blows my mind. We had a GAO study that points out that the contractors, the 40 contractors for Medicare part B, don't have an autoadjudicated payment screen system. So that, when they get bills submitted, a bill on a broken ankle and a chest x ray, an autoadjudicated system would throw that bill right out, and it would totally reject it.

The thing that blew our minds was that the contractors when they do it for their own health care programs use the autoadjudicated system, but when they do it for Medicare, when they don't have something at stake themselves because they just process the bills, they don't have any financial stake, they just pay the bills.

I see my time is really ending.

I just want to put out a big attention to you all, a big exclamation point that you take a careful look at the Medicare transaction system. We are spending tens of millions of dollars to unify the nine different separate regional computer systems that we have around the country, and we are trying to unify them. I think HCFA is not on top of it. I think this program is costing us a heck of a lot of dollars, and I don't know what we are going to end up with in the end.

To conclude, on these three areas, I just would encourage the Committee to look at adjustment of reimbursement rates, a lot of waste, look at the autoadjudicated claims review, and the centralized claims processing also deserves a tremendous amount of attention.

We have had seven hearings on these issues and are happy to provide any information that might be helpful to your Committee in moving forward on these issues.

I thank you, Mr. Chairman.

[The prepared statement follows:]

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STATEMENT OF REP. CHRISTOPHER SHAYS
BEFORE THE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
HOUSE WAYS AND MEANS COMMITTEE
APRIL 30, 1996

In seven oversight hearings on the Medicare and Medicaid programs, the Subcommittee on Human Resources and Intergovernmental Relations of the House Government Reform and Oversight Committee, has focused on four specific areas of vulnerability to waste, fraud and abuse: (1) criminal enforcement, (2)adjustment of reimbursement rates, (3)automated claims review and (4)centralized claims processing.

Provisions strengthening criminal enforcement against health care fraud were included in H.R. 3103, the Health Care Availability and Affordability Act of 1996. Mr. Schiff and I were gratified that this committee addressed the critical need for clear criminal sanctions in the fight against fraud.

I appreciate the opportunity to testify today, and to make recommendations for the improvement of the Medicare program based on that oversight work. I will focus my remarks today on the last three areas of Medicare vulnerability.

In general, we found the Health Care Financing Administration (HCFA) is not always the aggressive trustee of Medicare resources that Congress intends. On June 15 last year, we asked HCFA Administrator Dr. Bruce Vladeck why it appeared so difficult to exclude dishonest providers from Medicare; and why it appears so easy for excluded providers to get right back into the Medicare payment line. He responded that "as an observer in the process" there was little he could do to prevent the Inspector General and the Department of Justice from agreeing to settlements that failed to impose the exclusion remedy. I assure you, our dismay over that response was both strong and bipartisan.

Expanded mandatory exclusion and more aggressive use of permissive exclusion authority should be elements of any Medicare protection legislation, and I am pleased to note that both House and Senate health care bills contain stronger exclusion provisions.

1. Adjustment of Reimbursement Rates

But HCFA's reluctant or lethargic use of existing statutory authority to protect the integrity of Medicare is also evident in their approach to adjusting reimbursement rates. In failing to adjust prices in a timely fashion under the "inherent reasonableness" authority at 42 USC 1395m(a)(10)(B), HCFA makes Medicare an attractive target for fraud.

The General Accounting Office (GAO) recently concluded that "HCFA is slow and often ineffectual in addressing problems involving overpricing ...." The Department of Health and Human Services' Inspector General (HHS IG) characterized the current price adjustment system "absurd."

The HHS IG has a laundry list of items for which HCFA has paid higher-than-market reimbursement rates:

- HCFA paid $144 to $211 for home blood glucose monitors while the monitors could be purchased for $50 at a drug or grocery store. GAO estimates that in just one instance the delay in adjusting the price of home glucose monitors cost the Medicare program $10 million over 3 years.

- HCFA, on the average, paid 174 percent more than the Department of Veterans Affairs (VA) for oxygen concentrators. The HHS IG estimates that if Medicare were able to pay the same price as the VA the savings could be $4.2 billion over 5 years.

- HCFA often pays many times more than the purchase price of durable medical equipment such as hospital beds and wheelchairs. For example, Medicare pays up to $7000 over the useful life of an electric hospital bed while the bed can be acquired for $1000.

- Medicare pays more than the lowest suggested retail price for more than 40 types of surgical dressings.

There is a way to cap this geyser. H.R. 3225 would require the Secretary to issue an interim final regulation adjusting the price for a Medicare item or service within one year of initiating the review of that item under HCFA's inherent reasonableness authority. The net effect would be more timely adjustment of Medicare reimbursement rates.

Some suggest that the delay in adjusting reimbursement rates can be fixed administratively by streamlining HCFA's internal review process. But statutory restrictions on the use of the adjustment authority give HCFA all the excuses needed to avoid the use this important tool. Therefore a legislative remedy is necessary to counter HCFA's reluctance to launch the current time-consuming and expensive process.

2. Automated Claims Review

Better management of Medicare contractors could also dramatically enhance our first line of defense against Medicare fraud and abuse. In February this year, our subcommittee heard testimony that HCFA is failing to require Medicare Part B contractors to use computer software capable of screening out claims for inappropriate or widely overused medical services. Called "autoadjudication prepayment screens," this software compares the physician diagnosis to the treatment or service provided.

For claims that do not meet established criteria, the software can automatically deny payment, or suspend payment and subject the claim to further review. As a result, savings are captured on seventy-five percent of the claims initially denied or suspended by this technology.

For example, if the diagnosis is chronic pulmonary heart disease the software would allow payment for an echocardiogram but not for a colonoscopy. Failure to use this software means Part B contractors may be routinely paying claims that do not meet the test of medically necessity.

At the request of the subcommittee, GAO surveyed 17 Medicare Part B contractors to determine which contractors were using the medical necessity prepayment screens. GAO testified their survey revealed only 7 of the contractors were utilizing this commercially available software. For just the six groups of commonly prescribed services reviewed, GAO estimates use of this software could save up to $200 million.

GAO concluded that "[p]roblems with controlling payments for widely overused procedures persist because HCFA lacks an effective national strategy. Although the need for national leadership is compelling, HCFA has not exercised its statutory authority to take an active role in promoting more local medical policies and prepayment screens for widely overused services." GAO concluded HCFA should focus more of its fraud prevention efforts on these autoadjudication prepayment screens.

Incredibly, HCFA seems to be moving in the opposite direction. While more and more claims are flowing through the system, fewer and fewer claims are being screened. Despite a 32.5 percent increase in claims and a $54 billion increase in outlays between fiscal years 1991 and 1995, medical review as a percentage of Medicare outlays declined from .15 percent to .08 percent.

Although H.R. 3103 and S. 1028, the Health Insurance Reform Act of 1995, both include provisions to require third-party review of Medicare claims to detect fraud, those provisions do not fill the void noted by GAO for medical standards to guide those private contractors in screening for fraudulent or inappropriate claims. Screening guidelines should be established to ensure Medicare does not continue to pay claims for medically unnecessary services.

3. Centralized Claims Processing

In a November 16 joint hearing with the Subcommittee on Government Management, Information and Technology, our subcommittees found HCFA is endangering its Medicare Transaction System (MTS) project by its lack of a disciplined management process. The lack of a disciplined management process means the MTS project may not be able to achieve its goals of improved beneficiary service, improved information services to beneficiaries, providers and the government and improved fraud prevention.

HCFA's answer to these near-term vulnerabilities is the long-term, unified claims system under development - the Medicare Transactions System (MTS). HCFA rightly points to the MTS system as a potentially powerful tool to prevent and detect Medicare fraud. Once operational, the MTS could identify suspicious billing activities by processing claims through a single, integrated automated system. In his testimony, Dr. Vladeck reported "a single unitary national provider file... in concert with the implementation of MTS [would allow HCFA to] process claims in a way that can cross-reference national claims on a real-time basis."

However, whether the MTS will deliver the benefits of advanced data processing to Medicare, or whether it will succumb to the delays and design flaws that so often doom government computer acquisitions to early obsolescence, is still unclear. Nor is it clear whether the goals, deadlines and cost estimates for the MTS are realistic. But it is clear that HCFA is missing important near-term opportunities to enhance Medicare while placing all its hopes on the MTS project.

GAO found significant weaknesses in HCFA's approach to the MTS that are adding unnecessary risk to the project. Specifically, the GAO review found HCFA is not fully defining the necessary functions of the MTS system while shrinking the development process. By proceeding with uncertain development criteria in a shortened development process, HCFA risks the effectiveness and capability of the final system. Defining functions is the foundation upon which all other decisions for the system will be based.

And, according to GAO, by shrinking the development process, HCFA risks significant cost overruns. The MTS project has already cost $19 million. In the FY 97 HHS budget, HCFA has requested an additional $50 million for MTS. Perhaps further appropriations for the MTS project should be withheld while HCFA demonstrates that it has addressed these serious management challenges. The American taxpayers should not be asked to fund a large government computer acquisition like MTS unless the administrating agency can demonstrate it is controlling the risks to the project.

Through the oversight work of the subcommittee I chair, we have learned that more aggressive management, and strengthened statutory tools to fight fraud, can save hundreds of millions of Medicare dollars. I believe a streamlined price adjustment authority, standardized use of medical necessity screening and reprogramming of MTS funds for current anti-fraud activities would enhance the integrity of the Medicare program.

Chairman THOMAS. I thank you very much, Chris.

To begin with where you ended, HCFA has spent about $20 million on the Medicare transaction system. They are requesting for fiscal year 1997 another $50 million.

Did any of your hearings come up with some suggestions for how the funds might be reprogrammed?

Mr. SHAYS. The answer to your question is yes, but I want to say that on my Committee, we did a joint hearing with the Government Management, Information and Technology Subcommittee by Mr. Horn, and he has really taken the lead on this particular issue. We will make sure that he provides you some information because his Subcommittee, more than mine, is focused on that.

Chairman THOMAS. We will contact the gentleman from California as well.

Mr. SHAYS. Yes.

[The following was subsequently received:]

Mr. HORN. Your testimony projects about $200 million annually in administrative savings as a result of MTS. However, GAO estimates that the Medicare fraud, waste, and abuse is 10 percent of the program, which was discussed with Chairman Clinger. By the time MTS is scheduled to be in place, this could be about $25 billion a year.

Are we placing too much emphasis in holding administrative costs down when we could save money by investing in waste, fraud, and abuse detection systems?

Mr. VLADECK. Mr. Chairman, you are playing a tune that is somewhat familiar to us. We have felt for a long time that the arbitrary separation of administrative costs and appropriated accounts from trust fund expenditures in the entitlement accounts probably caused us to underinvest in certain program integrity activities. And, in fact, the administration has proposed legislation and has worked with the congressional majority in both Houses on legislation that would permit us to develop new financing vehicles so that the savings in—some of the savings in trust fund outlays could be reinvested in administrative activities, both on our part and that of the law enforcement agencies.

Chairman THOMAS. There is no sense in having three separate Subcommittees not share information on such a delicate program.

Did I understand that Bruce Vladeck basically identified himself as an observer? Especially in terms of exercising the inherent reasonableness authority, I would tend to see him more as a participant than as an observer.

Mr. SHAYS. Let me say this to you. With all respect to Mr. Vladeck, he only said it once, and he was encouraged by both Republicans and Democrats not to say it or to think in those terms, but it did give you a mindset.

I think they feel like there are all of these rules that we have imposed on HCFA, and that they are just kind of a referee and that they can't be as proactive as I think you and I intend them to be.

Chairman THOMAS. I would just tell you that from my time here, as a matter of fact, in this Committee room dealing with House oversight in the old House administration, it was not a dissimilar situation in terms of government purchases and the price that government paid versus what people could go down to a store and purchase for a similar piece of equipment. It is not a surprise to me that this same thing is going on in the purchase of medical equipment.

When you begin adding up various areas, as you have done, and you can reach $2.5 billion by only two particular categories, the Chairman agrees with you that there could very well be a signifi-

cant savings out there. Even if there isn't, it ought to be done that way.

Mr. SHAYS. Mr. Chairman, let me just say, absolutely, I practically stake my life on it, but you will realize tens of billions of dollars of savings over a significant period of time, but certainly hundreds of millions, and the solution we think is quite simple. There is a very definite process.

We would simply allow HHS to do an interim price and have the interim price be the acting price until final determination, and it may go back up to the higher price.

Chairman THOMAS. You could do as an interim, as you say, a target price and then see how close you come to the bull's-eye.

Mr. SHAYS. Yes, exactly.

Chairman THOMAS. Thank you very much.

The gentleman from California.

Mr. STARK. I welcome our colleague.

Mr. SHAYS. Thank you, Mr. Stark.

Mr. STARK. He raises some good points. I must suggest that you didn't quite blend in these instances of high cost. Amgen, for instance, rips us off for Epo, and we are the only purchaser. We could, in fact, get a better deal there, or kidney dialysis medicine, and we don't.

It may come as a surprise to you, and I hate to say this to the gentleman from Connecticut, but HCFA and Medicare still have the most efficient operating ratio or the lowest overhead of any insurance plan in the country, about 3 percent. Also, as PPRC will testify, this past year, HCFA was paying on average 71 percent to doctors of that of the comparable pay by private payers, and HCFA was paying 97 percent of the cost for hospitals as compared to private payers who were paying 124 percent of the cost.

So, if you take the aggregate of the lowest overhead, returning about 97 cents of every dollar paid in to patients, and the fact that we are paying 70 percent of what private insurers are paying for doctors and a lower rate for hospital care, you have got to come out and say it isn't a bad system. It could be improved, and this Committee for 8 years under a different leadership, but with the cooperation of Mr. Gradison, lowered the amount that Medicare spent every year in a row on a bipartisan basis. We changed formats and we changed charging practices. It can be done.

For instance, would you join me on this? Would you support legislation that I like to call most favored nation, and we could legislate that Medicare would be prohibited from paying a provider more than what that provider charged its lowest charge in an area?

So that, if a hospital in Connecticut or an ophthalmologist did a service for a private insurance company, and certainly, we have a bigger volume than any of them, then we would be entitled to that lowest rate. Could you be comfortable with that?

Mr. SHAYS. Let me just say, conceptually, first, I would never endorse a bill I haven't seen, but let me just say, I understand the argument that we are the bull in the china shop. We are the major purchasers. So we can almost determine price, and there has to be a fairness.

Mr. STARK. No question.

Mr. SHAYS. Yes.

I accept that, but could I just qualify something?

Mr. STARK. Sure.

Mr. SHAYS. We have a gaming of the system. It just is not useful to say we may pay doctors less, for instance, for a visit. When they go to a nursing home and they spend 15 minutes and poke their head in seven rooms, they have gamed the system. So you could say on a per-visit, it is cheaper, but it is just not.

Let me just make this other point.

Mr. STARK. Could I just reclaim on that point?

Mr. SHAYS. Sure.

Mr. STARK. I would urge you to think about this—for as long as I can remember, we have felt that we should stay out of that. We, Medicare, is really an insurance company.

The minute you and I or Bill and I start determining how long that visit should be or whether the visit should exist, we are getting into an area with which we have no expertise or no staff.

Mr. SHAYS. I wasn't suggesting that. I want to clarify what I am saying.

I am just suggesting that the statistics can be very misleading. When we, in fact, impose certain things on providers, they find a way to game the system. When other people visit them and they charge a little bit more, their visit may be more substantive, but they have justified in their own minds, since HCFA is not paying them, since the government is not paying them enough, they justify in their own mind, just poking their head in and saying, "Louise, how are you doing today?," going over to see Tom and saying how are you doing, and in the end, they have made what they made. It looks great because you said they had nine visits, but they probably only spent 15 minutes. Whereas, with another patient in the private sector, they literally spent 15 minutes with that patient.

Mr. STARK. Why do you think they do that? I find that difficult to believe, besides which, if they are seniors, they are all being paid by Medicare.

Mr. SHAYS. They are gaming the system to get around rules and regulations of the Federal Government.

Mr. STARK. You don't think they do that with Pru and Aetna and the others?

Mr. SHAYS. I don't think to the extent, no, absolutely not.

Mr. STARK. I think you would find quite to the contrary. It is the same.

If they are going to game the system, have excessive tests or shortchange their visits, that type of provider is perfectly willing. As a matter of fact, the private insurance companies spend nothing on fraud and abuse. All they do is add it to the premium, and we have had testimony after testimony that they are not interested in the private sector because it is too easy just to increase the premiums and not offend a lot of people.

Mr. SHAYS. That is the old cost-plus, but when it is your dollars and you can't pass it on because you are in a competitive marketplace and you go after waste——

Mr. STARK. That is what I am talking about. In the competitive marketplace, they don't do it.

Mr. SHAYS. In my hearing, we have had the private sector testify, and there was a reason why they wanted to make health care

fraud an all-payer fraud because they say they go from State to State and they go from government to private sector, and I think they are very concerned about the waste in their system because that is where they are going to make their profit.

Mr. STARK. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. I just want to thank you, Congressman Shays, for your excellent testimony, and the work that you have done as a Member of the Budget Committee has been far more indepth than any of your predecessors, myself included years ago when I served on the Budget Committee. It has been very helpful to us.

I am particularly interested in item 1 of your testimony about adjustment of reimbursement rates and HCFA's reluctance or unresponsiveness to use existing statutory authority.

I was absolutely appalled, and I am not sure of the statutory situation in this regard, but certainly, if the statute had been a problem, they could have come to us. They have let a number of automatic, very substantial increases go into effect without comment, a 12-percent increase for surgeons 1 year ago January and recently a 10-percent increase for everybody across the board, at a time when prices are declining in many of these areas. Some of those adjustments certainly could not have been justified, and I don't know whether anything your Committee has done bears on that.

Mr. SHAYS. All I can say is that I have had the sense that a lot of people in Congress feel that HCFA has been proactive in this area, and our hearings and our testimony in GAO reports basically demonstrate that they are not. They really feel that they have two bosses. They have the taxpayers and they have the health care community, and they are not kind of sure whether they are overseeing the health care community or they are kind of just in between the two.

Mrs. JOHNSON. There is more and more evidence of HCFA being a force to drive prices up rather than drive prices down.

Some years ago, they were clearly driving prices down, but they have not been looking at the specific level that you note, and there are other examples that have come to my attention that are appalling.

Mr. SHAYS. I do want to give them one out. The one out is this. Sometimes when they are too aggressive, Members of Congress representing a particular industry or particular interest in their own district, then kind of hit on HCFA. So I do want to say that they have been burned on both sides, in fairness to them, but I think the pendulum has swung too far in favor of the providers and not enough in favor of the taxpayer.

Mrs. JOHNSON. I think your point is well taken that they have often met irrational and unfair criticism from Congress. On the other hand, in an era of enormous changes, in the price structure in health care, for them not to have come back either last year or this with any recommendations about changing how we determine prices indicates to me that your comment that they are reluctant or lethargic is a pretty good description of where they are.

Thank you.

Mr. SHAYS. I thank you all because it has been a frustration for us, and it is nice to be able to voice it to the Committee that can really do something about it.

Chairman THOMAS. Chris, thank you once again and, notwithstanding the mind-boggling numbers that CBO is going to present us whenever a program is not run the way it probably should be run, we should focus on it.

Notwithstanding the Ranking Member's comment on his $124 billion proposal and the radicalness of a proposal I know you feel proud of and worked on, the President's proposal, the $124 billion, has an unprecedented $37 billion transfer from the general fund into the part A trust fund through the failure to pay the premium on the home health care funding.

So keep up the diligence. Our job is to make sure that the program is run the way it ought to be run, notwithstanding the enormous difficulty in finding the dollars that are currently needed according to the CBO report.

Thank you very much.

Mr. SHAYS. Thank you, Mr. Chairman.

Chairman THOMAS. Now it is our desire to call Dr. Van de Water. Dr. Van de Water is the Assistant Director for Budget Analysis, Congressional Budget Office.

Thank you for appearing before us. As you know, you were not originally scheduled to be part of this hearing, but based upon actions that you initiated, we thought it was appropriate that you come before us to help us better understand the change in the numbers.

I think I speak for all of us in indicating that we would have probably preferred not to have your numbers in the first instance. In the second instance, we need the most realistic numbers possible because if, in fact, this is what reality looks like tomorrow, we have to deal with it.

So, Dr. Van de Water, any written testimony you have will be made a part of the record, and you can inform us in any way you see fit.

STATEMENT OF PAUL N. VAN DE WATER, PH.D., ASSISTANT DIRECTOR, BUDGET ANALYSIS, CONGRESSIONAL BUDGET OFFICE

Mr. VAN DE WATER. Thank you, Mr. Chairman and Members of the Subcommittee for inviting me to be here today to discuss the financial status of the Medicare Program, particularly that of the Hospital Insurance Trust Fund.

In 1995, the last completed year, spending for Medicare benefits and administrative expenses totaled $180 billion, including both the HI and SMI, Hospital Insurance and Supplementary Medical Insurance Programs. Under current law, CBO projects that Medicare spending will double by 2003 and increase to $468 billion by 2006. That growth represents an average annual rate of increase of 9.1 percent a year over the period.

The growth in Medicare spending projected by CBO is broad-based. Hospital insurance outlays, which include spending for inpatient hospital care, home health services, skilled nursing facilities, and a share of premiums for beneficiaries enrolled in capitated

health maintenance organizations, are projected to increase at an average rate of 8.3 percent a year. Supplementary medical insurance, which pays for physicians' services, labs, durable medical equipment, and outpatient hospital services, is projected to increase at an average rate of 10.3 percent annually.

For both HI and SMI, payments to risk-based HMOs, health maintenance organizations, are the fastest growing component. Most of that growth, however, is attributable to rapidly increasing enrollment. CBO projects that enrollment in risk plans will increase 25 percent in 1996 alone, with the rate of growth slowing to 10 percent a year in 1999 and thereafter. CBO also projects that the number of Medicare enrollees in the traditional fee-for-service sector will actually decline over this period.

Despite that decline in fee-for-service enrollment, however, payments for home health, skilled nursing, and outpatient hospital services are still projected to grow at double-digit rates.

The financial transactions of Medicare are handled through two separate trust funds on the books of the Treasury. The trust fund technique involves earmarking specific taxes or other revenues to finance certain programs. That procedure helps to weigh the costs and the benefits of the programs and gives beneficiaries some assurance that their benefits will be protected.

Financial soundness is not an issue for the Supplementary Medical Insurance Program because the portion of spending not financed by premiums is covered by an open-ended appropriation from the general fund of the Treasury. The Hospital Insurance Trust Fund, however, does not have a tap on general revenues and is facing depletion within 5 years.

Last year, in 1995, spending for hospital insurance exceeded by a small amount earmarked payroll and income taxes and other income to the fund. CBO projects that outgo will exceed income by $7 billion this year. With HI outlays increasing more quickly than payroll tax receipts, the gap will widen each year, and the HI Trust Fund will become insolvent in 2001.

Over the past year, CBO has slightly modified its Medicare projections. Overall, as Mr. Stark indicated, CBO's April 1996 projections for Medicare spending are lower than its March 1995 projections. CBO has reduced its projected levels of spending for SMI. It has upped its projection for HI, and the projected insolvency of the HI Trust Fund has been moved forward by 1 year.

In March of last year, CBO projected that the HI Trust Fund would run a $3 billion surplus in 1995 and that outlays would exceed receipts beginning in 1996. In fact, outlays in 1995 slightly exceeded income to the trust fund. This change from a surplus to a deficit position has recently received a great deal of attention.

Given the size of the HI Program and the uncertainty that surrounds even short-run projections of outlays and revenues, however, that change provides little new information about appropriate directions for Medicare policy. At this point, apart from total outlays, we know very little about the details of recent developments in health benefits paid by the HI Program.

Similarly, the advance of 1 year in the projected date of insolvency confirms what we already knew, namely, that Medicare

spending continues to grow at rates significantly in excess of the payroll and other tax revenues used to pay for benefits.

As the Members of this Subcommittee recognize, fixing Medicare's financing problems will not be easy. Either taxes must be increased, expenditures reduced, or both, and the magnitudes involved are large.

To ensure solvency of the HI fund just through 2006 would require an increase in the HI payroll tax of 0.7 percentage points, about 25 percent, starting in January. Alternatively, to provide another illustration, the rate of growth of HI outlays would have to be slowed by more than 3 percentage points, from 8 to about 4.5 percent a year. Still larger changes would be required to bring the growth of SMI spending in line with the growth of the economy. Postponing action would make the necessary corrections even more severe.

That concludes my statement, Mr. Chairman. I would be happy to take your questions.

[The prepared statement and attachments follow:]

STATEMENT OF PAUL N. VAN DE WATER
ASSISTANT DIRECTOR FOR BUDGET ANALYSIS
CONGRESSIONAL BUDGET OFFICE

Mr. Chairman and Members of the Subcommittee, it is my pleasure to be here today to discuss the financial status of the Medicare program, particularly the Hospital Insurance (HI) trust fund.

Continuing growth in the cost of providing Medicare coverage to each beneficiary, coupled with a steady increase in the number of beneficiaries, is eroding the financial status of the program. Spending for Hospital Insurance and Supplementary Medical Insurance (SMI) combined has increased from 0.8 percent of gross domestic product (GDP) in 1975 to 2.5 percent in 1995. The Congressional Budget Office (CBO) projects that if current law is not changed, Medicare spending will increase to 3.8 percent of GDP by 2006. Program revenues, however, are not increasing nearly as rapidly. If left unchecked, those trends will create a problem of major proportions when the baby-boom generation begins to reach retirement age in 2010.

CBO'S BASELINE PROJECTIONS

In 1995, spending for Medicare benefits and administrative expenses totaled $180 billion, including both the Hospital Insurance and Supplementary Medical Insurance programs. Under current law, CBO projects that Medicare spending will double by 2003 and increase to $468 billion by 2006 (the last year for which CBO prepares detailed projections). That growth represents an average annual rate of increase of 9.1 percent over the 1995-2006 period (see Table 1).

The growth in Medicare spending projected by CBO is broad based. HI outlays, which include spending for inpatient hospital care, home health services, skilled nursing facilities (SNFs), and a share of premiums for beneficiaries enrolled in capitated health maintenance organizations (HMOs), are projected to increase at an average annual rate of 8.3 percent. SMI, which pays for physicians' services, labs, durable medical equipment, outpatient hospital services, and the remaining share of premiums for beneficiaries enrolled in risk plans, is projected to increase at an average annual rate of 10.3 percent.

For both HI and SMI, payments to risk-based HMOs are the fastest-growing component. Most of that growth, however, is attributable to rapidly increasing enrollment. CBO projects that enrollment in risk plans will increase 25 percent in 1996, with the rate of growth slowing to 10 percent in 1999 and subsequent years. CBO also projects that the number of Medicare enrollees in the traditional fee-for-service sector will actually decline over this period. Despite that decline in fee-for-service enrollment, however, payments for home health, SNFs, and outpatient hospital services are still projected to grow at double-digit rates. The growth in spending for those services partly reflects successful efforts to constrain the growth in spending for inpatient hospital services.

STATUS OF THE HOSPITAL INSURANCE TRUST FUND

The financial transactions of the HI and SMI programs are handled through two separate trust funds on the books of the Treasury. The trust fund technique involves earmarking specific taxes or other revenues for financing certain programs. That procedure helps to weigh the costs and benefits of the programs and gives beneficiaries some assurance that their benefits will be protected.

Financial soundness is not an issue for the SMI trust fund because the portion of spending not financed by premiums is covered by an open-ended appropriation from the general fund of the Treasury. The HI trust fund, however, does not have a tap on general revenues and is facing depletion within five years.

In 1995, spending for Hospital Insurance exceeded by a small amount earmarked payroll and income taxes and other income to the trust fund. CBO projects that outgo will exceed income by $7 billion in 1996. With HI outlays increasing more quickly than payroll tax receipts, the gap will widen each year, and the HI trust fund will become insolvent in 2001 (see Table 2).

COMPARISON WITH PREVIOUS PROJECTIONS

CBO has slightly modified its projections for Medicare over the past year. Overall, CBO's April 1996 projections for Medicare spending are lower than its March 1995 projections. Although CBO has reduced projected levels of spending for SMI, it has upped its projections for HI, and the projected insolvency of the HI trust fund has moved forward by one year.

In March of last year, CBO projected total spending of $463 billion in 2005, compared with a current projection of $428 billion. Most of the decrease stems from changes in projected spending for the SMI program. For 2005, CBO has reduced projected SMI spending from $216 billion to $173 billion. That decline reflects two factors: a lower base--actual 1995 spending was $2 billion lower than CBO's March 1995 projection--and a lower projected rate of growth. The lower projected rate of growth recognizes a slowdown in SMI spending over the past several years.

In contrast, CBO's current projections of HI spending exceed those of a year ago. In March 1995, CBO projected HI outlays of $247 billion in 2005; our current projection is $255 billion. That change primarily reflects an increase in actual 1995 outlays, which came in about $1 billion higher than CBO's original projection. Although complete information is not yet available, we attribute much of that increase to higher-than-expected hospital admissions and a change in the mix ofcases. Because it is not clear whether this trend will continue, we did not significantly change our projected rates of growth in HI outlays for the out-years.

In March 1995, CBO projected that the HI trust fund would run a $3 billion surplus in 1995 and that outlays would exceed receipts beginning in 1996. In fact, HI outlays in 1995 slightly exceeded income to the trust fund. That change reflects the higher-than-projected HI outlays noted above and lower-than-projected receipts.

CONCLUSION

The change from a surplus to a deficit in the HI trust fund in 1995 has recently received a great deal of attention. Given the size of the HI program and the uncertainty that surrounds even short-run projections of outlays and revenues, however, that change provides little new information about appropriate directions for Medicare policy. At this point, apart from total outlays, we know very little about recent developments in health benefits paid by the HI program.

Similarly, the advance of one year in the projected date of insolvency should be viewed not as telling us something new but confirming what we already know: Medicare spending continues to grow at rates signficantly in excess of the payroll and other tax revenues used to pay for benefits.

As the Members of this Subcommittee recognize, fixing Medicare's financing problems will not be easy. Either taxes must be increased, expenditures reduced, or both, and the magnitudes involved are large. To ensure solvency of the HI trust fund just through 2006 would require an increase in the HI payroll tax of 0.7 percentage points--about 25 percent--starting in January. Alternatively, the rate of growth of HI outlays would have to be slowed by more than 3 percentage points--from 8 percent to about 4½ percent a year. Larger changes would be required to bring the growth of SMI spending in line with the growth of the economy. Postponing action would make the necessary policy actions even more severe.

TABLE 1 PROJECTIONS OF MEDICARE OUTLAYS (By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Average Annual Percentage Rate of Growth, 1995-2006
Hospital Insurance	115	127	139	152	164	177	190	204	220	237	255	275	8.3
Supplementary Medical Insurance	65	72	79	88	97	106	116	128	141	156	173	192	10.3
Gross Outlays	180	199	219	240	261	283	307	332	361	393	428	468	9.1
Premium Receipts	-20	-20	-21	-23	-24	-25	-26	-27	-29	-30	-31	-32	4.3
Net Outlays	160	179	198	217	237	258	281	305	332	363	397	435	9.5

SOURCE: Congressional Budget Office

NOTE: Numbers may not add up to totals because of rounding.

TABLE 2. BASELINE PROJECTIONS OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
April 1996 Baseline												
Outgo	115	127	139	152	164	177	190	204	220	237	255	275
Income												
Payroll taxes[a]	104	110	117	122	129	136	142	150	157	165	173	182
Interest	11	10	9	7	5	3	b	-2	-6	-10	-14	-19
Total	115	120	126	130	134	139	143	147	151	155	159	163
Surplus or Deficit	b	-7	-13	-22	-30	-38	-48	-57	-68	-82	-96	-112
Fund Balance[c]	130	122	109	87	57	19	-29	-86	-154	-236	-332	-444
December 1995 Baseline												
Outgo	115	126	138	149	161	173	186	200	214	231	248	n.a.
Income												
Payroll taxes[a]	104	109	115	121	127	134	140	147	154	161	169	n.a.
Interest	11	10	9	8	7	5	3	b	-3	-7	-12	n.a.
Total	115	120	124	129	134	139	143	147	151	154	157	n.a.
Surplus or Deficit	b	-7	-13	-20	-27	-34	-43	-53	-64	-77	-91	n.a.
Fund Balance[c]	130	123	109	89	62	28	-15	-68	-132	-208	-299	n.a.
August 1995 Baseline												
Outgo	114	125	137	148	160	172	185	199	214	230	247	n.a.
Income												
Payroll taxes[a]	104	110	115	121	128	135	142	150	158	167	176	n.a.
Interest	10	10	9	8	6	4	2	-2	-6	-11	-17	n.a.
Total	114	120	124	129	134	140	144	149	152	156	159	n.a.
Surplus or Deficit	b	-5	-13	-19	-26	-33	-41	-51	-61	-74	-89	n.a.
Fund Balance[c]	129	124	112	93	67	34	-7	-58	-119	-194	-282	n.a.
March 1995 Baseline												
Outgo	114	125	137	148	160	172	185	199	214	230	247	n.a.
Income												
Payroll taxes[a]	106	113	118	124	131	138	145	153	161	170	179	n.a.
Interest	10	10	10	9	7	6	3	b	-3	-7	-12	n.a.
Total	117	123	127	133	138	143	148	153	158	163	167	n.a.
Surplus or Deficit	3	-2	-9	-15	-22	-29	-37	-46	-56	-67	-80	n.a.
Fund Balance[c]	132	129	120	105	83	53	16	-30	-85	-152	-233	n.a.

SOURCE: Congressional Budget Office.

NOTE: n.a. = not available. Numbers may not add up to totals because of rounding.

a. Includes a small amount of premiums and other noninterest income.
b. Less than $500 million.
c. At the end of the fiscal year.

Chairman THOMAS. Thank you very much, Dr. Van de Water.

I just want to put some statements in a proper context so that I can better understand or attempt to try to get people to focus on the magnitude of what we are dealing with.

This, I believe, is the statement of my friend and colleague from California. The Democrats repeat their offer to make $124 billion in Medicare savings and add 10 years to the life of the Medicare Trust Fund. My problem was, this morning, I was doing some math on our "position," which has been characterized by the gentleman as more significant and robust than theirs, and I believe that the balanced budget amendment falls short of these current numbers, as projected by the CBO.

How in the world, then, could the gentleman from California repeat his offer of $124 billion in Medicare savings and add 10 years to the life of the Medicare Trust Fund? Are you familiar with the President's proposal, which I assume is $124 billion?

Mr. VAN DE WATER. We certainly have done estimates on the administration's proposal.

Chairman THOMAS. Based upon the new numbers that you have looked at, would that add 10 years to the Medicare Trust Fund?

Mr. VAN DE WATER. No, it would not. As my statement indicated, under current law, we project that the HI Fund would become insolvent in 2001. Under the administration's policies, as best we can tell, CBO suspects that the fund would become insolvent in 2005. So it would add 4 years to the life of the fund.

Chairman THOMAS. So, basically, my statement at the beginning, and that is everybody has got to go back to the drawing board and we do have to rethink what we have done and hopefully we could do so in as minimal a political context as possible, because these numbers ought to sober everyone up, and that we ought not to offer old panaceas to the very new and real problem, I think has even more import.

Mr. KLECZKA. Mr. Chairman, one quick question, if I might.

Chairman THOMAS. Sure.

Mr. KLECZKA. What was the extension under the Republican plan? We have 2001 current. The 124 takes us to the year 2005.

Chairman THOMAS. Under the old numbers, we believed we were solvent until 2010. Under the new numbers projected by CBO, we probably would not make the 2006 date either. It will be somewhere around a 7-year effort, I believe, and that, I guess, is partly what I tell my friend from Wisconsin is the problem that we are faced with.

Now not only does the trust fund go broke 1 year earlier, but the spend out after that is such that any of the proposals that were offered previously really don't make the kind of curve adjustments necessary to put us in the ballpark, and in addition to that, I believe Dr. Van de Water said that on the part B spending, we would require even larger changes to bring the SMI part B spending in line with growth of the economy.

Would you elaborate on that? What did you mean by that?

Mr. VAN DE WATER. As I indicated in my statement, SMI spending is growing in our projection and in those of the administration at even greater rates than spending on the Hospital Insurance Program. So, simply as a matter of arithmetic, bringing that rate of

growth down to comparable levels would require a larger proportional reduction.

In dollar terms, it wouldn't be as great because, for the moment, SMI is still a smaller program than HI, but it is growing more rapidly.

Chairman THOMAS. Do you have any dollar figure that you could place on what that adjustment would be in terms of needed part B savings?

Mr. VAN DE WATER. As were the examples in my prepared statement, this is just illustrative, but if one were to try reducing the present rate of growth, which is projected to be in excess of 10 percent down to about the rate of growth of GDP which is roughly 5 percent, the cumulative savings in SMI over 10 years would be approximately $330 billion.

Chairman THOMAS. Of course, the pressure on part A is precisely because it is a trust fund and it has dedicated dollars. Part B can tap into the general fund, and to the degree that we do not have a payment scheme for beneficiaries to pay whatever "their fair share" is, we tap even more heavily into the general fund.

I guess at this stage, I am not all that excited about talking about solutions to combine part A and part B if it means you have access to the general fund to "solve your problem." I think it is the growth rate of 9 percent-plus in the trust fund and 10 percent in part B that we have to focus on.

The other problem that I have very much with your testimony is the idea that we would even suggest that the payroll tax be a solution to the problem. The American people were the beneficiary of a 1993 removal of the lid on the payroll tax by President Clinton and the Democrats who were then controlling the majority of the Congress. It was the largest tax increase in history, and that basically has been washed away by the numbers.

No question, we would be in much worse shape had they not had this enormous tax increase, but to say that we are going to go to a 25-percent increase on the HI payroll tax is, in my opinion, totally and unfairly continuing the shift of an intergenerational transfer of funds that I think are unprecedented in the history of this country.

If I were to ask you if we went to a 25-percent increase on top of the current payment, how much would that be?

Mr. VAN DE WATER. The current payroll tax rate for Medicare is 1.45 percent each for employers and employees making a total of 2.9 percent. So a 25-percent increase would bring that to a total of roughly 3.7 percent.

I might add, if I might, Mr. Chairman, that CBO was not recommending a payroll tax increase, just as we were not recommending any particular benefit cuts. I was running through some purely illustrative examples to try and add some tangibility.

Chairman THOMAS. I understand that, but on an illustrative example, I also need a ready answer from you to the 30-year-old who then says, "Well, OK, so I am going to pay this for 35 years. So what are the odds on my getting something at the end of this process, having paid out at the highest rate in history?," and the answer is you are going to be able to work longer and you are going to have to stay alive longer to get anywhere near the return that

the current generation gets. That is my problem in terms of this intergenerational transfer.

The gentleman from California wants to interject.

Mr. STARK. This is to ask along the lines of the Chairman's inquiry.

You give as an example at the end of your testimony that we would either have to increase 0.7 percent, and I assume that is 35 basis points on both sides, or cut the rate of growth from 8 to 4.5 percent, which many of us think perhaps is not sustainable by the system.

Do you have a tradeoff there? What if we got back to the good old days of compromise and say, well, maybe we will do 0.3 percent, 15 basis points? How low would we have to drop the growth rate, or could you later supply to us some options in that raise? I think 4.5-percent growth rate is too far a cut, and I would agree with the Chairman. I think 0.7 percent would be politically unpalatable, but not to suggest that somewhere in the middle there might not be options that would be more attractive.

If you don't know what 10 basis points does in the growth rate off the top of your head, I don't have any idea whether those are linear or what.

Mr. VAN DE WATER. They are, indeed.

Mr. STARK. Are they?

Mr. VAN DE WATER. Given the hypothetical approach that we use, both of those alternatives——

Mr. STARK. So you could extrapolate it just linearly.

Mr. VAN DE WATER. Right.

Mr. STARK. OK. Thank you.

Mr. VAN DE WATER. In other words, if you wanted to do half and half, you would require a——

Mr. STARK. A 1.5-percent cut in the growth rate and about 35 basis points. OK.

Mr. VAN DE WATER. Exactly.

Mr. STARK. All right. That answers it. Thank you.

Chairman THOMAS. You can go ahead if you want to.

Mr. STARK. I guess that is what I wanted to point out.

I did want to suggest to you that earlier in your testimony you suggest that we have got to——

Chairman THOMAS. Just one point on that, though, just to finish the discussion. Notwithstanding the fact that the longer we project out this shared structure, the chances of the old-fashioned hospital remaining separated from the physician side of payment says that current Medicare part A/part B concept is going to be less relevant to the beneficiaries in terms of the way in which health care is delivered. So I think, at some point, we may need to engage about that choices discussion that we previously engaged in and that perhaps a combination of the two under a new structure rather than a combination of the two under the current structure might be an option as well.

I thank the gentleman.

Mr. STARK. In your growth rate discussion, in the President's proposal, we cut to about 6.5 percent, and I think the Republican proposal, I am going to guess, is about cutting to a growth rate of 5.7 percent. The private sector growth rate based on those same as-

sumptions was projected to be around 7 percent. I guess what troubles me, and this is what I would ask for your comment, if we had a substantially lower growth rate locked in for the public sector program below the private sector, wouldn't we basically either push us toward rationing or cost shifting? I don't know whether you are able to comment. It is my opinion that that is what it would lead to; that we have to keep our growth rate in the public sector pretty close to what the private sector growth rate will be or will cause those kinds of problems in the market.

Is that a fair assumption, or is there something unique about the delivery of medical care?

Mr. VAN DE WATER. I don't think that I am as well-positioned as your following witnesses to address that, but I think the gist of what you suggest is probably correct.

The problem from our point of view is that these comparisons between rates of growth in the private sector and the public sector are very difficult to do.

For example, the benefit packages of the two sectors may be changing. The Medicare benefit package in recent years has probably been either roughly constant or perhaps getting better. The typical benefit package in private employer-sponsored health insurance may have been moving in the other direction. So that is one difficulty in comparison.

The demographic compositions of those in the public and in the private program may have been changing in different ways.

There are also technical problems in comparing the data because private health insurance spending includes, for example, spending for people covered by Medigap plans, and you really want to think of them in the elderly rather than the nonelderly group.

In response to concerns and questions such as yours, we at CBO are undertaking an analysis that is trying to look at how one can do an honest job of comparing growth rates in the public and private sectors, and we hope to have that available in the early summer.

Mr. STARK. Could I just finish with the comparing, though, within Medicare by itself? PPRC indicates that when we have people joining a Medicare managed care plan, we are really losing money because it tends to be the younger, healthier Medicare beneficiary. So we are getting some cost shifting, if you will, within the Medicare system. They collect the same rate for the healthy, younger people, and it gets paid out in a capitated rate every month, and that costs us more than if we didn't pay anything on their behalf.

Is there something we can do? Have you thought of any way to balance that out to move toward managed care? How do we do that? Do we pay a lot less for younger, healthier people?

Mr. VAN DE WATER. I believe that Dr. Newhouse addresses that issue in his prepared statement, especially where he focuses on trying to develop ways of adjusting for differences in risk between people.

Mr. STARK. Has something wondrous happened in that area in the last couple of years? Is there a risk adjustment of protocol which you are willing to subscribe to at this point, and could you lend me a copy of your formula if that is it?

Mr. VAN DE WATER. I am not aware of it at this point.

Mr. STARK. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. It is becoming the holy grail.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you.

Thank you for your testimony, Dr. Van de Water.

I, too, would like, just for the record, to say that financial soundness is not an issue for the SMI Trust Fund is theoretically correct, and I understand it is theoretically correct, but in fact, it is incorrect. There is absolutely no way that taxes can go up at the rate they would have to go up, as you have well described for tax revenues to deal with the problem even in part B. It is true, as you point out in your testimony, that in part A, there is not even this safeguard.

I want to ask you a little bit about your testimony in regard to the growth in HMOs. You mentioned that it is the fastest growing component. Membership in HMOs is the most rapidly growing component.

In those States where Medicare Select has been on the market for 2 years, is their growth rate faster or slower in the managed care plans as opposed to the HMO risk contracts?

Mr. VAN DE WATER. I don't know the answer to that question.

Mrs. JOHNSON. Could you get back to me on that?

Mr. VAN DE WATER. Indeed.

[The following was subsequently received:]

MEDICARE SELECT

Medicare Select is a type of Medicare supplemental health insurance that pays in full for supplemental benefits only if they are delivered by preferred providers. The program began as a demonstration in 1992 and was originally limited to 15 states. The program was made permanent and extended to all states in 1995.

Medicare Select policies have been on the market for at least two years in 12 states: Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Minnesota, Missouri, Ohio, Texas, and Wisconsin. From December 1993 to December 1995, 62 percent of the growth in enrollment in Medicare risk contracts took place in these 12 states, even though they are home to only 44 percent of Medicare enrollees. In the states with Medicare Select, enrollment in risk contracts grew from 1.4 million to 2.2 million over the period--an increase of 0.8 million or 57 percent. In the remaining states, enrollment in risk contracts grew from 0.4 million to 0.9 million--an increase of 0.5 million or 114 percent.

Mrs. JOHNSON. I think it is determinable.

Then, why in your estimates do you reduce your expected rate of growth in HMOs? You say that in 1996, it will be 25 percent, that is 25 percent of current enrollees, and current enrollees, as I recall, is only 9 percent. So 25 percent of 9 percent, you are expecting only a little over 2 percent growth.

Mr. VAN DE WATER. That is 2 percentage points.

Mrs. JOHNSON. Yes.

Does that take into account the availability of HMO risk contracts for seniors in parts of the country where they have not been available before, or is that estimate based on the rate of growth in those sectors of the market where there are currently HMO risk contracts?

Mr. VAN DE WATER. We certainly attempt to take account of what we think is going to happen in the future, not just look in the rearview mirror, but obviously, this is one of the many sources of uncertainty in the estimates.

Mrs. JOHNSON. I would be interested in getting into more detail with you on that at some other time.

Coming from a State that has not had much HMO or managed care activity until recently, I can tell you that the biggest fear of the hospitals and doctors is that by the time they get their networks up and running, the HMOs will have taken over.

I have never seen such a marketing operation. Nobody has ever seen such a marketing operation, but we now have a couple of HMO risk contracts that are all over every single senior citizen center. I can tell you, the difference in the way people are listening to them, the difference in the way they hear my conversation about the Republican proposal from 6 months ago and now is dramatic, and the number of seniors now, there is always in a seniors group now a few that have joined one of these programs and are doing very well, thank you, and so the word is spreading that you can get more benefits for the same or less cost.

The security that either a zero or a $5 or a $10 copayment gives retirees is simply enormous. They listen to that.

In the first year, from 1996 to 1997, you have it dropped from 25 to 20 percent. Then, by 1999, you project from 1999 to every year thereafter only a 10-percent growth.

Mr. VAN DE WATER. Could I clarify this?

Mrs. JOHNSON. By then, there will be a lot of plans in the market. They are offering far more benefits at far reduced cost, and I can't imagine when you look at the private sector's experience where you get that growth rate.

Mr. VAN DE WATER. Could I clarify this, Mrs. Johnson?

Mrs. JOHNSON. Yes.

Mr. VAN DE WATER. Perhaps my statement wasn't sufficiently clear on this.

Those figures may not be the clearest way, from your point of view, of looking at the increase in HMO enrollment. They simply reflect the fact that when you are starting out with a relatively small number, and as you say the current enrollment in risk plans is about 9 percent of the total, a given increase in HMO enrollment represents a relatively large percentage increase on the small base.

As more and more people join risk plans, that same absolute increase represents a smaller percentage increase per year.

Mrs. JOHNSON. I appreciate that.

Mr. VAN DE WATER. By 2002, for example, on our baseline, we project that enrollment in risk plans will be about 17 percent of the total.

Mrs. JOHNSON. In 10 years, you are going from 9 percent of the total to 17 percent. That is an 8-percent increase in 10 years. Frankly, you look at what happened in the private sector and I think you are not paying attention. We will get some other opinions on that, but the likelihood of going from 9 to 17 percent in 10 years strikes me as unlikely. I think it will be far greater than that. I think you are completely underestimating the seniors' interest.

Seniors are dying under the cost of their Medicare premium, figuratively speaking, perhaps literally, and the cost of Medigap insurance. Medigap insurance is beginning to outpace a senior's ability to buy it.

As that happens, their interest in zero premium HMOs that provide the benefits of a managed care plan or a Medigap policy is going to be extraordinary, and I don't think you are looking at that.

When I talk to seniors and hear what they are paying in Medigap premiums, they cannot keep doing it, and this year, those premiums went up in Connecticut.

Mr. ENSIGN. Would the gentlelady yield?

Mrs. JOHNSON. That makes the HMO option far more desirable.

So I would just like to help you look at your growth rates and what you think is going to happen in this because I think you are really significantly off.

Yes, I would be happy to yield.

Mr. ENSIGN. Real quickly, just one comment in my area, we for several years have only had two HMOs provided for Medicare recipients. We have 30 percent of our population now that is covered in the senior population.

Mrs. JOHNSON. And 2 years ago, you had one HMO risk option in the Boston market. Now you have four, and they are all zero premiums, with the exception of Harvard which has gone down from $85 to $15, but the rapidity of change doesn't seem to be reflected in your numbers. I understand your numbers are honest. They are based on your assumptions, but I certainly would like to begin to spend some time with you on what your assumptions are because it doesn't check with my experience, and particularly this issue of the rising cost of Medigap insurance driving people to look for alternatives.

Thanks.

Chairman THOMAS. The gentlewoman's time has expired.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I thank you for your testimony. If there was ever an issue where I thought the American people could come together on and the Members of Congress and the administration could come together on and work together in a bipartisan fashion, it would be solving this whole challenge that we have before us.

I look at the numbers in your testimony. Many of us have conducted townhall meetings and forums, and we have heard, but, oh,

there is $122 billion in the reserve, it is going to be there, we are not really facing any problem. I see, this year, you are projecting $7 billion loss, next year $13 billion, 1998 $22 billion loss, $30 billion, $38 billion, $48 billion, $57 billion, $68 billion, $82 billion in year 2005, and $96 billion deficit. It is amazing that we can't come to some kind of agreement on this and get this solved.

Even our program wasn't based before these projections came out. It would not get us as far as we needed to get to saving the program.

So I guess my question is, back when you were looking at modifying the projections for this past year, what were some of the parameters that you used in modifying your projections?

Following up on Nancy Johnson's comment, did you look and examine what was going on in some of the markets that are using the HMOs, such as Arizona, in modifying your projections and your results?

Mr. VAN DE WATER. As you probably noticed in looking at these numbers as carefully as you have, the changes on both the outlay and the revenue side of our projections are really fairly modest on a year-by-year basis, but when you add them all up over 10 years, when you accumulate them to find out what the effect on the accumulated deficit or surplus is, they turn out to be rather large.

There is no single earth-shaking fact that one can point to that accounts for the change in projections. On the income side, we have just slightly lower receipts reflecting two things: First, the projection of slightly less rapid growth in the wage and salary base on which payroll taxes are levied, and second, an even smaller reassessment on the part of the Social Security Administration with regard to the portion of wages and salaries which would be subject to the payroll tax.

On the outgo side, we have changed the rate of growth in hospital insurance very little. Most of the change simply reflects the fact that spending in the current year is running a bit higher than we had thought a year ago at this time, and if you just project out a small difference, it comes close to tripling over the 10-year period that we are showing.

So there is no smoking gun, so to speak, that one can point to that accounts for these changes. They are really very modest, but on balance, they do shorten the life of the fund by a year and add roughly $100 billion to the accumulated deficit over 10 years.

Mr. CHRISTENSEN. Mr. Chairman, as a freshman on this Committee and as someone who has been targeted by the AFL–CIO and an opponent who is the recipient of hundreds of thousands of big labor dollars focused on the issue of "cutting" Medicare because we supposedly don't care about our seniors, I am outraged by those who are defenders of the status quo that would allow this system to go bankrupt.

To hear people even contemplating the thought of raising taxes really should be an outrage to the American people because even raising taxes won't fix this problem. Until this Congress has the will to do what is necessary, to change the entire program, it is not going to get done.

If we can't come together in a bipartisan fashion to achieve the results that are needed to save this system, so that we don't have

the intergenerational transfer that is going on today, I pity where this program goes, and it is shameful that we have defenders of the status quo that will play politics with this issue with the Republican majority.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. A bipartisan solution might be doable if all parties had input into the solution, but for one side to do it and to try to ram it down the other side is not compromise and is not bipartisan.

Mr. CHRISTENSEN. Would the gentleman yield for a moment?

Mr. KLECZKA. Dr. Van de Water, the question I have is, you indicated that the rate of growth in HI for 1996, even though it is exceeding the projection by $7 billion, is still modest? Was that your terminology?

Mr. VAN DE WATER. The modest differences in outlays and revenues separately produce relatively large differences in the annual surplus or deficit and the accumulated trust fund balance.

Mr. KLECZKA. In your review of the expenditures from this particular account, have you been able to decipher what the actual factors were? Is it totally utilization, or what might we be seeing here?

Mr. VAN DE WATER. As I indicated in my statement, the detailed data on the composition of Medicare spending with respect to type of service or category of beneficiary only become available with a very great lag. So, in fact, at this time, all we know is total Medicare spending.

Mr. KLECZKA. You don't have any guesstimate on historical trends or trends from 1995?

The entire statement has a lot of data on things that have occurred and will occur up to 2006. I wonder if you just can't pinpoint something going on there that we should be aware of as we talk about it today.

Mr. VAN DE WATER. These things change unexpectedly, and in ways that even the experts have a great deal of trouble explaining.

Again, referring to Dr. Newhouse's statement, I was struck by the chart that compares sources of growth in Medicare over recent time periods. In the most recent time period, if I am remembering his chart correctly, we have a substantial increase in utilization on the part of Medicare beneficiaries. In the preceding time period, there was very little growth in utilization, but a very large increase caused by the so-called residual factor, which is the analyst's word for everything that we don't understand.

I don't think there is a clear understanding of what the residual is or why it is so large in some time periods and so small in others.

Mr. KLECZKA. Thank you very much.

Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Mr. Chairman, may I?

Chairman THOMAS. Certainly.

Mr. CHRISTENSEN. Mr. Kleczka, I would be more than happy to work with you in a bipartisan fashion. You have always been good about your openness, and this issue is a bipartisan issue that we could work together on, but when people in your party have used this as a political tool to target a number of freshmen, it makes one

less inclined to work together, but maybe we can work together outside of this room.

Chairman THOMAS. As the Chair stated in his opening remarks, even the Washington Post has indicated that there was a degree of medigoguery being carried out by the President, but the point I tried to make was that the numbers ought to be sobering enough. If we refer to Dr. Newhouse's charts, which we will get to shortly, I guess the thing that ought to drive us together to move toward a solution as soon as possible is that the CBO numbers prove that it can get worse.

This is not, I don't think by any means, the bottom end of the scenario based upon the various factors, and that is one of the things we have to get at.

I believe the gentlewoman from Connecticut wanted to clarify.

Mrs. JOHNSON. Thank you very much. I do want to just clarify.

You gave us some information about what you thought would be the impact of the President's proposal to reduce Medicare spending by $124 billion over 7 years, and you said that instead of extending the life of the program 10 years that it would add 4 years to the life of the program.

Of the present savings, how much of the savings comes from part A and how much from part B?

Mr. VAN DE WATER. In our estimation, the total Medicare savings over 7 years in the President's latest submission are $116 billion.

The part A savings are, in fact, $128 billion; that is, the part A savings exceed the total savings because of the shift of some of the home health spending from part A to part B that the Chairman referred to.

Mrs. JOHNSON. How much of that $128 billion is due to the shift?

Mr. VAN DE WATER. In that 7-year period, the number is $55 billion. I had incorrectly indicated earlier that it was $37 billion, but the correct number is $55 billion.

Mrs. JOHNSON. So $55 billion of the $128 billion is "saved" in part A because it shifted to part B, correct?

Mr. VAN DE WATER. Yes.

Mrs. JOHNSON. So it is not a real savings. It is not like cutting reimbursement rates and, therefore, the money isn't going out the door. It is going out the door, just from a different fund, correct?

Mr. VAN DE WATER. Correct.

Mrs. JOHNSON. So there is no savings in part B. In fact, there is an increase in cost in part B of $55 billion?

Mr. VAN DE WATER. Yes. It is simply a shift.

Mrs. JOHNSON. That increase in cost of $55 billion, what would be the premium increase necessary in part B, to just cover the percent of that new cost that is parallel to the percent of cost that the current part B premium is carrying? When I say current part B, I don't mean the current part B in current law, whatever is in the President's proposal? In other words, he lowers the part B premiums, but he pegs them at dollar amounts, and those dollar amounts cover a certain percent of part B spending.

If you were to require seniors to carry that same percent of the new home care expenditures, what would be their increase in premium costs? I would like to know the same figure. You may not

have those now. If we did this through the tax structure, what would be the increase in taxes that would have to be levied, Medicare taxes, if we were to cover this $55 billion cost through increasing Medicare taxes?

Mr. VAN DE WATER. The President proposes, as you know, to set the SMI premium so as to cover 25 percent of program costs. Under that assumption, the premium that would attach to part B spending is 25 percent of $55 billion.

Mrs. JOHNSON. So under his program is 25 percent of program cost, but because he is shifting new cost into part B, his premiums actually would go up?

Mr. VAN DE WATER. No, because the President also specifies that these particular additions to part B spending would not be counted for purposes of determining the premium.

Mrs. JOHNSON. So they will be paid for entirely through the tax income, the tax dollars that flow in?

Mr. VAN DE WATER. Yes.

Mrs. JOHNSON. Would you get back to me later on as to what kind of increase they would trigger if they were counted as part of the 25 percent?

Mr. VAN DE WATER. That was the earlier answer I gave you. If they were counted, it would lead to a premium increase of 25 percent of $55 billion, roughly $13 billion.

Mrs. JOHNSON. Oh, I see. I didn't understand that.

Then, if you could get back to me about how that would work out in terms of payroll tax, I would be interested in that.

Mr. VAN DE WATER. What payroll tax rate it would take to finance?

Mrs. JOHNSON. Right. What kind of payroll tax increase it would take to fund those, the home care expenses, so that we would not have a new tax through other avenues. I just want to know for a matter of fact. I think the problem with $124 billion is not only that it only adds 4 years instead of 10, but also that it is a sleight of hand, and I am appalled that the $55 billion was not allowed to have any weight in the premium and it is totally a generational tax shift.

Thank you.

Mr. VAN DE WATER. Mrs. Johnson, I could actually give you an indication of that answer right now. The 0.7-percent increase in the payroll tax, which I used in my hypothetical example, generated about $200 billion over 7 years. So, to raise about a quarter of that amount, the required increase would be about a quarter of 0.7, or close to 0.2 percent on the payroll tax.

Mrs. JOHNSON. Thank you. I appreciate that.

Mr. STARK. Mr. Chairman.

Chairman THOMAS. The gentleman from Nevada was going to try to get in on it first, but is this followup of that?

Mr. STARK. It is a followup. I just wanted to stipulate that I am sure that in our bill there has been sleight of hand, but I think I am also correct that in the Republican bill, the part B premium increase was transferred into part A for several billions of dollars, and the GME Trust Fund was taken out and an appropriated trust fund was created. So that, in both bills, we used transfers from one trust fund to the other. While one may be better than the other,

I didn't want the record to suggest that the Democratic bill was the only one that transferred money in or out of trust funds. Both bills did it, and indeed, we could have a discussion as to which is a better way to do it, but it is in both bills.

Chairman THOMAS. I want to tell the gentleman that we transferred savings. Your bill transferred costs, and that is a final retort, I think, that we ought to offer here because we were not the ones who offered the old program as a continuing solution to the new problem.

I tried in my opening statement to point out all of us had better sober up and look at these new numbers in light of the CBO report. It was the gentleman from California's opening statement that reoffered the President's $124 billion, which led to the analysis of the inadequacy of that plan. I never offered our plan as the solution to the current problem. We thought it met the old problem. I am sobered by the fact that you talked about it being so extreme. It may not cover the numbers that we are now dealing with.

We have a real problem, and I have asked the President to step forward in the mode of nonpolitical leadership to address this problem. For us to lob political grenades back and forth over our old plans doesn't advance this one whit, in my opinion, toward solving this increased problem.

Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

I apologize if I am repeating simply because I wasn't here earlier.

Just in general terms, because of the political situation that we are in on Capitol Hill with the Presidential election year, I have two questions. One is, let us just say that we are not able to come to an agreement with the President this year and we have to wait until next year. How much more severe do the changes have to be each year you put this off?

In other words, we may not come to an agreement this year, but there is no guarantee there would be agreement next year. There is no guarantee there would be agreement the year after that or the year after that. The bottom line is, what happens if we get to the year 2001 and we are bankrupt? What are our options at that point?

Mr. VAN DE WATER. If you did not take any steps before that date, you would be left with much more draconian solutions, namely, even sharper reductions in benefits or—dare I say it—greater increases in payroll taxes than what you would have had, had you started to take steps earlier.

Alternatively, if those increases are so large as to seem politically unpalatable, which might well be the case, one could well imagine that there would be pressures for general revenue financing or some other approach that would avoid those tough choices.

Mr. ENSIGN. It sounds like to me that if we don't have the courage to make the tough political votes today, the solutions that are available to us are not solutions that would be available to us, simply because, politically, solutions have to be political as well as meeting within the systems that you have, and while the politics of today are very difficult, as they were last year, it still seems to me that they are easier this year than they will be 3 years from now or 4 years from now or 5 years from now.

I think that is, as a matter of fact, what Chairman Thomas is talking about. The longer that we wait, the more we let politics get in the way of saving Medicare, the more difficult that it will be to save Medicare, if not impossible.

Mr. VAN DE WATER. If you start now, you can deal with the problem simply through slowing the rate of growth in the program. If you actually waited until 2001, however, then you are faced with the choice of reducing the absolute level of spending below what it was in the previous year, which is clearly quite a different matter.

Mr. ENSIGN. Just real briefly, in science there is something known as error bars, and I know yours is not an exact science, but, percentagewise, what are your errors bars on your estimates on, say, the amount of the trust fund? It is now, what, $332 billion in deficit in 2005? Is that the projection?

Mr. VAN DE WATER. That is the projection.

Mr. ENSIGN. What would be your error bars on that, plus or minus what percent?

Mr. VAN DE WATER. We don't know enough to have a statistical model that would allow us to develop error bars in any sophisticated way, but you can see simply by the fact that that number has changed by $100 billion over the past 13 months that the error bar is extremely large. As Mr. Thomas said, we hope that we are not going to be bringing still more bad news of this sort next year at this time, but if it has happened once, it could happen again.

Alternatively, if the rate of growth of spending were to slow even slightly, as some people project, we could come back next year and say that it looks as if we had a bit of a false alarm. But the error bars are extremely large when you are talking about projections 10 years away.

Mr. CHRISTENSEN. Would the gentleman yield?

Mr. ENSIGN. Certainly.

Mr. CHRISTENSEN. In 1965, when the program was started, the CBO or some actuary projected that in 1992, it would cost $9 billion. The error bars were a little off because it cost $175 billion. I hope your error bars are better than your 1965 predecessor's.

Mr. VAN DE WATER. That is one of those statements that is easily disproved because CBO wasn't created until 1974.

Mr. CHRISTENSEN. Whatever.

Mr. VAN DE WATER. I believe you are referring to the actuary's projections, but we face the same issues that they do. I should say on their behalf that a lot of the change has to do with the differences in the projected rates of inflation because, in the midsixties, the rapid rates of inflation during the following 15 years were not expected.

Mr. CHRISTENSEN. Hopefully, you are closer.

Mr. VAN DE WATER. You are absolutely right. That is an illustration of how far things can go awry.

Mr. ENSIGN. Just real briefly on my remaining time, on these projections and the closer that we get to the destruction day of Medicare, just briefly your comments. You have been around here for a while. Do you think that we can sit down in this type of a political atmosphere? I am asking you not as a statistician now, but more as somebody who is an observer of the process.

Mr. VAN DE WATER. That is probably a question I shouldn't even attempt to answer, but I will cite an example.

You will remember that in the early eighties, this same situation that is now looming in the Hospital Insurance Trust Fund was facing the Old-Age and Survivors Insurance Program. The Social Security Program itself was projected to run out of money. D-day was looming within just a few months.

Ultimately, the so-called Greenspan commission was appointed, and that group was able to work with both sides of the Congress to work out a solution that was put into place. Now, of course, the Social Security Trust Fund is projected to be solvent not for 75 years, but well beyond the projected date of insolvency of the Hospital Insurance Program. So I think that that experience does provide a model of the kind of solution that could be worked out.

Mr. ENSIGN. I hope you are right.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

Paul, I would only say that if you come back in a few months and say that it is a false alarm, what you really mean to say is that the indicators that you assumed were going to continue have changed, and as a matter of fact, that would be the final request.

If you can, to the best of your ability, break out for us what you think the cost factors are. For example, I know that the number of new beneficiaries is a fairly constant number. The hospital admissions is the one that is puzzling us; not the fact that it has gone up, that is a fact. Why is the thing that concerns us. If we are going to try to work together on a bipartisan basis, we need to know what it is we are working on.

So, to the best of your ability, if there are macroeconomic indicators that have shifted as well, at least we would like to know that. So, if you would, to the best of your ability, give that to us, I would love to have them weighted in terms of the most significant to the least significant shift that has occurred between last year and this year. That would give us an indication of where the gremlins are.

Mr. VAN DE WATER. Yes, Mr. Chairman.

[The following was subsequently received:]

CBO April 1996 Baseline: MEDICARE

17-Apr

Outlays by fiscal year, in billions of dollars

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
PART A: HOSPITAL INSURANCE (HI)												
TOTAL HI OUTLAYS /1	114.9	127.1	139.3	151.8	164.2	177.0	190.4	204.5	219.7	236.6	255.0	275.2
Annual Growth Rate		10.7%	9.5%	9.0%	8.2%	7.8%	7.6%	7.4%	7.5%	7.7%	7.7%	7.9%
TOTAL HI MANDATORY /2	113.6	126.0	138.0	150.5	162.9	175.6	189.0	203.0	218.2	235.0	253.2	273.4
TOTAL HI BENEFITS /3	113.4	125.7	137.8	150.2	162.6	175.3	188.7	202.6	217.8	234.6	252.9	273.0
Annual Growth Rate		10.8%	9.6%	9.1%	8.2%	7.8%	7.6%	7.4%	7.5%	7.7%	7.8%	8.0%
Hospitals	79.8	84.1	88.5	93.7	99.2	104.7	110.1	115.3	120.8	126.6	132.5	138.6
Annual Growth Rate		5.4%	5.2%	5.9%	6.0%	5.5%	5.2%	4.7%	4.7%	4.8%	4.7%	4.7%
HMOs	7.7	10.5	13.6	16.9	19.9	23.3	27.3	31.9	37.3	43.6	51.0	59.7
Annual Growth Rate		36.5%	29.9%	24.0%	17.7%	17.2%	17.0%	16.8%	16.9%	17.0%	17.1%	17.0%
Hospice	1.9	2.5	3.1	3.7	4.2	4.7	5.2	5.7	6.2	6.7	7.3	7.9
Annual Growth Rate		32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%	8.5%	8.5%	8.5%	8.5%
Home Health	14.9	17.5	20.1	22.5	24.6	26.7	28.9	31.3	33.8	36.5	39.4	42.4
Annual Growth Rate		17.7%	15.0%	11.7%	9.3%	8.6%	8.4%	8.2%	8.1%	8.0%	7.8%	7.8%
Skilled Nursing Facilities	9.1	11.0	12.4	13.6	14.7	16.0	17.3	18.6	20.0	21.4	22.9	24.6
Annual Growth Rate		20.6%	12.9%	9.3%	8.5%	8.4%	8.1%	7.7%	7.4%	7.3%	7.1%	7.1%
PART B: SUPPLEMENTARY MEDICAL INSURANCE (SMI)												
TOTAL SMI OUTLAYS /1	65.2	71.9	79.3	87.8	96.5	106.0	116.4	127.9	141.3	156.5	173.4	192.4
Annual Growth Rate		10.2%	10.4%	10.7%	9.9%	9.8%	9.8%	9.9%	10.5%	10.8%	10.9%	10.9%
TOTAL SMI BENEFITS /3	63.5	70.1	77.5	85.9	94.5	103.9	114.2	125.6	138.8	153.9	170.8	189.6
Annual Growth Rate		10.4%	10.5%	10.9%	10.0%	9.9%	9.9%	10.0%	10.6%	10.9%	11.0%	11.0%
Benefits paid by Carriers /4	41.7	44.6	47.6	51.3	54.8	58.3	61.9	65.6	69.9	74.8	80.1	85.7
Annual Growth Rate		6.9%	6.9%	7.6%	6.8%	6.4%	6.2%	5.9%	6.6%	7.0%	7.1%	7.1%
Physician Fee Schedule	33.0	35.1	37.0	39.3	41.3	43.1	44.8	46.3	48.3	50.7	53.4	56.2
Annual Growth Rate		6.2%	5.6%	6.2%	5.0%	4.4%	4.0%	3.4%	4.3%	5.0%	5.2%	5.3%
Benefits paid by Intermediaries /5	15.4	17.3	19.4	21.9	24.6	27.7	31.2	35.0	39.1	43.4	47.9	52.7
Annual Growth Rate		12.5%	12.4%	12.4%	12.7%	12.6%	12.4%	12.2%	11.7%	11.1%	10.4%	9.9%
Group Plans	6.4	8.2	10.4	12.8	15.2	17.9	21.2	25.1	30.0	35.9	42.9	51.4
Annual Growth Rate		28.0%	26.6%	23.0%	18.6%	18.1%	18.3%	18.5%	19.4%	19.6%	19.7%	19.6%

1/ Includes discretionary administration.
2/ Includes mandatory administration.
3/ Includes the impact of PL 104-121, enacted on March 29, 1996. This impact is not distributed to the components of Medicare benefits.
4/ Includes all services paid under the physician fee schedule, durable medical equipment, independent and physician in-office lab services, ambulance services paid by carriers, and other services.
5/ Includes outpatient hospital services, lab. services in hospital outpatient departments, hospital-provided ambulance services and other services.

CBO April 1996 Baseline: MEDICARE

26-Apr

Outlays by fiscal year, in billions of dollars.

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Part A Information:												
HI Trust Fund Income	114.8	119.9	126.0	129.7	134.3	138.8	142.8	147.3	151.4	155.1	159.2	163.0
HI Trust Fund Outlays	114.9	127.1	139.3	151.8	164.2	177.0	190.4	204.5	219.7	236.6	255.0	275.2
HI Trust Fund Surplus	-0.0	-7.2	-13.3	-22.1	-30.0	-38.2	-47.6	-57.1	-68.3	-81.5	-95.8	-112.2
HI Trust Fund Balance (end of year)	129.5	122.3	109.0	86.9	56.9	18.7	-28.9	-86.0	-154.3	-235.8	-331.6	-443.8
Part A FY Enrollment (in millions)	36.9	37.5	38.1	38.6	39.1	39.5	40.0	40.6	41.1	41.7	42.3	43.0
HI Deductible (calendar year, in dollars)	$716	$736	$764	$796	$832	$868	$904	$940	$980	$1,020	$1,064	$1,108
Monthly Premium (calendar year, in dollars)	$261	$289	$311	$334	$356	$378	$402	$426	$451	$480	$510	$538
Premiums collected	$1.0	$1.1	$1.2	$1.4	$1.5	$1.6	$1.7	$1.9	$2.0	$2.2	$2.4	$2.6
PPS Market Basket Increase	3.6%	3.5%	3.3%	3.5%	3.5%	3.4%	3.4%	3.3%	3.4%	3.4%	3.4%	3.4%
PPS Update Factor (average)	1.9%	1.5%	2.8%	3.5%	3.5%	3.4%	3.4%	3.3%	3.4%	3.4%	3.4%	3.4%
Part A Hospital Inpatient Payments:												
PPS Hospitals	69.2	72.6	75.5	78.7	82.3	86.0	89.5	92.9	96.3	99.9	103.4	107.2
Non-PPS Hospitals/Units	10.6	11.5	13.0	14.9	16.9	18.6	20.6	22.4	24.4	26.7	29.0	31.5
Disproportionate Share Payments	3.9	4.6	4.8	5.0	5.2	5.4	5.6	5.8	6.0	6.3	6.5	6.7
Indirect Medical Ed. Payments (for patient care)	4.9	5.2	5.5	5.8	6.3	6.7	7.2	7.7	8.2	8.8	9.3	9.9
Inpatient Capital Payments	7.9	9.6	10.4	11.1	11.8	12.6	13.0	13.3	13.7	14.1	14.4	14.8
Part A and Part B Hospital Inpatient Payments:												
Direct Medical Ed. Payments (for teaching program	2.3	2.4	2.5	2.6	2.7	2.9	3.0	3.1	3.3	3.4	3.6	3.7
Part B Information: (in calendar years, except as noted)												
Deductible (in dollars)	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100
MEI percentage change	2.1%	2.0%	2.2%	2.1%	2.0%	2.0%	1.8%	1.8%	1.9%	1.8%	1.7%	1.7%
Physician Update (weighted average)	7.4%	0.4%	1.2%	0.0%	-3.0%	-2.6%	-3.2%	-2.9%	-0.6%	0.0%	1.2%	1.7%
Conversion Factor	$36.11	$36.28	$36.75	$36.74	$35.65	$34.75	$33.66	$32.68	$32.49	$32.51	$32.91	$33.50
Primary Care Update	7.9%	-2.7%	2.5%	7.2%	-3.0%	-1.0%	-3.2%	-3.2%	-0.5%	-0.5%	1.5%	2.5%
Conversion Factor	$36.38	$35.42	$36.31	$38.93	$37.77	$37.40	$36.22	$35.08	$34.89	$34.71	$35.24	$36.13
Surgical Update	12.2%	3.4%	2.2%	-2.9%	-3.0%	-3.0%	-3.2%	-3.1%	-0.6%	0.7%	1.7%	2.2%
Surgery Conversion Factor	$39.45	$40.80	$41.68	$40.48	$39.27	$38.07	$36.87	$35.73	$35.52	$35.76	$36.37	$37.15
Anesthesia Conversion Factor	$14.77	$15.28	$15.61	$15.16	$14.71	$14.26	$13.81	$13.38	$13.31	$13.39	$13.62	$13.92
Other Physician Update	5.2%	0.0%	0.3%	-1.3%	-3.0%	-3.0%	-3.2%	-2.7%	-0.6%	-0.0%	0.9%	1.2%
Conversion Factor	$34.62	$34.63	$34.74	$34.30	$33.28	$32.26	$31.24	$30.39	$30.21	$30.21	$30.47	$30.84
Laboratory Update	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
DME Update	3.2%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
P+O Update	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
ASC Update	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
Monthly Premium (in dollars)	$46.10	$42.50	$44.40	$48.70	$50.20	$51.70	$53.20	$54.70	$56.30	$58.00	$59.70	$61.50
SMI Premium Receipts (fiscal years, in billions) /1	19.2	18.8	19.4	21.2	22.5	23.5	24.5	25.5	26.6	27.8	28.7	29.5
Fiscal Year Enrollment (in millions)	35.5	36.0	36.5	36.9	37.3	37.7	38.2	38.6	39.0	39.5	40.0	40.6

1/ Includes the impact of PL 104-121, enacted on March 29, 1996.

CBO April 1996 Baseline: MEDICARE

17-Apr

Outlays by fiscal year, in billions of dollars.

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
RISK HMO SPENDING AND ENROLLMENT												
Part A Risk HMO Outlays (FY)	7.7	10.5	13.6	16.9	19.9	23.3	27.3	31.9	37.3	43.6	51.0	59.7
Part B Risk HMO Outlays (FY)	5.4	7.3	9.5	11.9	14.3	17.1	20.4	24.3	29.2	35.1	42.2	50.7
Total	13.1	17.8	23.2	28.8	34.2	40.4	47.7	56.2	66.5	78.7	93.2	110.3
Part A Risk HMO Outlays (CY)	8.4	11.3	14.5	17.7	20.8	24.3	28.4	33.2	38.8	45.4	53.2	62.2
Part B Risk HMO Outlays (CY)	5.9	7.8	10.1	12.5	14.9	17.8	21.3	25.4	30.5	36.7	44.1	52.9
Total	14.3	19.1	24.6	30.2	35.7	42.1	49.7	58.6	69.4	82.1	97.3	115.1
Part A Enrollment (FY)	36.9	37.5	38.1	38.6	39.1	39.5	40.0	40.6	41.1	41.7	42.3	43.0
Part A Enrollment (CY)	37.1	37.7	38.2	38.7	39.2	39.7	40.2	40.7	41.2	41.8	42.4	43.1
FY Risk HMO enrollment March '96 baseline	2.7	3.4	4.1	4.7	5.1	5.7	6.2	6.8	7.5	8.3	9.1	10.0
Year to Year Change		25.0%	20.0%	15.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
CY Risk HMO enrollment	2.9	3.6	4.2	4.8	5.3	5.8	6.4	7.0	7.7	8.5	9.3	10.3
Year to Year Change		23.6%	18.6%	13.6%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Memo: FY HMO penetration rate /1	7.3%	9.0%	10.7%	12.1%	13.2%	14.3%	15.5%	16.9%	18.3%	19.9%	21.6%	23.3%
Memo: CY HMO penetration rate /1	7.8%	9.4%	11.0%	12.4%	13.4%	14.6%	15.9%	17.2%	18.7%	20.3%	22.0%	23.8%

1/ Risk HMO enrollment as a percent of Part A enrollment

Chairman THOMAS. Thank you very much.

It is now my pleasure to ask the new Chairman of the Prospective Payment Assessment Commission, Dr. Joseph P. Newhouse, accompanied by a familiar face, Dr. Don Young.

This is, I guess, the second Chairman of ProPAC. The first Chairman, Dr. Stuart Altman, was Chairman for 13 years, but he is back at Brandeis University. We certainly are grateful for the 13 years of Dr. Altman's service.

I would tell you, Dr. Newhouse, I hope that doesn't mean that you are being condemned to a 13-year sentence. Hopefully, we will get some good years out of you.

As the Republican Chairman of the Subcommittee, I have to indicate that notwithstanding the educational background of Dr. Newhouse, both undergraduate and graduate work at Harvard, he does partially redeem himself by two decades in Santa Monica at the Rand Institute.

It is a pleasure to have you with us. Your written testimony will be made a part of the record. It is extensive. There are a number of excellent charts that are associated with it, as alluded to by Dr. Van de Water, and you may inform us in any way you see fit. If you feel it is appropriate to refer to a chart, I think it is worth the time of the Members to turn to that chart and begin to look at it.

Joining us at the table is Dr. Gail Wilensky of the Physician Payment Review Commission. If you will allow me, Dr. Wilensky, although it is probably more comfortable there, I would like to get through ProPAC, and then we would turn to PPRC, notwithstanding some of the similarities in the testimony.

Dr. Newhouse.

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; ACCOMPANIED BY DON YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. NEWHOUSE. Thank you very much, Mr. Chairman. I am very pleased to be here in my maiden voyage. I am accompanied by Dr. Donald Young, the Executive Director.

On March 1, the Commission submitted to the Congress its eleventh annual report containing recommendations for improvements to the Medicare Program. I am going to comment briefly on certain of these recommendations today, and I should say, however, that they were developed by the Commission before I became Chairman.

The Commission supports the efforts of this Committee to rein in the growth of Medicare spending. ProPAC believes spending for medical services in a private sector with market forces that encourage cost containment and high quality care provides a benchmark for the Medicare Program.

Judgments regarding the appropriate spending levels and rate of increase, however, should be based on several years experience to account for short-term factors that may give a misleading picture of the overall trends.

Indeed, the ability to compare and forecast Medicare and private sector spending is a complicated task, with a lot of data limitations. We are continuing to examine the available data and will present

more on this issue in our June report to Congress, "Medicare and the American Health Care System."

The changes that are occurring in the private sector financing of care are having a substantial effect on the way hospitals and other providers operate. ProPAC has been following closely the factors contributing to the growth of total hospital expenses, and we depict some of those in chart 2 which Dr. Van de Water also referred to.

Two of the factors shown there, general inflation and population growth, of course, are outside a hospital's control. They do have some control over real input prices, and they have some control over utilization of services, that is, the number of admissions and outpatient visits.

Between 1985 and 1992, over half of the cost growth was due to increases in the intensity of services furnished to inpatients and outpatients. That is over in the far right end of the chart. During this time, changes in hospital utilization, that is, admissions and outpatient visits, had little effect on total cost growth. However, after 1992, up through 1995, there is a dramatic change in this picture. The number of hospital outpatient visits continued to grow and admission rates began to climb, as you noted.

The most striking finding, however, is on the right. It is the virtual absence of any increase in the intensity of services to those people who were admitted. Consequently, total spending rose due to general inflation and increases in the number of people receiving care, but as I am going to come to momentarily, the growth in the cost to provide services to each patient slowed dramatically.

We believe that this slowing in cost, overall cost, is a response to the recent financial pressure from private payers, and in addition, much of the increase in utilization is due to an acceleration in admission rates for Medicare beneficiaries rather than private patients.

Let me turn to the capitation program. ProPAC strongly supports your efforts, Mr. Chairman, to control spending by reforming the Medicare capitation program and expanding beneficiary choice.

A major flaw in the current risk contracting program is the wide variability and volatility in payment rates across the country, which are shown in chart 4. Those are deciles of the AAPCC across all counties in the country.

In many areas the lower rates may discourage plan participation. The Commission supports your intent to reduce this variability. We are concerned, however, that even with the modifications you proposed, the rates may not accurately reflect appropriate cost of care in many areas. We believe over time the rates should better reflect the evolution of market forces that are occurring in each area.

There is another problem with Medicare's capitation program that you are aware of. Indeed, it has already come up today, and it must be resolved if the program is to succeed, and that is the lack of adequate risk adjustment methods to modify capitation payments. Effective risk adjustment is necessary to prevent unwarranted financial rewards and penalties to plans and incentives to avoid Medicare enrollees with chronic illnesses.

As you have said, the knowledge base in this area continues to be limited. We believe the Secretary should use available information to make modest improvements while vigorously supporting

further research. Other approaches to limit risk selection are also necessary, such as the improvements in enrollment and disenrollment policies you proposed.

I see the yellow light is on.

Chairman THOMAS. I will tell the gentleman that you are in Washington, DC, and no one pays attention to the yellow light or the red light.

Mr. NEWHOUSE. I see. I thought it was only in Boston that people don't pay attention to the traffic lights.

Chairman THOMAS. Don't pay any attention to it, and you will feel very comfortable here in the District.

Mr. NEWHOUSE. Thank you, sir.

When ProPAC appeared before you in September 1995, we noted the dramatic decline in hospital cost growth which began in the early nineties. That trend of lower cost growth continues.

If you look at chart 6, from 1984, the first year of PPS through 1990, Medicare PPS operating cost per discharge increased at an annual rate of 9 percent. Since then, it has moderated substantially and actually turned negative in the eleventh year of prospective payment, and as a result of that, margins have increased, as shown on the next chart, chart 7.

The Commission considered the decline in hospital cost growth as it developed its recommendation for fiscal year 1997 on the amount of the update. The framework that the Commission has used over time supports an update of about market basket minus 1.5 percentage points in fiscal year 1997.

In light of the significant changes occurring in health care delivery, including the recent gains in hospital productivity, it may be possible to hold PPS payment rate increases to an even lower level for the next few years, but we are concerned about the ability of hospitals to continue to provide high quality care if updates are constrained at this level through 2002.

It is unclear how long hospitals are going to be able to maintain the large productivity improvements we have seen in recent years. ProPAC plans to monitor these trends closely, and we will keep you informed.

I think I will skip over my comments on teaching and disproportionate share hospitals.

I will note, as you have already noted, that post-acute care has been an area of extremely rapid growth. We support your efforts there to control spending by moving to prospective systems that are at the episode level.

Outpatient hospital services have also grown substantially, and we support a prospective payment system that is consistent across all payers with volume control methods. We believe also that the growing financial burden on enrollees who receive services in hospital outpatient departments should be alleviated, should be limited to 20 percent of the Medicare-allowed payment, as in other settings, and are proposing to finance that, in part, by correcting flaws in the hospital outpatient payment formula.

That summarizes my formal statement, Mr. Chairman, and I will be pleased to answer questions, as you would like.

[The prepared statement and attachments follow:]

STATEMENT OF JOSEPH P. NEWHOUSE
CHAIRMAN
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good Morning, Mr. Chairman. I am Joseph Newhouse, and I am pleased to be here for the first time as Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Dr. Donald Young, the Executive Director of ProPAC. On March 1st, the Commission submitted to the Congress its eleventh annual report containing recommendations for improvements to the Medicare program. This morning, I am briefly going to discuss these recommendations, which were developed by the Commission before I became Chairman. During my testimony, I will refer to several charts. These charts are appended to the end of my testimony.

Since 1965, the Medicare program has provided financial protection from the high costs of illness to individuals age 65 and over and, beginning in 1972, to many disabled people, as well as those with end-stage renal disease. This protection for the elderly and disabled, however, has come at a substantial cost to the Federal government and taxpayers and to many Medicare beneficiaries. Medicare program spending climbed from $4.8 billion in 1967 to an estimated $177 billion in 1995. This rapid rise in expenditures is contributing to the Federal deficit, threatening the solvency of the Hospital Insurance Trust Fund, and is a growing burden to Medicare beneficiaries, who share in the costs of the program.

SLOWING MEDICARE SPENDING GROWTH

The Commission supports the efforts of this Committee to rein in the growth in Medicare expenditures. ProPAC believes spending for medical services in a private sector with market forces that encourage cost containment and high quality care provides a benchmark for the Medicare program. Judgments regarding appropriate spending levels and rates of increase, however, should be based on several years' experience to account for short-term factors that may give a misleading picture of the trends. In addition, spending growth should be compared on a per person basis. It also is important to recognize that the proportion of Medicare enrollees who are disabled or who have end-stage renal disease is increasing faster than the elderly population. The added costs of caring for these people, who require a larger amount of services than the elderly, must also be considered.

The ability to compare and forecast Medicare and private sector spending is a complex task, complicated by substantial data limitations. ProPAC continues to examine available data and methods to assess spending trends, and we will present more on this issue in our report to Congress on *Medicare and the America Health Care System*, which we will submit to you in June.

In the decade beginning in the early 1980s, real Medicare spending per capita (removing the effects of inflation) grew much more slowly than real per capita private insurance expenditures (See Chart 1). More recently, the private sector has outperformed Medicare.

The changes that are occurring in the private sector financing of care are having a substantial effect on the way hospitals and other providers operate. ProPAC has been following closely the factors that contribute to the growth of total hospital expenses (See Chart 2). Two of these factors, general inflation and population growth, cannot be controlled by hospitals. Hospitals have some control over real input prices, which reflect hospital cost inflation above that in the general economy. The utilization of services, that is the number of admissions and outpatient visits, and the intensity and complexity of the care furnished to those who are served, however, can be controlled by hospitals.

Between 1985 and 1992, over half of the growth in hospital costs was due to increases in the intensity of the services furnished to inpatients and outpatients. During this time, changes in hospital utilization had little effect on total cost growth as the overall use of hospital services increased at about the same rate as population growth. From 1992 to 1995, the picture changed dramatically. The number of hospital outpatient visits continued to grow and admission rates began to climb. The most striking finding, however, is the virtual absence of increases in the intensity of services furnished to those who were provided care. Consequently, total hospital costs rose due to general inflation and to increases in the number of people receiving care. But as I will discuss in a few minutes, growth in the costs to provide services to each patient slowed dramatically. We believe that this slowing in the rise of per case

hospital expenses is a response to recent financial pressure from private payers. In addition, much of the increase in utilization is due to a recent acceleration in admission rates for Medicare beneficiaries, rather than private patients.

Increases in the utilization of hospital and other services is responsible for much of the growth in Medicare spending. Constraining the rise in spending is complicated by Medicare's continued reliance on fee-for-service (FFS) payment methods. About 90 percent of Medicare beneficiaries continue to be covered by the traditional FFS program, although enrollment in the risk-based capitation program is growing rapidly (See Chart 3). As of April 1, 1996, there are 202 plans with risk contracts, and applications are pending from another 50 plans.

IMPROVING MEDICARE'S CAPITATION PROGRAM

The Commission strongly supports your efforts, Mr. Chairman, to control spending by reforming the Medicare capitation program and expanding beneficiary choice of health plans. A major flaw in Medicare's current risk contracting program is the wide variability and volatility in payment rates across the country (See Chart 4). In many areas, these rates may discourage plan participation. The variability also results in some Medicare beneficiaries receiving substantial extra benefits that are not available to other beneficiaries. The Commission supports your intent to reduce this variability. We are concerned, however, that even with the modifications you have proposed, the rates may not accurately reflect appropriate costs of care in many areas. We believe that, over time, the rates should better reflect the evolution of market forces that are occurring in each area.

There is another problem with Medicare's capitation program that you are aware of and that must be resolved if the program is to succeed. This is the lack of adequate risk adjustment methods to modify capitation payments to better reflect variations in Medicare enrollees' likely need for medical care. Effective risk adjustment of payments is necessary to prevent unwarranted financial rewards and penalties to plans and incentives to avoid Medicare enrollees with chronic illnesses. It is equally important to ensure that funds are allocated fairly to meet the medical needs of Medicare's beneficiaries enrolled in both the capitation and the fee-for-service programs.

The need to adjust capitated payment rates to reflect the medical condition and service needs of the enrolled population is more important for the Medicare population than for private sector. Medicare beneficiaries are much more likely to have illnesses and disabilities that require costly care. Further, many of these conditions are chronic and easily identifiable.

While the knowledge base in this area continues to be limited, we believe the Secretary should obtain and use available information to make modest improvements in risk adjustment, while vigorously supporting further research. Other approaches to limit risk selection also are necessary, such as the improvements in enrollment and disenrollment policies you included in your proposal.

The lack of good risk adjustment tools also may result in excess Medicare spending for the high deductible medical savings account (MSA) option proposed by the Congress, if healthier beneficiaries select this choice as expected. This undesirable effect could be lessened if Medicare enrollees were required to remain in the MSA option for several years. This option also represents a substantial departure from traditional Medicare policies, and the Commission believes that experience with MSAs should be monitored closely. It is likely that policy modifications will be necessary over time to meet the needs of the Medicare program and its beneficiaries.

As I noted earlier, the Commission strongly supports your intention to offer Medicare beneficiaries a wider choice of capitation and managed care options. The lack of a full range of capitation plans and options and flaws in current policies all have undoubtedly contributed to plan participation and enrollment lagging behind that in the private sector. It is important to recognize, however, that private sector managed care has grown, in part, because many employers no longer offer the choice of a traditional indemnity FFS plan, as Medicare does (See Chart 5). Further, many

Medicare beneficiaries are very comfortable with this traditional program and would be very reluctant to forego this choice. Additional factors, therefore, may also be contributing to the lags in Medicare capitation plan enrollment.

To assist beneficiaries in making the choices that meet their needs, the Commission believes that the Medicare program should expand the information it makes available to them, including clear information on plan benefits, premiums and other cost-sharing requirements, plan performance, and the availability of local providers. In addition, the Secretary needs to continue efforts to identify the information beneficiaries need to make informed health plan choices and the most appropriate format and methods for disseminating these data.

Assuring that Medicare beneficiaries make informed decisions is especially important with the MSA option and the MedicarePlus fee-for-service option. Although these options may be very attractive to some beneficiaries, they also contain the risk of substantial increases in out-of-pocket spending. ProPAC is concerned that some beneficiaries may choose these options without being fully aware of their implications.

A capitation payment system intentionally provides health plans with an incentive to limit the type and number of services delivered. While this is generally desirable as a means to control spending, health plans must be held accountable for the quality of care they provide. In the private insurance market, employers act as an agent for their employees by selecting health plans that will meet their contractual responsibilities and provide access to needed high quality care. The Commission believes that the Medicare program also needs to be vigilant in ensuring that plans meet their responsibilities to provide appropriate care. To do so, measures of health plan performance need to be strengthened and enforced.

THE MEDICARE FEE-FOR-SERVICE PROGRAM

I would like to turn now to a brief summary of ProPAC's recommendations regarding policies in Medicare's traditional fee-for-service program. This program continues to be responsible for about 90 percent of total Medicare spending, and it will continue to provide the funding for the care furnished to a majority of beneficiaries for many years to come. It is important, therefore, that you continue to analyze and appropriately modify these policies to rein in spending growth, while assuring quality care for Medicare's beneficiaries.

INPATIENT HOSPITAL COSTS AND PAYMENTS

When ProPAC appeared before you in September 1995, we noted the dramatic decline in hospital cost growth, which began in the early 1990s. That trend of lower cost growth continues today. From 1984 (the first year of PPS) through 1990, Medicare PPS operating costs per discharge increased at an average annual rate of 9.4 percent (See column 3 in Chart 6). This increase was substantially higher than the growth in PPS payments per case. Consequently, by 1990 PPS inpatient margins, the difference between operating and capital payments and costs as a percentage of payments, had become negative (See Chart 7). Hospital per case cost increases then began to moderate, and in 1993 the average PPS margin again turned positive. In 1994, PPS inpatient costs per case declined by 1.3 percent. We estimate that the average PPS margin will climb to 8.8 percent in 1996, if current trends hold.

This decline in hospital cost growth reflects a dramatic change in the pattern of cost shifting we have previously described to you. In 1992, Medicare's total hospital payments (for the operating and capital costs of inpatient, outpatient, and hospital-based SNF and home health services) covered 89 percent of hospitals' reported costs. In contrast, payments from private payers were 131 percent of costs. By 1994, Medicare's payments had climbed to 97 percent of costs while those from private payers had fallen to 124 per percent (See Chart 8). Based on preliminary data for 1995, we believe that the gap in payment to cost ratios between Medicare and private payers will continue to narrow. The narrowing of the difference in payment to cost ratios reflects the success of private payers in slowing the rise in hospital payments, as well as the slower cost growth resulting from the increased pressure on revenues.

PPS Update

The Commission considered this decline in hospital cost growth as it developed its fiscal year 1997 update recommendation for hospitals paid under Medicare's prospective payment system. The approach we used is the same one we have used over the years. This method accounts for the effects of inflation on hospital costs, changes in the mix and complexity of admissions, added costs of new technology, and hospital productivity improvements. ProPAC's framework supports an update of about market basket minus 1.5 percentage points in fiscal year 1997. In light of the significant changes occurring in health care delivery, including the recent substantial gains in hospital productivity, it may be possible to hold PPS payment rate increases to an even lower level for the next couple of years.

We are concerned, however, about the ability of hospitals to continue to provide high quality care if updates are constrained at this level through 2002. It is unclear how long hospitals will be able to maintain the large productivity improvements we have seen in recent years. ProPAC plans to continue to monitor these trends closely, and we will keep you informed as the findings emerge.

Payment for Capital

The Medicare program is currently halfway through the transition from cost-based to a fully prospective payment system for hospital inpatient capital. The capital payment rates in effect are based on estimated 1992 hospital capital costs per discharge, updated by historical capital cost increases through 1995, subject to a budget neutrality adjustment. Beginning in 1996, the budget neutrality requirement is eliminated, and an update framework is used to adjust the rates. Because of flaws in the data used to calculate the initial rates, together with the updating approach used by the Secretary, actual capital payment rates increased by more than 20 percent in 1996.

The Congress has proposed continuing to link capital updates to projected costs and extending the budget neutrality requirement through 2002. While this would correct for the inappropriate 1996 payment increase, the Commission believes that a better policy would be to break the link between capital cost increases and the update to capital rates. Under such a system, an appropriate base payment rate would be established with updates based on a formula similar to that applied to PPS operating payments.

Payments to Teaching Hospitals

Medicare pays an additional amount to teaching hospitals to recognize the indirect costs of operating approved graduate medical education programs. In fiscal year 1995, these indirect medical education (IME) payments accounted for 5.9 percent of all PPS operating payments, or about $3.9 billion. In addition, Medicare provided about $2.0 billion to hospitals in graduate medical education (GME) payments for the training of interns and residents. Another $400 million was paid for the direct costs of hospital-based nursing and allied health professions training programs.

The Congress has proposed reductions in the level of Medicare IME and GME payments. It also has supported the creation of a new Teaching Hospital and Graduate Medical Education Trust Fund, which includes Medicare's payments as well as general revenues.

ProPAC supports the notion of the trust fund and believes that explicit financial support for the added costs of graduate medical education should not be limited to the Medicare program. The costs of teaching activities are difficult to separate from the costs of patient care, and these hospitals are at a disadvantage in a competitive market because of higher prices relative to their teaching mission. Many of them also care for a large number of uninsured individuals. As competition among hospitals increases, it will be increasingly difficult for many of these teaching institutions to compete for patients from price-sensitive insurers and plans.

In our report, we raise some concerns about the distribution of teaching-related payments as proposed in the Teaching Hospital and Medical Education Trust Fund.

We recommend that funds to provide broader financial support for graduate medical education should be distributed in a way that corresponds to the additional costs incurred by teaching facilities for treating all of their patients. Under the current proposal, general revenue funds would be distributed based only on Medicare payment levels in a base year. Hospitals with a high share of Medicare teaching payments would receive a proportionately higher share of these new payments, compared to hospitals with the same amount of teaching activity but less Medicare business.

We also believe that improvements are necessary in the distribution of funds from the proposed MedicarePlus Incentive Account. These payments should allow teaching hospitals to compete effectively in the managed care market and allow plans in Medicare's capitation program to use teaching hospitals as needed. As currently structured, the distribution of these payments would not be related to differences in the intensity or size of hospital residency programs. Also, because the total payments available through this account would be fixed, they would not reflect the actual enrollment of Medicare beneficiaries in the capitation program.

ProPAC is continuing to examine alternative approaches for distributing payments from the Trust Fund to hospitals providing care to Medicare beneficiaries who choose the traditional fee-for-service program as well as those enrolled in the capitation program. We will keep you informed as our work progresses.

The Financial Condition of Teaching Hospitals

The Medicare program plays an important role in assuring that its enrollees have access to the specialized care furnished by teaching hospitals. The effects of Medicare's payment policies, and those of other payers, on the financial condition of these hospitals is demonstrated by their PPS and total margins. In 1994 (PPS 11), the average PPS inpatient margin for major teaching hospitals was 15.6 percent, compared with an average of 0.4 percent for non-teaching hospitals (See Chart 9). Despite the profits from Medicare, however, these hospitals had the lowest total margins of any group at 2.5 percent (See Chart 10). In contrast, the average total margin for non-teaching hospitals was 5.7 percent.

The high PPS margin is due in part to the level of the Medicare IME adjustment being greater than the actual relationship between teaching intensity and costs. ProPAC recommends that this adjustment initially should be reduced from its current level of 7.7 percent for each 10 percent change in the number of residents per bed to 7.0 percent. The final level of the adjustment should depend on the other changes made in the Medicare program. We also believe that the current formula for distributing IME payments needs to be improved, and we plan to examine alternative methods to measure teaching intensity and its relationship to costs.

We also support changes in both Medicare IME and GME policies to encourage an appropriate distribution of residents across specialties and to discourage inappropriate growth in the total number of residents.

Disproportionate Share Hospitals

Medicare also provides a special payment to disproportionate share hospitals (DSH). The DSH adjustment is intended to compensate hospitals that treat large proportions of low-income patients. These payments totaled about $3.8 billion in FY 1995.

During the past year, ProPAC spent a considerable amount of effort attempting to improve the distribution of Medicare payments to these hospitals. The distribution of DSH payments is determined partly by each hospital's Medicaid days as a share of total patient days. Medicaid utilization has always been a poor measure of service to low-income individuals, and its effectiveness will continue to diminish with the changes in the Medicaid program that are taking place.

The Commission has concluded that the objectives of the DSH policies need to be reexamined and the structure of the adjustment modified to make certain that available funds are distributed to the hospitals most in need. This may require

collecting new data to provide a better measure of the services hospitals provide to the indigent.

Many of these hospitals also have teaching programs, and their financial status is similar to that of large teaching hospitals. Due to Medicare's policies, large urban disproportionate share hospitals generally have high PPS margins, but their average total margin in 1994 was only 3.3 percent. With increasing numbers of people lacking health insurance and contraction in state and local programs designed to fund care for them, hospitals' uncompensated care burdens will likely be higher than ever in the coming years. Many of the hospitals that treat a large number of the uninsured, also have substantial Medicare and Medicaid patient loads. ProPAC is concerned that large reductions in DSH payments could threaten the continued ability of many of these hospitals to serve the populations that depend on them for access to care.

POST-ACUTE CARE

Payments to post-acute care providers are the fastest growing component of Medicare expenditures. Rehabilitation facilities, long-term care hospitals, skilled nursing facilities, and home health agencies accounted for 22 percent of Medicare Part A spending in 1993, up from about 7 percent in 1986. This increase in expenditures is driven primarily by a dramatic increase in the utilization of services (See Chart 11).

Changes in Medicare's coverage policies account for some of the increased use of post-acute services, but Medicare payment policies also encourage growth in utilization. Medicare's PPS provides incentives for hospitals to reduce lengths of stay by moving patients quickly to post-acute settings. In response to these incentives, many hospitals have moved into the business of furnishing post-acute care. Medicare's policies also have encouraged the increase in the number of free-standing facilities.

Medicare has modified its policies over the years to slow the rise in payment per unit of service furnished. The ability to control the number of services furnished, however, has remained elusive. The overlap of similar services across different types of providers, the lack of a uniform definition of service units, variation in payment policies based on type of provider, and absence of good measures to assess the value and outcome of the services provided all have contributed to the difficulties in correcting the problem.

The Commission strongly supports the implementation of prospective payment systems for post-acute services. The prospective payment should cover all of the services furnished over an appropriate episode of care. Policies that link payment for inpatient hospital care with post-acute care should also be explored. Options to examine include bundling acute and post-acute services for certain DRGs into a single rate and developing DRGs that reflect the use of post-acute services.

Ultimately, it may be possible to implement a single system that could be used across all providers. If this is not feasible, the Commission believes that the payment methods and incentives should be consistent across all delivery sites. HCFA has been sponsoring research and demonstration projects to develop prospective payment systems for post-acute services for a number of years. Despite the similarity in services furnished by these providers, these projects have not been coordinated. In addition, much of their focus has been on per diem or per unit payment techniques. These types of prospective payment systems will do little to control the major problem driving expenditure increases, the growth in service volume.

It is especially important that HCFA coordinate the development of case-mix measures for post-acute services furnished by all types of providers, over an episode of care. Reliable case-mix measurement systems are necessary to account for patient characteristics that affect resource use. Further, they allow for comparisons of service use and expenditures across beneficiaries and across providers.

Interim Improvements in Skilled Nursing Facility and Home Health Policies

The Commission supports the implementation of interim payment methods to control the growth in routine and ancillary services furnished by skilled nursing facilities until a comprehensive prospective payment system is established (See Chart 12). The Commission notes, however, that interim payment limits should be designed that do not unduly restrict this evolving industry. Basing prospective payments on facility-specific or average national base payments has important deficiencies, and the Commission suggests that alternative methods should be explored. These could include calculating payments based on a larger geographic area or using a blend of facility-specific and regional rates to establish the appropriate payment amount.

ProPAC also recommends the use of episode-based payment limits for home health services until a fully prospective payment system can be implemented. Since 1990, the number of visits furnished to each person served has grown rapidly (See Chart 13). In addition, beneficiary copayments, subject to an annual limit, should be introduced. The Commission believes that it is appropriate initially to blend regional and national costs to establish prospective limits. It is concerned, however, that maintaining regional variations in the payment amounts would perpetuate unjustified differences in utilization and expenditures across geographic areas. The Commission, therefore, recommends a transition from regional to national rates, as was used in establishing hospital prospective payment rates.

HOSPITAL OUTPATIENT SERVICES

The Commission continues to recommend that a comprehensive prospective payment system for all hospital outpatient services should be implemented as soon as possible. Because almost all services provided in the hospital outpatient setting can be obtained from other ambulatory providers, consistent payment policies should be established across all settings. To constrain growth in the number of services provided, a strategy for controlling volume is also necessary. Imposing volume controls on hospital outpatient services only, however, could lead to a shift in services to other sites. Ultimately, therefore, volume control methods should apply to all ambulatory providers.

ProPAC also recommends that the growing financial burden for Medicare enrollees who receive services in hospital outpatient departments should be alleviated. Beneficiary coinsurance for these services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, the Secretary could estimate beneficiary copayments since they cannot be calculated precisely when services are delivered.

The Commission is aware, Mr. Chairman, that reducing beneficiary coinsurance would increase Medicare outlays. This increase could be offset in part by correcting current flaws in the hospital outpatient blended rate formula, as the Congress has proposed. If necessary, the reduction in beneficiary liability could be phased in over several years.

UPDATE TO THE COMPOSITE RATE FOR DIALYSIS SERVICES

Medicare spending for end-stage renal disease (ESRD) beneficiaries is growing rapidly. A large part of the increase is due to an expanding ESRD population. But these beneficiaries also are using more acute care, home health, and other dialysis-related services. A comprehensive payment method that includes a broad array of services should be explored. Most ESRD beneficiaries are not eligible to enroll in Medicare's risk program. These individuals should be allowed to enroll in Medicare's expanded capitation program, with suitable payment adjustments, or a separate capitation program should be established.

In the interim, the Commission has concluded that the composite rate for hospital-based dialysis facilities should be updated by 2.7 percent and for free-standing facilities by 2.0 percent. This recommendation is based on our analysis of available Medicare cost report data as well as a comprehensive review of the literature related to quality of care for dialysis patients. Unlike Medicare payments to other providers, the composite rate has not been updated for many years. The Commission

is concerned that many dialysis facilities may not be able to continue to provide quality services without an update to the payment rate. Unfortunately, information is not available to accurately assess the relationship between payments and quality of dialysis care. The Commission, therefore, recommends that the Secretary develop reliable measures to analyze the relationship among treatment processes, patient outcomes, and costs. These factors are critical to evaluate the need for and the level of future payment updates.

THE FAILSAFE BUDGET MECHANISM

As I have described, spending in the fee-for-service program continues to grow rapidly. This program directly pays hospitals, physicians, and other providers for the care they furnish. The more care these providers give, the more they get paid. Consequently, even when Medicare controls the price it pays for each unit of service, spending escalates as the number of services increases.

To assure that fee-for-service spending would not exceed budget targets, the Congress included a "failsafe budget mechanism" in the bill it passed. The failsafe mechanism would allocate a fixed benefit budget (based on the number of enrollees) for both Medicare's capitation and FFS programs. If spending in any of the nine major FFS provider sectors exceeded budget targets, in subsequent years payments to providers in the sector would be reduced to bring spending back in line with the target. This mechanism would ensure that Medicare spending would not exceed the targets set by the Congress.

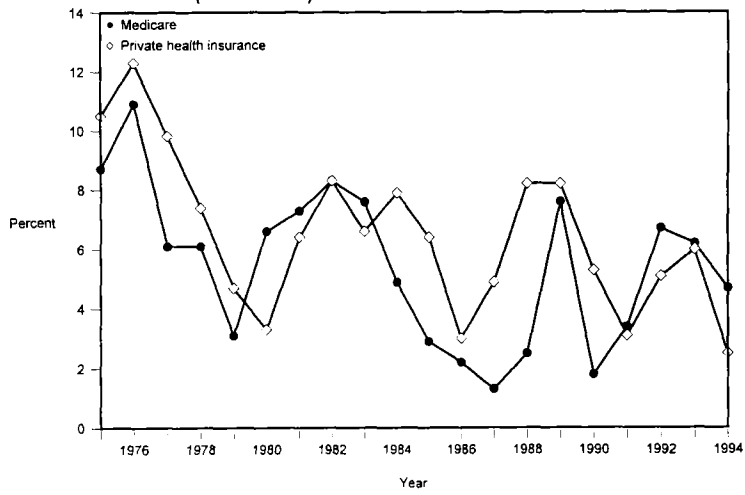
The Commission is concerned, however, that the failsafe mechanism could have unintended consequences. The major problem in allocating a budget between the traditional fee-for-service and capitation programs is the same one I mentioned earlier in regard to the capitation program and that is the lack of robust risk adjustment methods to set capitation payments. The adjustment methods currently used in Medicare's risk contracting program are limited in their ability to account for increases in patient complexity and severity of illness. Thus, if healthier enrollees were to select Medicare's capitation program, per enrollee payments could be high relative to the needs of this population, with payments in the traditional fee-for-service program that are too low.

The Commission also is concerned that there is no provision to adjust the benefit budget if future inflation differs notably from CBO's forecast. Further, the spending allocations across fee-for-service sectors would be determined by projected expenditures based on past spending patterns. This type of failsafe mechanism thus could lead to payment inequities among provider groups as patterns of care continue to change. The Balanced Budget Act recognizes that adjustments to the failsafe mechanism would be needed over time, and ProPAC would be pleased to assist you with the analytic work necessary to ensure payment equity between the capitation and fee-for-service programs in future years.

CONCLUSION

This concludes my formal statement, Mr. Chairman. I realize that I have covered a wide range of complex policies that ProPAC has considered over the past year, and I would be pleased to answer any questions you or the members of the Subcommittee may have. In many cases, as I indicated, we are continuing to work on these issues, and we will keep you and your staff informed of our progress.

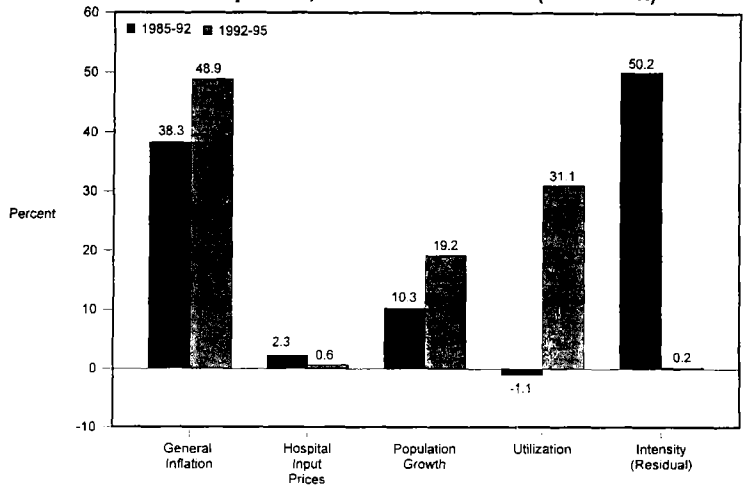
Chart 1. Change in Real Per Capita Medicare and Private Health Insurance Expenditures, 1975-1994 (In Percent)



Note: Expenditures are adjusted using the consumer price index for all urban consumers.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 2. Factors Contributing to the Growth of Total Hospital Expenses, 1985-92 and 1992-95 (In Percent)



SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

Chart 3. Medicare Risk Program Participation, 1990-1996

Year	Enrollees: Number (In Millions)	Enrollees: As a Percentage of Total Medicare Enrollment	Contracts
1990	1.2	3.5%	95
1991	1.3	3.7	85
1992	1.5	4.2	83
1993	1.7	4.7	90
1994	2.1	5.7	109
1995	2.9	7.7	154
1996	—	—	189

Note: Enrollment data are as of September each year; contract data are as of January each year.

SOURCE: Health Care Financing Administration, Office of the Actuary and Office of Managed Care.

Chart 4. Deciles of County AAPCC Values, All Counties, 1995

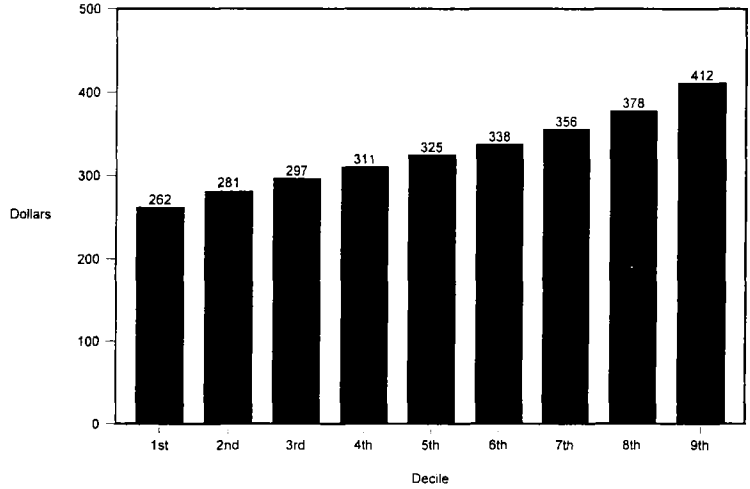
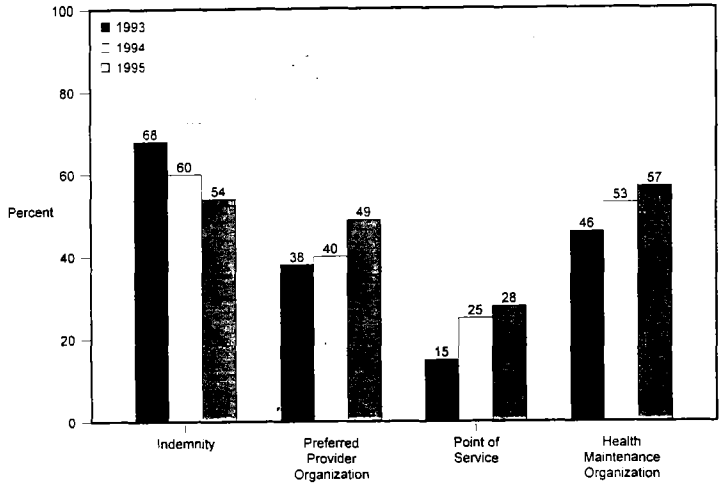


Chart 5. Percentage of Large Employers Offering Selected Health Plans, 1993-1995



Note: Large employers are those with 500 or more employees.

SOURCE: A. Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1995.

Chart 6. Annual Change in PPS Operating Costs and Payments, First 11 Years of PPS (In Percent)

Year	PPS Costs and Payments						Consumer Price Index[2]
	Operating Costs	Payments	Operating Costs Per Case	Payments Per Case	Market Basket Index	Update Factor[1]	
PPS 1	-4.6%	11.0%	1.8%	18.5%	4.9%	4.7%	4.1%
PPS 2	4.7	4.2	11.0	10.5	3.9	4.5	3.7
PPS 3	5.6	-0.5	9.7	3.4	3.9	0.5	2.5
PPS 4	7.4	3.9	8.9	5.3	3.5	1.2	2.9
PPS 5	9.8	6.7	9.0	6.0	4.7	1.5	4.1
PPS 6	10.4	7.7	9.3	6.6	5.5	3.3	4.7
PPS 7	10.5	8.2	8.6	6.3	4.6	4.7	5.0
PPS 8	9.0	8.0	6.9	5.8	4.3	3.4	5.1
PPS 9	7.0	7.3	4.9	5.2	3.1	3.0	3.0
PPS 10	3.5	5.9	1.3	3.6	3.0	2.7	3.1
PPS 11	0.3	5.2	-1.3	3.5	2.4	2.0	2.6

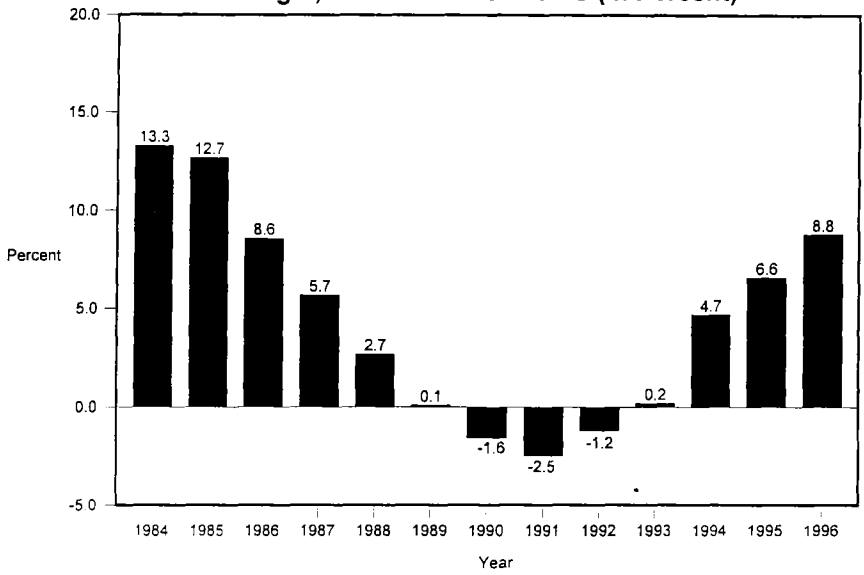
Note: Data on costs, payments, and discharges for each PPS year (PPS 1, etc.) correspond to each hospital's cost reporting period beginning in that Federal fiscal year. For instance, PPS 1 data are from hospitals' cost reports beginning during the first year of PPS (fiscal year 1984). Data on the market basket index, the update factor, and the consumer price index are from the corresponding Federal fiscal year (1984 for PPS 1, etc.). Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York beginning with PPS 3 and New Jersey beginning with PPS 6. Changes are based on cohorts of hospitals with cost reports available in each of two consecutive years.

[1] Average update factor beginning with PPS 5 (fiscal year 1988). Update factor for PPS 7 (fiscal year 1990) adjusted for 1.22 percent across-the-board reduction in diagnosis-related group weights.

[2] Increase in the average consumer price index for all urban consumers for the corresponding Federal fiscal year.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration and the Bureau of Labor Statistics.

Chart 7. Aggregate PPS Inpatient (Operating Plus Capital) Margin, First 13 Years of PPS (In Percent)



Note: PPS margin estimated for 1995 and 1996.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 8. Hospital Payment to Cost Ratios for Medicare, Medicaid, and Private Payers, 1980-1993

	Payment to Cost Ratio		
Year	Medicare	Medicaid	Private
1980	0.96	0.91	1.12
1981	0.97	0.93	1.12
1982	0.96	0.91	1.14
1983	0.97	0.92	1.16
1984	0.98	0.88	1.16
1985	1.01	0.90	1.16
1986	1.01	0.88	1.16
1987	0.98	0.83	1.20
1988	0.94	0.80	1.22
1989	0.91	0.76	1.22
1990	0.89	0.80	1.27
1991	0.88	0.82	1.30
1992	0.89	0.91	1.31
1993	0.89	0.93	1.29
1994	0.97	0.94	1.24

Note: Payments and costs include both inpatient and outpatient services. These ratios cannot be used to compare payment levels, because both the mix of services and the cost per unit of service vary across payers. They do, however, indicate the relative degree to which payments from each payer cover the costs of treating its patients. Due to reporting inconsistencies related to Medicaid disproportionate share payments and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992 and 1993.

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

Chart 9. PPS Inpatient Margin, by Hospital Group, First 11 Years of PPS (In Percent)

Hospital Groups	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8	PPS 9	PPS 10	PPS 11
All hospitals	13.3%	12.7%	8.6%	5.7%	2.7%	0.1%	-1.6%	-2.5%	-1.2%	0.2%	4.7%
Urban	14.3	13.6	9.6	6.6	3.3	0.6	-1.3	-2.3	-1.2	0.4	5.4
Rural	7.7	7.3	2.2	0.2	-1.3	-2.9	-3.8	-3.8	-1.6	-1.0	0.6
Large urban	15.0	13.5	9.8	6.6	3.0	0.4	-0.8	-1.5	0.1	1.9	7.3
Other urban	13.4	13.7	9.3	6.6	3.6	0.9	-2.0	-3.5	-3.2	-1.9	2.3
Rural referral	9.5	12.4	7.9	5.5	3.3	0.5	-1.1	-1.5	1.4	0.6	3.1
Sole community	8.2	6.5	2.0	0.4	-1.3	-2.6	-1.0	-0.6	2.8	4.4	5.5
Other rural	7.0	5.9	0.1	2.0	-3.2	-4.4	-5.8	-5.9	-4.4	-3.8	-2.5
Major teaching	18.1	18.1	14.9	12.5	10.3	7.2	7.1	7.5	8.8	10.1	15.6
Other teaching	14.8	14.6	10.4	7.2	3.8	1.5	-0.9	-2.1	-1.3	0.3	4.8
Non-teaching	11.2	10.0	5.2	2.5	-0.7	3.3	-5.2	-6.4	-5.0	-3.7	0.4
DSH:											
Large urban	15.4	13.7	10.3	8.1	5.7	3.4	3.1	2.9	4.8	7.1	12.8
Other urban	13.4	14.3	10.1	7.9	5.2	2.5	0.1	-1.3	-1.1	0.3	4.4
Rural	8.3	8.7	3.4	0.9	-0.2	-2.4	-3.3	-2.9	-1.2	-1.4	0.7
Non-DSH	12.4	11.6	7.1	3.5	-0.5	-3.1	-5.6	-6.8	-5.6	4.6	-0.6
Teaching and DSH	15.9	15.6	12.1	0.0	7.8	5.3	4.3	3.8	4.8	6.6	11.7
Teaching only	15.3	15.6	11.3	6.7	1.9	-0.7	-3.5	-4.2	-3.2	-2.3	2.0
DSH only	11.5	10.7	6.0	3.6	0.9	-1.6	-3.1	-4.0	-2.4	-0.8	3.5
No teaching or DSH	10.9	9.4	4.5	1.5	-2.0	-4.6	-6.9	-8.5	-7.2	-6.2	-2.2
Voluntary	13.8	13.4	9.4	6.4	3.1	0.7	-1.4	-2.5	-1.4	-0.1	4.1
Proprietary	13.0	11.2	6.6	3.7	0.0	-3.7	-5.4	-4.3	-1.9	1.0	8.7
Urban government	13.0	12.7	8.1	6.2	4.9	1.9	2.2	1.1	1.9	3.7	9.4
Rural government	6.6	4.9	0.8	-2.6	-2.7	-4.1	-4.5	-4.7	-2.9	-2.8	-2.7

Note: Data for each PPS year are from hospital cost reporting periods beginning during that Federal fiscal year. For instance, PPS 1 data are from hospitals' cost reports beginning during the first year of PPS (fiscal year 1984). Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York beginning with PPS 3 and New Jersey beginning with PPS 6.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 10. Total Hospital Margin, by Hospital Group, First 11 Years of PPS (In Percent)

Hospital Group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8	PPS 9	PPS 10	PPS 11
All hospitals	7.1%	6.4%	4.2%	3.5%	3.3%	3.5%	3.5%	4.4%	4.3%	4.3%	4.8%
Urban	7.5	6.7	4.4	3.6	3.4	3.4	3.4	4.3	4.2	4.2	4.7
Rural	4.8	4.5	2.9	2.7	3.2	4.0	4.4	5.0	5.2	5.2	5.5
Large urban	7.2	6.4	3.9	3.1	2.7	2.8	2.3	3.5	3.6	3.6	3.8
Other urban	8.1	7.2	5.3	4.6	4.4	4.6	5.2	5.6	5.3	5.3	6.1
Rural referral	7.5	8.4	6.0	6.0	5.5	6.4	6.8	6.6	6.4	6.4	6.9
Sole community	4.6	3.9	2.3	1.9	2.1	3.1	3.7	5.0	5.2	5.2	5.8
Other rural	4.0	3.5	2.0	1.8	2.7	3.4	3.7	4.4	4.7	4.7	4.7
Major teaching	4.5	5.2	2.1	2.2	2.1	1.7	0.8	3.6	3.3	3.3	2.5
Other teaching	8.2	7.3	5.3	4.3	4.0	4.5	4.2	4.5	4.3	4.3	5.0
Non-teaching	7.3	6.2	4.4	3.6	3.4	3.7	4.2	4.7	4.8	4.8	5.7
DSH:											
Large urban	6.3	5.5	2.9	2.2	1.8	2.1	1.3	2.9	3.1	3.1	3.3
Other urban	8.0	7.1	5.4	4.6	4.5	4.7	5.2	6.0	5.8	5.8	6.4
Rural	5.4	5.7	3.0	3.2	3.6	4.5	5.2	7.0	7.0	7.0	5.8
Non-DSH	7.4	6.8	4.8	4.1	4.0	4.0	4.2	4.5	4.4	4.4	5.0
Teaching and DSH	6.4	5.9	3.4	3.0	2.6	3.0	2.4	3.9	3.8	3.8	3.9
Teaching only	8.7	8.2	5.7	4.7	5.0	4.3	4.2	4.7	4.1	4.1	4.4
DSH only	7.8	6.5	4.5	3.3	3.4	3.5	4.1	5.1	5.2	5.2	6.1
No teaching or DSH	6.8	6.0	4.3	3.7	3.5	3.8	4.3	4.3	4.5	4.5	5.3
Voluntary	7.7	6.9	4.7	3.7	3.6	3.8	3.8	4.2	4.0	4.0	4.6
Proprietary	8.5	7.6	5.4	4.6	3.4	2.7	3.6	5.2	6.2	6.2	8.7
Urban government	3.6	3.8	0.9	2.2	1.9	2.5	1.7	4.5	4.4	4.4	3.2
Rural government	4.5	2.8	1.8	1.1	2.2	3.0	3.5	4.8	5.3	5.3	4.7

Note: Data for each PPS year are from hospital cost reporting periods beginning during that Federal fiscal year. For instance, PPS 1 data are from hospitals' cost reports beginning during the first year of PPS (fiscal year 1984). Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York beginning with PPS 3 and New Jersey beginning with PPS 6. DSH = disproportionate share.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 11. Medicare Utilization for Selected Part A Services, 1986-1993

Year	Admissions Per 1,000 Beneficiaries[a]			Persons Served Per 1,000 Beneficiaries[b]	
	PPS Hospital	Rehabilitation	Long-Term Care	Skilled Nursing	Home Health
1986	316.5	2.9	0.4	9.8	50.9
1987	304.4	3.3	0.4	9.3	49.2
1988	298.7	3.7	0.5	11.9	49.1
1989	288.0	4.0	0.5	19.4	51.3
1990	285.6	5.0	0.5	19.0	57.9
1991	284.7	5.9	0.5	19.6	64.9
1992	285.5	6.6	0.6	22.4	72.1
1993	285.3	7.2	0.7	25.4	80.3
1994	—	—	—	25.9	91.3
1995	—	—	—	26.7	97.4
Percent change					
1986-1993	-9.9%	148.3%	75.0%	150.0%	60.8%

[a] Admissions per 1,000 beneficiaries counts all admissions, not the number of beneficiaries who were hospitalized at any time during the year.

[b] Persons served per 1,000 beneficiaries counts the number of beneficiaries who were provided the service in a given year, not the number of admissions.

SOURCE: ProPAC analysis of Medicare Cost Reports and data from the Health Care Financing Administration.

Chart 12. Medicare Skilled Nursing Facility Payments and Utilization, 1983-1994

Year of Service	Skilled Nursing Facility		People Served		Days	
	Payments (In Billions)	Percent Change	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1983	$0.5	—	265	9	9,314	35.1
1984	0.6	6.9%	299	10	9,640	32.2
1985	0.6	2.9	314	10	8,927	28.4
1986	0.6	0.2	304	10	8,160	26.8
1987	0.6	8.8	293	9	7,445	25.4
1988	0.9	47.1	384	12	10,667	27.8
1989	3.5	275.7	636	19	29,780	46.8
1990	2.5	-29.0	638	19	25,139	39.5
1991	2.9	18.4	671	20	23,651	35.3
1992	4.5	55.3	785	22	28,971	36.9
1993	6.4	42.8	906	25	34,332	39.6
1994*	8.3	28.5	945	26	36,926	39.9
1995*	10.3	23.8	990	27	38,756	41.0

Note: Payments represent program liabilities incurred during the year and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 13. Medicare Home Health Care Payments and Utilization, 1983-1994

Year of Service	Medicare		People Served		Visits	
	Payments (In Billions)	Percent Change	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1983	$ 1.6	—	1,318	45	36,898	28
1984	1.9	17.5%	1,498	50	40,422	27
1985	1.9	4.0	1,549	51	39,449	25
1986	1.9	-0.5	1,571	51	38,000	24
1987	1.9	-1.2	1,544	49	35,591	23
1988	2.0	8.6	1,582	49	37,132	23
1989	2.6	23.8	1,685	51	46,199	27
1990	3.9	53.2	1,940	58	69,532	36
1991	5.6	45.6	2,223	65	100,226	45
1992	7.9	40.5	2,523	72	135,612	53
1993	10.3	30.0	2,888	80	169,377	60
1994*	13.4	30.7	3,325	91	221,890	65
1995*	16.0	19.0	3,615	97	252,341	—

Note: Payments represent program liabilities incurred during the year and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chairman THOMAS. Thank you very much, Dr. Newhouse.

There is a rather dramatic difference in terms of the hospital margins as proposed by some studies that had been done. However, I want to try to put this in its proper context.

Let's look at your chart 7 from 1993 to 1996. Would PPS payments have been increasing at a declining percentage, holding steady, or decreasing?

Mr. NEWHOUSE. On chart 6, the PPS payments per case over there in the fourth column have been decreasing through PPS–11, which is 1994.

Chairman THOMAS. The cost per case has been going down.

Mr. NEWHOUSE. Correct.

Chairman THOMAS. So the relative increase has been the difference between the hospital's rather dramatic ability to hold down costs, notwithstanding the declining payments.

Mr. NEWHOUSE. That is correct.

Chairman THOMAS. The assumption, then, is that that is a finite relationship. They can only go so far.

Why has it occurred in the 1993–96 period and it didn't occur in the 1989–93 period? Do we have any feeling for that at all?

Mr. NEWHOUSE. Well, that is necessarily speculative, Mr. Chairman. The Commission feels that it is increased pressure from private payers that has been the principal factor responsible here.

Chairman THOMAS. I think it is a response to the real world, and my question would be, although you indicated 1.5 percent, would a market basket of minus 2 percent be out of the question, at least for the next several years?

Mr. NEWHOUSE. The Commission indicated in its report that market basket minus 2 points would have been reasonable, at least within the framework it used. How long hospitals could sustain that is speculative. I think we will just have to see how things go as we go along.

Chairman THOMAS. If you might in just a minute or two, give us ProPAC's response to the whole question of graduate medical education.

Mr. NEWHOUSE. Yes.

Chairman THOMAS. As you know, we suggested a fundamental new way of dealing with the issue. I guess the easiest way is to simply talk about utilizing Medicare as an ongoing base for financing graduate medical education, appropriate or inappropriate.

Mr. NEWHOUSE. As you know, the Commission recommended a decrease in the add-on, as it were, for teaching hospitals from 7.7 to 7.0 percent and believes that that should head downward in the future.

It also supported the notion of the trust fund, and the Commission believed that there ought to be considered, anyway, an all-payer system for graduate medical education.

Chairman THOMAS. Has there been an ongoing discussion about the whole question of whether or not Medicare should be budgeted and the dollar amounts?

Mr. NEWHOUSE. I was not present for the Commission's deliberations this past year. So I might ask Don Young to comment on that.

Chairman THOMAS. Have you since coming on as Chairman had any discussions?

Mr. NEWHOUSE. No. I have been Chairman for one meeting. So we have not had any discussions of budgeting, at least not in that session.

Chairman THOMAS. In for a dime, in for a dollar. Either in for a dime or for an open-ended entitlement, you have got to make a decision.

Any continued discussion? I know there was some concern in looking at some of the proposals about the idea of dealing with an ultimate absolute amount that might be structured in the program.

Dr. YOUNG. Yes. The Commission was concerned by the continued growth and particularly the continued growth in the number of residents that was driving that spending, and that growth and the number of residents was coming at a time when manpower experts believed that we should not be increasing the number of residents to that amount. So they were interested in finding ways to ensure that the Medicare contribution, but contributions overall, met manpower needs and other needs that were in the country. At the same time, they were very concerned about the hospital portion as opposed to the manpower portion because that group of hospitals also tended to be hospitals that treated a large number of the uninsured and of the poor. So those two things tended to balance each other in the Commission's discussion and deliberations.

Chairman THOMAS. Thank you.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, and welcome to so many of you at the table for the information that you have been able to provide over the last year as we have worked to look at how to go about reform.

Whether we pass a Medicare reform bill or whether we don't, is the Commission planning to do some analysis of the impact of reducing reimbursement rates to first certification or lowering them for work beyond first certification, or how we would go about allocating the medical education dollars as we effect a downsize in the number of residencies that we support, so that we preserve our major medical centers and don't simply divide the dollars equally of the whole system?

That whole issue of how you allocate the dollars, if you can no longer allocate them through patients treated, is an issue that we have not addressed, and I wonder if that kind of issue, as there are four or five different issues in the medical education area, if you are planning any studies in that area.

Mr. NEWHOUSE. That is a very good question. The Commission, first of all, was concerned that the trust fund dollars not be allocated strictly in accordance with Medicare activity, but with respect to all teaching activity. It thought that teaching hospitals with a high share of Medicare patients shouldn't be better off than a similar teaching hospital with a lower share.

This also ties up with another issue that we are going to have to take up, I think, next year, although we won't settle our work plan until June, but that is the overlap between the teaching payments and the disproportionate share payments.

The disproportionate share payments are now allocated in part, as you know, on the percentage of Medicaid admissions or admis-

sions of Medicaid patients. As several States are moving toward less restrictive eligibility in their Medicaid Programs, this is becoming an increasing problematic method of distributing the disproportionate share payments, and because those go heavily to teaching hospitals, there is a disproportionate share somewhere, but not here. It is a high proportion of disproportionate share payments, 66 percent, that go to teaching hospitals. How that is resolved will have an effect on teaching hospitals.

Mrs. JOHNSON. Both of those are very important issues. I hope, also, that you are going to look at the issues that are raised simply by adapting a freeze on the number of residency positions, and the impact of this freeze on urban hospitals or that approach on urban hospitals and the combination of that kind of a freeze with a change in the funding for advanced levels of certification.

I hope that as you plan your work for the next year that you will also help us look at the issues raised in that area as well.

The last issue that I wanted to raise, and there are a number of issues in particular that concern me in regard to reimbursement rates for home health care and nursing homes, but rather than going in that direction, I would like to hear you talk a little bit about capitation rates versus premium rates.

I believe there is a strong case to be made for enabling Medicare to pay premiums if we are going to bring managed care plans into the Medicare system. There is a difference between premiums in my estimation and capitation. Would you agree or disagree?

Mr. NEWHOUSE. I am sorry. I am not clear on the distinction you are making.

Mrs. JOHNSON. Capitation tends to look at a bundle of services. If it rises to a bundle of the total Medicare package, like the AAPCC concept, then it becomes a premium, but if you look at the history of payment policy in Medicaid, you can only conclude that poor payment policy can destroy health care access and quality.

Seeing some of that happening in Medicare, I personally am not very comfortable with our bundling services and moving toward capitation.

In general, the economic theory that costs should not be related to product is, I think, a poor theory, and where we have used that in our reimbursement policy in Medicare, I think we have gotten in trouble.

Premiums, however, are not unrelated to capitation. On the other hand, since they are market basket-oriented for the total bundle of services, they tend to be less dangerous, if they are honestly set.

So I think this is an area where I would like a lot more information before we move forward.

Mr. NEWHOUSE. I am not sure this answers your question, but I would only observe on the capitation side or the at-risk side of the program that as long as you have organizations offering zero premium packages, you could probably infer that you are going to avoid the Medicaid kind of problem you are worried about.

Mrs. JOHNSON. Right. At that point, the capitated payment becomes a premium. Below that, it doesn't. So I realize I haven't asked my question very sharply, but it is an area that I need to

know more about and get into more because I think we could do this wrong.

Thank you.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Newhouse, in your report, you do address the old question of medical savings accounts, and I know that was part of the Medicaid/Medicare proposal, which I personally had some problems with. Would you review for the Committee what the upshot of those findings were, regarding MSAs for the Medicare population?

Mr. NEWHOUSE. Yes. The Commission had some concerns that, as proposed, the medical savings account could lead to selection against the Medicare fee-for-service program; that is, the better risks would opt for medical savings accounts, but the degree of that selection is difficult to estimate and is probably going to depend on the length of the lock-in period for the medical savings account. The Commission recommended that there be a reasonable lock-in period as a protection against selection.

Mr. KLECZKA. Does the Commission have a recommendation on that lock-in period?

Mr. NEWHOUSE. The length of the lock-in period?

Mr. KLECZKA. My amendment before the Committee was 5 years, which did not prevail, but I thought that was a reasonable period of time.

Mr. NEWHOUSE. I am trying to recall, since I wasn't there when this recommendation was formulated.

Mr. KLECZKA. Dr. Young.

Dr. YOUNG. The Commission did not come up with a year recommendation, but they thought it should be substantial, and during the discussion, the discussion focused on 4 or 5 years as an example, but they did not come up with a specific year.

Mr. KLECZKA. Can you translate your research on the medical savings account to the general population since, as we all know, the MSA is part of another piece of legislation moving through Congress, the Kassebaum-Kennedy bill? Would that same adverse selection happen to the general population as we know or suspect it could happen to the Medicare population?

Mr. NEWHOUSE. I don't believe the Commission has tried to project outside the Medicare context, and clearly, the general population context is a different context.

Mr. KLECZKA. I think you still might get some of the same adverse selection and things of that nature.

Thank you, Mr. Chairman.

Chairman THOMAS. I will just tell the gentleman briefly that the idea of talking about extending the period of time that you have to be enrolled or the notification for exit is one approach. Some of us have been exploring requiring monthly or quarterly examinations of the profile on the risk selection to a program like an MSA, setting up an early warning signal system in terms of enrollments or not enrollments since we know so little about the area. A lot of it is speculative, but it seems to me that you can monitor who is coming in, and to the degree they have a risk profile that fairly fits the general population, you wouldn't be concerned. To the degree

that they didn't, you would. I think this kind of information would be invaluable in getting a better feel not just for the seniors, but for the others as well.

The point being, I think there are a number of ways for us to resolve some concerns about the disturbance that an MSA might bring about to the current risk selection structure.

Mr. KLECZKA. Once you see the adverse selection or something like it, such as the excess spending, would you then cut off enrollment?

Chairman THOMAS. You could talk about either slowing down or cutting off enrollment.

Mr. KLECZKA. If I am next in line, I am not going to be a happy camper.

Chairman THOMAS. Saying that you have to sign up for 5 years may never make you a happy camper.

Mr. KLECZKA. I think 5 years is fair because, at that point, we are both sharing the risk. You could be healthy for 10 years or 3 years. If this were to go through for the Medicare Program, any retiree in relatively good health would be silly not to take advantage of the MSA for the first 2 or 3 years of retirement, and then as soon as the first ache or pain came about start to get out of it. We talked about that.

Chairman THOMAS. I think now is the time to ask the gentleman from Nebraska if he wants to inquire because I believe he has some views on this as well.

Mr. CHRISTENSEN. I will just make a quick comment. Take my father, for example. I really don't have a question for Dr. Newhouse, but my father recently passed away, and he was 6 months away from being one of those 65-year-olds who was going to be involved with an MSA. He was looking forward to that.

However, in his situation, if he would have gotten sick, his deductible, which would have been around $10,000 for where he was, would have kicked in right away, and all the costs above that would have been covered by the insurance that he purchased.

The idea about the adverse selection, I see, really, as a suspect issue because it is going to be the free market with the private carrier or the catastrophic insurance coming in and the high deductible taking over.

Jerry, I just don't understand where you are coming in with this. I don't agree.

Mr. KLECZKA. If you siphon off all the healthy or healthier individuals?

Chairman THOMAS. Does the gentleman from Nebraska wish to yield to the gentleman from Wisconsin?

Mr. CHRISTENSEN. I would be glad to.

Mr. KLECZKA. If, in fact, the healthy seniors are siphoned off from the Medicare Program for the MSAs, the Medicare Program itself will get stuck with the most unhealthy or the sickest individuals, and naturally, that is going to exacerbate Medicare's costs.

Chairman THOMAS. I will tell the gentleman, we continue to get findings come in. One of the reasons some folks go into HMOs and would probably sign up for MSAs is that they are extremely sick, and it limits their exposure in terms of actual out-of-pocket cost far better than the old-fashioned Medicare structure does. So the de-

bate will continue until we make them available and then we examine what happens in the real world.

Thank you very much, Dr. Newhouse.

We now welcome her certainly not for her maiden voyage, but neither is she a salty dog, the Chairman of the Physician Payment Review Commission, Dr. Wilensky, for her statement, accompanied by Dr. LeRoy, the Executive Director of PPRC, as we say.

Gail.

STATEMENT OF GAIL R. WILENSKY, PH.D., CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY LAUREN B. LE ROY, PH.D., EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Ms. WILENSKY. Thank you for not referring to me as a salty dog.

This is the first time I am here to discuss the annual report of the Physician Payment Review Commission, and I am pleased to do so.

This was a somewhat unusual year because of the high level of interest in Medicare, and for the most part, the staff spent the time, and the Commissioners as well, responding to issues that were raised by Members and by your staffs, and that impacted the structure of the report far more than it has in previous years.

What I would like to mention are some of the broad areas that we have covered in this report, and they really divide up into three ways. One are some of the key policy issues that were raised in the Medicare Preservation Act and other discussions that the Congress had.

The second was ways to strengthen traditional Medicare. After all, as much as we may foresee growth in managed care in this area or in medical savings accounts or any other of the choice plans, the fact is that, for the moment, about 90 percent of Medicare beneficiaries are in the traditional fee-for-service program, and so we had some suggestions about how to make that function better.

Finally, there are some issues that relate both to the choice plans and fee-for-service. Let me just mention a few in each of these categories.

It is very important when we talk about broadening choices of plans, for which there was substantial support among the Commissioners, that we recognize it will be urgent to set standards for plan participation and to help seniors get information, so that they can choose well.

We have spent some time talking about the need to set standards that were similar, but that were not necessarily rigid. That is, we tried to acknowledge the fact that because some of the plans were different in their design and structure, that for example, precisely how you go about achieving quality would have to differ.

Further, we spent some time talking about the need to make sure that seniors have information about the process of an annual enrollment, which would make it easier to provide information to seniors.

We also discussed some of the issues related to what would happen if seniors were required to stay in the plan that they chose for as long as 1 year, and some of the need to make sure that market-

ing restrictions that have been in place in the past get put forward into any additional legislation and a mechanism for treating people who indicated in a variety of ways that they didn't understand the choice that they had made.

We spent a substantial amount of time talking about capitation rates. Dr. Newhouse has already talked about this. This was an issue of great concern.

There is concern that has been raised about the volatility of the capitation rates. There has been concern that has been raised by the Congress on about how much they differ from one part of the country to the other, and some of that was dealt with in the legislation that had been proposed. That took one of several choices that we have discussed; that is, putting a floor in place, so that very low rates would cease to exist over time.

In particular, I have had some concern that while that solves one problem of having few plans operating in areas that have had very low capitation rates. There is another concern that as long as traditional Medicare goes along a different path, you might have very different per capita payments in traditional Medicare developing vis-a-vis what would go on in the choice plans. So we need to remember that what we do in one area may have unintended consequences for what goes on in other areas, and it is an issue that we will look at in the next year.

Before I go on, let me talk about medical savings accounts, the issue that was just raised.

This is an issue that the PPRC also looked at. We did not take a position as to whether or not we wanted to advocate having medical savings accounts, although it is certainly a part of the choice structure that was being promoted. But we did raise the issue that adverse selection could cause problems.

We think there are many ways to deal with this. One is the one that was discussed earlier which was having a longer choice period or a longer opt-out period before you go into traditional Medicare or other plans. Another is to make sure that you are monitoring who is going in. In fact, whatever else you do, we think it is important that we monitor the effects of a medical savings account.

There are some very important things that need to be done to fix the traditional Medicare Program. As much as we all wanted to spend time focusing on how to broaden choice under Medicare, we want to remind people that there are things that we can do to make traditional Medicare function better, many of which were included in the legislation that had been passed by the Congress. These include using a single conversion factor and making sure the sustainable growth rate is a concept that is used rather than the volume performance standard, which has arbitrary reductions in payments that over time would impose great burdens on the physician population.

We are also concerned about how practice expense will be implemented; in particular, that a phase-in be used there in the same way that a phase-in was used when the relative value scale for physician work was initially adopted.

So, while we liked to focus on the structural changes in Medicare and in the reform context, I want to make sure that Members re-

member that there are things we need to do to have traditional Medicare function better.

There are changes the private sector has made that may well be useful for traditional Medicare as we broaden choices for the near term at least it will remain a very important program. We have got to do whatever we can to make sure that it functions better.

Finally, the single most important technical issue, for those who are interested in broadening choice to the seniors or to the under 65, has to do with risk selection and risk adjustment. We don't use that as a reason not to open up choices. We use that as a reason to push and promote better ways to make risk adjustment.

PPRC staff has spent a substantial amount of time during the year trying to push forward our technical knowledge. We think there are ways that we can do risk adjustment. HCFA has been pushing forward some of the areas.

Dr. Newhouse, when he was a member of PPRC, had some ideas about mixing a partial capitation with a traditional payment. We think it is important that people understand that risk selection and risk adjustments are technical issues that need to be dealt with rather than excuses for not moving forward in the future.

Thank you.

[The prepared statement follows:]

STATEMENT OF GAIL R. WILENSKY
CHAIR
PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to be here today to discuss aspects of the Physician Payment Review Commission's 1996 *Annual Report to Congress* that are of interest to this committee. Responding to congressional interest in restructuring Medicare, the report presents recommendations and analyses on key policy issues related to broadening the range of health plan options available to Medicare beneficiaries. Issues covered in the report include methods for setting capitation payments, standards for plan participation in Medicare, facilitating beneficiary choice among plans, promoting quality of care, managed care coverage decisions and the appeals process, and medical savings accounts (MSAs).

The report also focuses on strengthening Medicare's traditional fee-for-service program, still the option chosen by nearly 90 percent of beneficiaries. Our analyses consider the effect of the Medicare Fee Schedule on beneficiary access, evaluate the impact of the fee schedule on physician payments, and assess the Sustainable Growth Rate system proposed by the Congress and the Administration to slow growth in Medicare physician expenditures. The potential for better managing the delivery of care under Medicare fee for service is also discussed.

In addition, we have examined a number of issues that relate to both Medicare managed care and fee for service. These include new analyses of risk selection within Medicare, and an examination of various risk adjustment methods. Other analyses play out the implications of the failsafe budget mechanism included in the Medicare conference agreement. We present initial work on two other issues: changes in secondary insurance for Medicare beneficiaries, and geographic adjustment of Medicare payments. Also explored is the question of how the changing market for health services is affecting the labor market for physicians.

To set the context for these issues, I will begin today by describing some of the important concerns that set the stage for restructuring efforts. I will then briefly outline several key issues included in the report, highlighting the Commission's recommendations to the Congress. We are hopeful that these analyses and recommendations will prove useful as you continue work on Medicare restructuring legislation. As our work progressed over last fall and the winter, Commission staff worked closely with the staff of this committee to provide technical advice in designing the MedicarePlus program and crafting improvements in the traditional program. We look forward to such continued interaction in the months ahead.

Given this subcommittee's recent hearing on physician supply and the financing of graduate medical education (GME), I would also like to take this opportunity to remind you of the Commission's work in this area. Since 1991, the Commission has provided analysis and recommendations on how Medicare could leverage its GME dollars to help achieve broader policy goals. Most recently, we recommended that the capitation payment methodology for Medicare risk-contracting plans be revised so that Medicare payments to providers for medical education costs are removed from capitation payments, and that separate mechanisms be explored for paying plans directly for medical education expenses they may incur in training residents or using teaching facilities. We will consult with committee staff to identify specific options of interest and will keep you apprised as our work progresses.

The Context for Reform

Today, there are many challenges facing the Medicare program. Despite progress in slowing the rate of growth in spending on physicians' services, overall Medicare expenditures continue to increase at a rate many consider unaffordable. Between 1984 and 1993, Medicare expenditures rose at 7.7 percent annually, outpacing growth in most other types of federal spending and in the gross domestic product. Total Medicare expenditures are expected to continue accelerating at annual rates of 8.3 percent to 10 percent from now until 2005. By contrast, projected growth rates for physicians' services expenditures are projected to be in the range of 4 percent to 6 percent.

Also at issue is how to respond to the changing nature of the U.S. health care system, with its growing emphasis on integrated systems of care; capitated payment; and new roles for purchasers, plans, providers, and consumers. Dynamic changes in the private sector have attracted policymakers' attention for several reasons. First, with strong pressure to reduce the federal budget deficit, slowed growth in premiums for private insurance has created expectations that increased penetration of managed care within Medicare will help moderate increases in federal spending. During the late 1980s, private spending was rising faster than Medicare at an average annual rate of 9.7 percent per capita compared with 8.4 percent for Medicare. Since then, this trend appears to have reversed, with private-sector growth rates now below those for Medicare.

The Commission has considered the reasons for the differential in growth rates between Medicare and the private sector. Lower recent rates of increase in the private sector may reflect success in creating incentives for delivery of more cost-effective approaches to medical care. Medicare might benefit from adopting these innovations. On the other hand, Medicare had lower rates of growth in

the 1980s as a result of strategies such as paying discounted fees to doctors and hospitals. These initiatives are only now being adopted in the private sector. In any case, it is important that comparisons be made on a per capita basis so that they do not reflect changes in the number of people insured. During the 1990s, the number of Medicare beneficiaries has been growing at 1 percent to 2 percent annually. By contrast, between 1988 and 1993, the number of people with employer-provided health insurance dropped by almost 6 percent.

I would also point out that it is unclear whether private sector spending has permanently slowed. Over short periods, health spending is quite volatile so it will be some time before it is clear whether this is the beginning of a long-term trend.

Opening up the Medicare program to more innovative methods of service delivery and payment than permitted under current law may result in a better match between program offerings and consumer preferences. Although Medicare beneficiaries have had the option of selecting managed-care plans for more than a decade, this option has not been uniformly available around the country and has been chosen by only a small percentage of beneficiaries nationally.

Until recently, the only private health plans available to Medicare beneficiaries were health maintenance organizations (HMOs). Most are paid under a full-risk contract, while a few use cost-based contracts (Table 1). Enrollment in risk-contracting plans has more than doubled in the past four years, but still accounted for only 8.8 percent of beneficiaries in 1995. Combined enrollment in risk and cost plans was 10.7 percent. Enrollment growth seems to have resulted from both rising interest among newly eligible beneficiaries and even faster increases for those who have been in Medicare for a year or more.

Table 1. Enrollment Rates for Medicare Risk-Contract and Cost-Contract Plans, 1991- 1995 (percentage)

Type of Plan	1991	1992	1993	1994	1995
Risk-Contract Plans	3.8%	4.4%	5.3%	6.6%	8.8%
Cost-Contract Plans	2.1	2.2	2.4	2.1	1.9
Total	5.9	6.6	7.7	8.7	10.7

SOURCE: Physician Payment Review Commission analysis of year-end enrollments for each year from the Managed Care Contract Reports published by the Office of Managed Care, Health Care Financing Administration.

Despite Medicare beneficiaries' growing interest in managed-care options, many of the new delivery arrangements now proliferating in the private sector have not been introduced into the Medicare program. While there is broad agreement about the benefits of expanding choices, there are substantial differences of opinion about the design of such a system. In part, these differences have arisen over how the private sector experience should be adapted to the unique structure of the Medicare program and the populations it covers.

There are also conflicting views about what Medicare can learn from the experiences of aggressive private purchasers. Because of its size, Medicare has substantial market power. If given the ability to act as an aggressive purchaser, Medicare has considerable potential to gain savings for the program, improve plan performance on behalf of beneficiaries, and influence changes in the delivery of medical care systemwide. This potential is threatening, however, to those who fear that Medicare might take the health system in the wrong direction.

Restructuring Medicare

Setting Capitation Payments. One of the key elements of Medicare restructuring proposals has been the design of a payment method for private health plans contracting with Medicare. Currently, Medicare risk-contracting plans are paid on a capitated basis, using a method based on adjusted average per capita costs (AAPCCs) in the Medicare fee-for-service program. Inadequacies in this methodology have contributed to uneven participation by health plans and beneficiaries across the country.

As you know, the existing AAPCC-based rates have a number of shortcomings: wide geographic variation in payments, volatility over time, inclusion of medical education and disproportionate share hospital payments that may not reflect use of these providers by plans, exclusion of certain expenditures such as for care provided by the Department of

Veterans Affairs, and limits on Medicare's ability to recapture cost savings achieved by participating health plans. In addition, the current risk adjustment of AAPCC-based payments captures only a small fraction of differences in enrollees' health care costs.

Variation in the AAPCC rates at the county level reflect local differences in both provider input prices (for example, costs of wages and supplies) and per capita service use patterns (the volume and intensity of care) in Medicare's fee-for-service program. In Table 2, the variation in AAPCC rates is shown as well as the variation in those rates after adjusting for differences in input prices across counties. The 1995 AAPCC rates ranged from a low of $177 per month to a high of $679, while the input price-adjusted rates ranged only from $324 to $530.

Table 2. Average Medicare Risk-Plan Payment Rates, Payment Volatility, and Enrollment Rates, by Urban and Rural Location, 1995

	AAPCC Rate (standard deviation)	Input-Price-Adjusted Rate (standard deviation)	Payment Volatility*	Enrollment Rate
All Counties	$402 (92)	$402 (46)	2.2%	7.3%
Urban Counties	428 (87)	418 (42)	2.1	9.4
Central urban	499 (83)	441 (40)	1.8	16.8
Other urban	393 (64)	406 (37)	2.2	5.8
Rural Counties	323 (50)	357 (20)	2.9	0.6
Urban fringe	330 (51)	357 (18)	2.7	0.7
Other rural	317 (48)	354 (21)	3.1	0.5

SOURCE: Physician Payment Review Commission analysis of Medicare AAPCC payment rates for 1991 through 1995 and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

* Payment volatility is measured as the annual average magnitude of change (higher or lower) in a county's payment index for 1991 through 1995 as a percentage of its five-year average index for that time period. The payment index is the ratio of the county's AAPCC rate to the national average rate per beneficiary.

Table 2 also presents a measure of payment volatility. These changes result from fluctuations in service use patterns and tend to be larger for areas with small Medicare populations. Health plans serving counties with volatile rates face greater uncertainty regarding payment rates for future years.

Several methods -- blended rates, payment floors or ceilings, and differential updates -- have been considered to reduce geographic variation in rates because of local service use patterns while allowing for variation in input prices faced by plans. Volatility could be reduced in a variety of ways as well.

The Commission's report analyzes several of the legislative proposals to address problems with the AAPCC methodology. In general, these proposals would reduce geographic variation in capitation rates moderately, primarily by raising very low rates. They also would reduce payment rate volatility by uncoupling capitation rates from Medicare fee-for-service spending.

It is the Commission's view that mechanisms will be necessary to monitor the effect of any change in the capitated payment method. For example, will lower-than- average rate increases in areas with currently high rates lead to benefit reductions by plans and disenrollments? Will larger-than-average rate increases attract health plan participation in small markets? Also of interest is how differences between capitation rates and fee-for-service per capita costs within local markets affect the choices available to beneficiaries, their enrollment decisions, and resulting Medicare costs.

Facilitating Beneficiary Choice. Several other issues demand attention when designing a system offering multiple choices to Medicare beneficiaries. Among these, risk selection, which I will discuss later, is of critical importance. Other key policy issues considered by the Commission include the number and types of plans that will be available, whether beneficiaries will have the option to enroll at any point during the year (as under current law) or only during an open season period, the types of information needed to support the choice process, and how quality of care and plan performance might be assessed.

The Commission's report offers some guidance on these issues, some of which were addressed in the congressional conference agreement. For example, one key issue has been the design of a more structured enrollment process. Last year, the Commission recommended that coordinated open enrollment was necessary to ensure that beneficiaries have full comparative information on their options. Implementing such a policy raises questions about the timing of open enrollment for plans and the length of time beneficiaries must stay enrolled.

If the Congress chooses to eliminate the current option giving beneficiaries the right to disenroll at any time, it is the Commission's view that certain protections for beneficiaries should be adopted. We recommend, for example, that the current policy of retroactive disenrollment should be available to beneficiaries who fail to understand the consequences of their choice of a private plan option. Moreover, if there is an annual lock-in requirement for beneficiaries and if a plan makes a major change in its network of providers during the year, beneficiaries should have the right to disenroll before year-end or to purchase services on a special point-of-service basis for the rest of the year. The exact circumstances under which such a policy would be invoked should be specified in regulations.

Information plays a critical role in beneficiaries' decisionmaking about plans. The Commission has considered what beneficiaries need to know about their options and the importance of this information to an effective choice-based program. Several key steps still need to be addressed, including creating materials responsive to beneficiary needs, developing effective dissemination methods, and providing enough resources to accomplish these goals.

The Commission has also explored the role of marketing rules in promoting informed choice and the working of a competitive market. Current Medicare policy permits plans to distribute information about plan features to beneficiaries in their service area. Continuation of several rules that have protected beneficiaries in the marketing process will be important if the array of plan options is broadened. To this end, the Commission has recommended that explicit marketing provisions included in current regulations be incorporated in any new regulations developed for private health plans participating in Medicare. These should include prohibitions on discriminatory marketing practices, misrepresentation of the Medicare program or the plan, door-to-door solicitation, and the giving of gifts or payment to prospective enrollees.

Risk Selection and Risk Adjustment. One of the most critical impediments to expanding Medicare choices is the potential for some plans to attract beneficiaries with low expected health care costs (referred to as favorable selection), while others attract those with complex medical problems and high costs (referred to as adverse selection). Although Medicare's per capita payment should be adjusted to reflect this risk selection, current risk adjustment approaches capture relatively little of any biased selection across plans.

Risk selection raises at least three problems for Medicare. First, costs increase if Medicare pays managed-care plans more than it would have cost to treat the same enrollees in fee for service. Second, inadequate risk adjustment hampers competition. That is, a poorly performing health plan may survive if it attracts low-cost beneficiaries, while a good plan may struggle if inadequately compensated for high-cost patients. Finally, inadequate risk adjustment of capitated payments may raise barriers to care for beneficiaries with high-cost conditions.

Numerous published studies have shown that beneficiaries who joined HMOs in the 1980s tended to have below-average costs in the period prior to enrollment. The Commission's analysis of more recent data shows that this is still true in the 1990s. New HMO enrollees' pre-enrollment costs are 20 percent to 40 percent below average, while those who disenroll from HMOs tend to have extremely high costs. Findings based on pre-enrollment and post-disenrollment utilization should be interpreted with caution, however, because neither new enrollees nor new disenrollees are typical of the average HMO enrollee. Hospitalization and mortality rates for new enrollees increase significantly during HMO enrollment (even after adjusting for the aging of the population), a phenomenon typically termed "regression toward the mean." The Commission plans to explore these results and their implications for risk-adjusting payments to managed-care plans.

In our report, we also note the progress made toward identifying those techniques that could be used to improve the current risk adjustment of Medicare payments to plans. For example, the Health Care Financing Administration (HCFA) has developed diagnosis-based risk

adjusters that offer a significant improvement over current techniques. Alternatively, methods that would pay plans partly on a capitation basis and partly on a fee-for-service basis would also reduce over- and underpayments due to selection. As this work proceeds, data requirements and the need for testing and validation must be addressed.

Medical Savings Accounts for Medicare Beneficiaries. Risk selection issues also anse in considering whether to offer medical savings accounts to Medicare beneficiaries. Medicare MSA options appear more likely than others to attract significant favorable selection. Beneficiaries who expect to spend little on health care in the coming year may disproportionately find MSAs financially attractive because they could keep more of the money deposited into the medical savings account. Conversely, those who expected high expenditures might find MSAs unattractive because it would be cheaper to buy Medigap insurance than to spend up to a large deductible. As a result, policies must be carefully considered to protect the Medicare program from increased expenditures due to selection.

To address these concerns, the Commission recommends that the enrollment and disenrollment rules of Medicare medical savings account plans be structured to reduce the potential for risk selection. Examples of restructured rules include a minimum enrollment period of several years in a Medicare MSA or requiring beneficiaries to announce their disenrollment from an MSA one or more years in advance. Moreover, if a Medicare MSA option is adopted, the Congress should require studies of selection into MSA plans both to determine what effect, if any, selection has on total program outlays and to identify a way to compensate for any selection that occurs.

Other elements of the design of a Medicare MSA option might also necessitate explicit policy decisions by the Congress. First, Medicare MSAs are typically envisioned in a traditional fee-for-service environment, but managed-care plans or other entities may be capable of offering them. If a Medicare MSA option is adopted, the Commission suggests there be no undue legal restriction of their ability to offer this product, and that federal laws limiting deductibles and copayments or mandating benefits richer than the ones offered by Medicare be waived for managed-care plans' Medicare MSA products. In addition, state laws should be preempted when they conflict with this provision of federal law.

Finally, there are issues regarding Medicare beneficiaries' ability to meet their financial obligations under an MSA option, particularly those with low-incomes. Of concern to the Commission is the possibility of access problems if providers become less willing to treat beneficiaries without a guaranteed source of payment. Medicare MSAs also raise important coordination-of-benefits issues for beneficiaries entitled to Medicaid or other tax-funded health care. Thus, any Medicare MSA proposal should be structured to reduce the potential for adverse effects on low-income beneficiaries, on providers who disproportionately serve them, and on state Medicaid programs.

Strengthening the Fee-For-Service Program

The Commission's 1996 annual report also devotes a number of chapters to issues affecting Medicare's fee-for-service program. In part, these reflect the Commission's ongoing responsibility to monitor the implementation of physician payment reform. But they also focus on improving program performance.

Physician Payment under Medicare Fee for Service. As the transition to payment under the Medicare Fee Schedule nears completion, there is much good news to report. Access to care appears to be good for most beneficiaries. Physician participation and acceptance of assignment continue to grow with 95 percent of claims now accepted on assignment. Balance billing has declined dramatically. And despite reductions in some Medicare payment rates, beneficiaries' use of almost all services continues to grow (Table 3).

In addition, Medicare does not appear to be pricing itself out of the market for physicians' services. Medicare now pays, on average, 71 percent of private rates. This gap is narrower than in 1992 when Medicare paid 61 percent due to higher Medicare payment rate updates and lower inflation in the private sector.

Despite these successes, there are still areas of concern. For example, the distribution of physician payment has changed less under the fee schedule than originally anticipated. Gains for evaluation and management services have not been as large as expected because of use of separate conversion factors for surgical services, primary care services, and all other services. In addition, the Commission remains concerned that access problems persist

for vulnerable groups such as African Americans, and those living in urban poverty areas, and urban Health Professional Shortage Areas.

Table 3. Change in Medicare Payment and Volume, by Type of Service, Location, and Specialty, 1994-1995 (percentage)

Type of Service, Location, and Specialty	Medicare Payment per Service	Volume and Intensity per Physician	Medicare Payment per Physician[a]	Medicare Revenue per Physician[b]	Percentage of 1995 Medicare Payments
All Services	3.8%	4.1%	8.0%	7.9%	100.0%
Evaluation and Management Services					
Primary care	9.0	3.1	12.4	12.2	20.0
Other	6.7	0.3	6.9	6.9	16.5
Surgical Services	5.0	4.5	9.7	9.6	23.2
Other Nonsurgical Services	-0.4	5.9	5.4	5.4	40.3
Location					
Metropolitan areas					
>1 million	3.5	2.8	6.4	6.4	53.0
<1 million	3.8	5.6	9.6	9.5	34.5
Rural counties					
>25,000	4.8	7.1	12.2	12.1	10.1
<25,000	6.6	1.4	8.1	7.9	2.5
Specialty					
Cardiology	-1.4	3.5	2.1	2.0	8.4
Family/general practice	7.5	-0.1	7.4	7.2	10.1
Gastroenterology	1.2	-2.6	-1.5	-1.6	2.9
Internal medicine	5.0	5.1	10.4	10.2	16.7
Other medical specialties	5.7	8.0	14.2	14.2	8.2
General surgery	6.1	7.5	14.1	14.0	5.6
Dermatology	7.8	4.2	12.3	12.1	2.1
Ophthalmology	1.1	2.2	3.4	3.3	9.0
Orthopedic surgery	5.7	3.8	9.7	9.5	4.8
Thoracic surgery	5.2	4.2	9.6	9.5	2.4
Urology	5.9	5.8	12.0	11.9	4.1
Other surgical	5.8	2.4	8.3	8.2	3.2
Radiology	1.6	-1.5	0.1	0.0	7.9
Pathology	-1.6	2.3	0.7	0.6	1.2
Other	2.5	4.8	7.4	7.5	13.4

SOURCE: Physician Payment Review Commission analysis of 1994-1995 Medicare claims, 5 percent sample of beneficiaries; American Medical Association 1994 and 1996.

[a] Medicare payments are allowed charges.

[b] Medicare revenue is allowed charges on assigned claims and submitted charges on unassigned claims not in excess of charge limits.

It is also important to note that although the fee schedule transition period is now over, the fee schedule, physician payment patterns and policies will continue to evolve as a result of changes in relative values, the conversion factors, and geographic adjustment factors (Table 4). Policy developments on the horizon include implementation of resource-based practice expense relative values in 1998, completion of the five-year review of work relative values, and improvements in the definition of payment areas.

Of these, Commission is particularly concerned about activities under way to develop resource-based practice expense relative values. These include HCFA's ability to develop values in time for implementation in 1998, the difficulty in collecting reliable data, and the lack of a clear plan for establishing values from the various research projects envisioned as part of the process. As a result, it recommends that the Congress should revise current law so that resource-based practice expense relative values will be phased in over a three-year period beginning in 1998. In addition, it should direct HCFA to develop a process and timetable for refinement of resource-based practice expense relative values, which should be announced when proposed values are released for public comment.

Table 4. Effect of Policy Changes on Fee Schedule Payments, 1994-1995 (percentage)

Type of Service, Location, and Specialty	Total Change in Medicare Payment per Service	Change Due to: Relative Value Unit Changes	Geographic Adjustment Factor Changes	Conversion Factor Updates	Transition to Fee Schedule
All Services	3.8%	-1.9%	0.1%	7.5%	-1.9%
Evaluation and Management Services					
Primary care	9.0	-1.0	0.0	7.9	2.1
Other	6.7	-1.0	0.0	5.2	2.5
Surgical Services	5.0	-3.7	0.0	12.2	-3.5
Other Nonsurgical Services	-0.4	-1.6	0.1	5.2	-4.1
Location					
Metropolitan areas					
>1 million	3.5	-1.8	0.1	7.4	-2.2
<1 million	3.8	-2.0	0.1	7.7	-2.0
Rural counties					
>25,000	4.8	-1.9	-0.2	7.7	-0.8
<25,000	6.6	-1.4	-0.3	7.4	0.9
Specialty					
Cardiology	-1.4	-2.6	0.0	5.7	-4.5
Family/general practice	7.5	-1.1	-0.1	7.2	1.5
Gastroenterology	1.2	-1.9	0.1	5.7	-2.7
Internal medicine	5.0	-1.1	0.1	6.4	-0.4
Other medical	5.7	-1.0	0.1	5.6	1.0
General surgery	6.1	-1.4	0.0	9.9	-2.4
Dermatology	7.8	-1.0	0.1	10.5	-1.8
Ophthalmology	1.1	-5.7	0.1	10.0	-3.3
Orthopedic surgery	5.7	-3.0	0.0	10.5	-1.8
Thoracic surgery	5.2	-1.4	0.0	11.2	-4.6
Urology	5.9	-1.2	0.1	10.1	-3.1
Other surgical	5.8	-2.0	0.1	10.0	-2.3
Radiology	1.6	-1.0	0.0	5.3	-4.8
Pathology	-1.6	-1.6	0.1	5.2	-5.3
Other	2.5	-0.8	0.1	7.3	-4.1

SOURCE: Physician Payment Review Commission analysis of 1994-1995 claims, 5 percent sample of beneficiaries.

NOTE: Changes due to the transition to fee-schedule based payments are calculated as the difference between total payment changes and the sum of changes attributable to relative value changes, geographic adjustment factor changes, and conversion factor updates.

The Commission is also concerned how payment policy changes may affect the fee schedule's integrity. Whenever relative values are changed, the relationship of values across codes and the components of the fee schedule (physician work, practice expense and malpractice expense) may be changed. Moreover, there is some evidence to suggest that revenue shares originally allocated to the three components of the fee schedule are changing. To address these concerns, the Commission recommends that:

- Implementation of any changes to work relative values as a result of the current five-year review should be budget neutral with respect to work values and should not affect practice expense and malpractice expense relative values.
- HCFA should continue to achieve overall budget neutrality by adjusting the conversion factors as it did for 1996, rather than by adjusting relative values, as it has in previous years.
- The relationship between the three components of the fee schedule should be rebased annually to reflect the three-year moving average of physician revenue shares as reported in national surveys.

Improving the Volume Performance Standard System. The report also analyses the design of the Sustainable Growth Rate system, proposed by the Congress and the Administration, as an alternative to the current system of Volume Performance Standards (VPS). As you know, the VPS curbs Medicare spending for physicians' services by linking

payment levels to the growth in the volume and intensity of services. The system uses performance standards to set target rates of expenditure growth, and annually updates conversion factors depending on whether expenditure growth met the targets two years earlier.

While the VPS has constrained spending for physicians' services, several methodological flaws prevent it from working as intended. First, limitations in the formula now used to set updates will result in substantial reductions in the conversion factor over the next five years. Second, the existence of three performance standards is introducing serious distortions in the patterns of relative payment, the very problem the Medicare Fee Schedule was intended to correct (Table 5).

Table 5. Conversion Factors, by Category of Service, 1992-1996 (dollars)

Category of Service	1992	1993	1994	1995	1996
All Services	$31.00	-	-	-	-
Surgical Services	-	$31.96	-	-	-
Nonsurgical Services	-	31.25	-	-	-
Surgical Services	-	-	$35.16	$39.45	$40.80*
Primary Care Services	-	-	33.72	36.38	35.42*
Other Nonsurgical Services	-	-	32.90	34.62	34.63*

SOURCE: Physician Payment Review Commission compilation of conversion factors as reported in the *Federal Register.*

* These conversion factors include an additional 0.36 percent reduction due to a budget-neutrality adjustment. This adjustment offsets increases in spending from changes to the relative value units and other payment policy changes for 1996.

The proposed Sustainable Growth Rate system incorporates many of the Commission's previous recommendations to correct these limitations. It would establish a single conversion factor that would remove the current distortion created by multiple conversion factors. In addition, target rates of growth would be linked to growth in per capita gross domestic product instead of the five-year historical trend for volume and intensity growth of physicians' services currently used under the VPS system. Conversion factor updates would be based on comparisons of total actual versus allowed spending accrued since a base year, replacing the year-to-year comparisons and two-year delay in the current system.

Although these changes correct many of the limitations of the VPS system, the Commission's report points out two limitations inherent in any administered price system. While the proposed system establishes more realistic targets, no such system can set targets that reflect appropriate levels of care or changes in the medical marketplace. Also, limits on the size of annual conversion factor updates are necessary for constraining volatility in annual adjustments. Otherwise, the updates would reflect year-to-year fluctuations in volume and intensity growth, as well as the changes necessary to recoup any excess or surplus spending in a single year. An additional limitation of both the VPS and the proposed systems, which results from incorporating projection errors into the calculation of conversion factor updates, could be readily corrected. To address these concerns, the Commission recommends that any revision to the Volume Performance Standard system should annually correct for any projection errors in the target growth rate from prior years.

Because the VPS remains in law, the Commission will continue to make annual recommendations regarding fee updates and performance standards as mandated by the Congress. Our 1996 VPS report will be discussed at the Commission's meeting later this week. It will be transmitted to you to meet the May 15 deadline required under the Omnibus Budget Reconciliation Act of 1989.

Managing Medicare's Fee-for-Service Program. A new area of work represented in this year's report is exploration of techniques that Medicare and private indemnity payers have been introducing to manage delivery of health care on a fee-for-service basis. To better understand the state of the art, the Commission sponsored a survey of 10 innovative Blue Cross Blue Shield plans. Four approaches were used by all or almost all the plans surveyed: *case management, practice guidelines, rebundling of services, and provider profiling.* Providing financial incentives to physicians was also considered important in reducing costs.

Many of Medicare's initiatives mirror those in the private sector. For example, various aspects of Medicare's provider profiling techniques and activities appear comparable to those of private payers. Profiling activities could be strengthened by comparing profiles with practice guidelines; this would make it possible to detect deviation from appropriate care rather than from common practice patterns. Another initiative is HCFA's recent implementation of changes to enhance its ability to detect the use of inappropriate billing codes. Medicare is also experimenting with case management through demonstrations and is investigating methods of paying for case management by using bundled payments.

It is important to recognize the differences between the Medicare fee-for-service program and private payers that may bear on the effectiveness of management techniques, and in some cases, the feasibility of implementation. As a public program, Medicare's rules and authorizing legislation require that it operate differently from private payers. For example, current law permits all providers to participate in the program and that beneficiaries be guaranteed freedom to choose providers. This provision may complicate the implementation of management strategies that offer financial incentives to modify provider or patient behavior. Moreover, increased flexibility may be necessary in Medicare coverage and payment policies to accommodate management techniques such as case management.

In addition to continuing with the initiatives that are easily applied to Medicare, the Commission recommends that HCFA should explore ways that Medicare can make use of other cost-effectiveness techniques that appear promising yet conflict with current policies. As a first step, the Commission recommends that HCFA work more intensively with its Part B carriers and Part A fiscal intermediaries to implement the best private-sector practices for managing cost and quality of care within a fee-for-service context. This could include a formal request for proposals from carriers and intermedianes to test promising methods and increased financial flexibility to implement new management techniques.

Additional Issues

Several issues included in the 1996 Annual Report have implications for both Medicare's fee-for-service and managed-care programs.

The Failsafe Budget Mechanism. The failsafe budget mechanism included in the congressional conference agreement relies on assumptions about the rate of growth in managed-care enrollment and spending growth in fee for service. While the Commission appreciates the need to slow the rate of growth in Medicare expenditures, several methodological limitations may keep the failsafe budget mechanism that was proposed from operating as intended. First, the failsafe only lowers payment levels and makes no provisions for increasing payment. Because payments would be dropped permanently to meet any anticipated excess spending, the mechanism would take larger reductions than needed in order to reach budget goals. In addition, payment reductions under the failsafe budget mechanism may reflect fluctuations in annual spending growth and errors in projections of spending. While the mechanism corrects for overspending that may have occurred two years earlier, it does not adjust for projections that were too low. The mechanism could be improved to better limit the effects on annual variation by revising the methodology so that savings in one year offset spending excesses in other years. This mechanism could also adjust for all errors in projections of spending.

If a failsafe budget mechanism is adopted, the Commission recommends that it be modified in three ways. Any payment reductions should apply for one year only, and then payment levels should be returned to the level they would have achieved had the failsafe budget mechanism not been triggered. The mechanism should also be based on comparisons of total actual spending and total allowed spending accrued since a base year. In addition, it should correct annually for any projection errors regardless of whether these errors were too high or too low.

Secondary Insurance for Medicare Beneficiaries. Another issue affecting both Medicare fee for service and managed care is the impact of secondary insurance coverage on Medicare expenditures and the types of choices available to Medicare beneficiaries. As this issue was new to the Commission this year, we began our work in this area by developing background material, identifying the pertinent policy issues, and laying out potential options. Roughly three-quarters of Medicare beneficiaries have some private health insurance in addition to their Medicare coverage. Although these arrangements provide valuable financial

protection to Medicare beneficiaries, they also have implications for the Medicare program. Higher utilization among Medicare beneficiaries with Medigap insurance translates directly into increased costs for Medicare. The Commission's analysis of the 1993 Medicare Current Beneficiary Survey confirms previous estimates that Medicare beneficiaries with first-dollar supplemental coverage have rates of service use from 25 percent to 33 percent higher than those for beneficiaries without supplemental coverage.

Medigap insurers and Medicare risk-contracting plans operate under different rules governing their premium rate-setting and underwriting practices. This raises two important issues: the appropriateness of applying different standards to the two types of insurance coverage, and the implications that these different pricing strategies have for beneficiary access to and beneficiary choice of supplemental coverage. The artificial barriers to choice raised by these different rating and underwriting standards will become even more critical if the Medicare program is restructured to broaden beneficiary choice.

Options for modifying current supplemental insurance fall into three general approaches: revising current policy, creating partial risk-sharing arrangements, or allowing or requiring insurers to assume full risk for both Medicare and supplemental benefits. The Commission is now planning work to examine the advantages and disadvantages of these approaches.

The Changing Labor Market for Physicians. Finally, the Commission's report takes a look at whether and how changes in the organization and financing of health care are affecting the labor market for physicians. Two types of change in the labor market have been assessed: whether there is evidence that increasing demand for primary care physicians is leading to changes in specialty mix, and if there is any indication that changes in the market have reduced the overall number of physicians being trained.

The Commission's review suggests that change is occurring, but that it is relatively modest. For example, generalists' incomes have exhibited small gains relative to those of specialists, and both the percentage of senior medical students expecting to be certified in generalist fields and match rates for generalist residencies are increasing somewhat. Overall growth in the number of residents has declined, with the most substantial decreases in specialist fields. Growth in the number of international medical graduates in training may overwhelm any changes made in response to market dynamics by graduates of U.S. medical schools. Because most data sources are national in scope, it is difficult to know whether change is more pronounced in the most competitive markets.

As you well know, restructuring the Medicare program encompasses a wide range of policy and technical issues. The Commission's 1996 annual report addresses a number of those issues to respond to the needs of the Congress. We look forward to working with this committee as it continues to consider changes in Medicare in the months ahead.

Chairman THOMAS. Thank you, Dr. Wilensky.

You mentioned this expense of relative values that HHS has to set up. How comfortable are you in their ability to meet the deadline? I believe it was January 1, 1998.

Ms. WILENSKY. We are uncomfortable, in short.

We think that to move to this payment in its entirety, January 1988 would be difficult, with probably unintended consequences. Therefore, we recommend a phase-in over a 3-year period.

Chairman THOMAS. So that is the primary reason you offer the transition period?

Ms. WILENSKY. It allows for HCFA to make some adjustments as it goes. We are concerned whether they will be ready at all in January 1998. Even if they claim to be ready, we think the potential for unintended consequences, if you go the full change, is too great.

Chairman THOMAS. I believe one of the common areas between the President's plan and our plan was movement toward a single conversion rate.

Ms. WILENSKY. Correct.

Chairman THOMAS. It might have been a year or two difference between the two.

Ms. WILENSKY. Correct.

Chairman THOMAS. How are your feelings about moving, whether a transition or implementation, while at the same time we are talking about moving toward a single conversion rate?

Ms. WILENSKY. It also will become complicated, and we think the implications of how you make that transition probably had enough attention paid to them. Not making a transition to a single conversion factor, though, is going to exacerbate the problems of undoing the relative value scale, which you are aware have been a concern of this Committee for several years.

Chairman THOMAS. The last hearing, as a matter of fact, was on graduate medical education, and I learned a number of interesting things. One of them was that apparently, there is a much better open line of communication between what the marketplace will take and what young people's interests are in terms of fields of medicine.

Have you folks looked at that, and do you believe that the marketplace exchange of information will be adequate to direct career match ups, or do you still think from our end of it, we ought to do some pushing and structuring regarding who gets funded?

Ms. WILENSKY. The answer is some of both. Let me explain. There does appear to be getting a message out that primary care will be more attractive than radiology for a variety of reasons in the future. There has been a substantial increase in the reported match rates for interns and residents in primary care over what had occurred in the last few years.

I think that word is going out, as well as the difficulty for residents in some highly specialized areas, such as radiology and anesthesiology, to find jobs.

There appears to be a very modest slowing of income growth and of bringing together in a very modest way the gap between primary care and specialty physicians. So I think that the word seems to be getting out, although it is interesting that applications to medical school remain at an all-time high, which may be as much a

statement about views of other areas as it is about the future of medicine.

I think because the Federal Government is spending a substantial amount of money in the area of graduate medical education that it can't ignore the effects that it has produced.

There appears to be something of an intermediate market that has developed at the institutional level because of the substantial amount of payments that are available. These may not have a lot to do with the final demand of physicians in certain areas. I also think we can't ignore the fact that several billions of dollars, $6 or $7 billion that go out in graduate medical education payments has an effect whether or not you intend it. Therefore, the issue of how much, why the Federal Government is making payments in this area at all, where you want to be and how you want to transition from the present program to where you ought to be in 5 years will remain very important.

Chairman THOMAS. One of the other things I would ask, and I want to make sure I say this correctly because I don't want anyone to misunderstand me, is that information that we received was that it appeared that foreign medical graduates were involved in the specialty areas at a higher rate. That may increase in the future. I just want to make sure that as we monitor where primary physicians and the specialties are coming from, if there is any signaling of an inordinate number of foreign medical graduates, it might be possible to look at several concerns and deal with them at one time if, in fact, there is a high propensity in that direction.

Ms. WILENSKY. This is certainly possible to alert you as to the choices that are being made by various groups.

Chairman THOMAS. Thank you very much.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, and welcome, Dr. Wilensky.

Ms. WILENSKY. Thank you.

Mrs. JOHNSON. In your testimony, you recommend that in the capitation payment methodology for Medicare risk contracting plans, that we remove Medicare payments to providers for medical education costs from the capitation payments.

We did not go that far in our recent proposal because of our concern that premiums would not be high enough to command a basket of services that would be adequate for seniors, and not having the time to change the AAPCC technology, we simply did not withdraw the medical education component from the capitated rate.

When you look at the challenge of revising AAPCC versus simply finding alternative sources of medical education dollars, what route do you recommend we go?

Ms. WILENSKY. I actually think because of the small number of seniors who are in capitation plans, your choice was a perfectly reasonable one, especially if you separate out the growth rate of the capitation plans from what goes on in fee-for-service. What you are really doing is locking in an 8- or 9-percent population factor that is in the AAPCC that has to do with medical education.

If you were to wait until the capitation plan represented 20 or 30 or 40 percent of the population, then having a differential which may or may not be correctly attributable to the plan that was real-

ly meant for graduate medical education would become far more serious.

By separating out, you took what was representing 8 or 9 percent of the Medicare population. You froze it at that level. It would become an increasingly smaller and smaller share of the capitation program. So, if you do something soon, I actually think what you propose doing was perfectly fine. It did not have a major effect, especially because you had set up a trust fund, but that doesn't mean if you had the time to develop a way to, first, extract and then, more importantly, decide how to distribute those graduate payments, that would be fine. I just don't think you did much damage at this point.

Mrs. JOHNSON. Because no legislation has been passed in this area, I am beginning to see in our medical centers the impact of the managed care deal, so to speak, and so we are already beginning to see a hemorrhaging of resources that are critical to the survival of these medical centers. Has any of your data begun to reflect that yet?

Ms. WILENSKY. The distribution, as you know, is not even. The 8 or 9 percent who choose capitation plans tend to be targeted in high-payment areas. So, in those areas, you will do a little more than just the 8 or 9 percent.

We have not seen any impact yet, and I think the reason is because both ProPAC and PPRC have indicated that the moneys going to the academic health centers, in fact, are substantially greater than one would justify strictly on the basis of what Medicare does to them for reasons that have to do with providing uncompensated care or other roles that these institutions play.

So I think, actually, that is not a problem to date. The longer you wait, the more it could become a problem.

Mrs. JOHNSON. I would hope that you would focus some of your resources on areas of the country, and of course, I am particularly familiar with the Northeast, where managed care has not been a big component in the market for seniors particularly, nor have HMOs. So the sudden influx of those and the pace at which now I think in the next year and 2 years, even 6 months and 1 year, people are going to be joining those plans, it seems to me it could create a problem for the medical centers of Boston and Connecticut, and perhaps, to some extent, New York. I am a little less familiar with that situation.

So I think we need to begin tracking that early, so that we can see what will be the consequence if we don't do anything.

Ms. WILENSKY. Yes, I agree, and we will do so.

It certainly could have an impact in those areas that have academic health centers and traditionally have not had very much in the way of managed care growth, and we will do that.

Mrs. JOHNSON. You won't have time to answer this, but I would appreciate your help in taking a look at the kinds of issues that Chris Shays raised in his testimony.

I have served on this Committee for many years, and frankly, we have been notably ineffective in many instances in getting at the kinds of problems that he describes. I would say that those kinds of problems are being brought to my attention far more frequently now than they have in the past, which reminds you that the pri-

vate sector is affecting the cost structure in the health industry, and our rates aren't changing. So, in many areas, we are increasingly overpaying. We need your help in better identifying these areas.

Ms. WILENSKY. Mrs. Johnson, let me conclude my answers to you by saying the issue that you had raised earlier with Dr. Newhouse struck me as going to the heart of something that I am sure this Committee will take up in the future. This has to do with the differences between defined benefits and defined contributions and to what extent can we assume that a defined contribution will leave you satisfied with the benefits that go with it.

This is probably one of the most important issues that the Commissions could provide some assistance with, and I am sure we would both be glad to do so, and to do so in a joint way if that would help.

Mrs. JOHNSON. That would be very helpful. I appreciate that. Thank you.

Chairman THOMAS. I thank the gentlewoman.

Given the sobering effect of the numbers, I think at least that discussion needs to go on to be able to look at the parameters.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you.

I am sorry I missed your presentation. I will try to outline a few questions I had based on the prepared testimony.

Just one of the issues that I have been concerned about and the PPRC recommendations touches on—on page 18 of the report under Recommendations—that the same core standards be applied to all private health plans participating in Medicare.

Ms. WILENSKY. Right.

Mr. STARK. Were you referring to the fact that some of the new organizations recommended in legislation have easier or different standards than others? It has been my assessment that we ought to come as close as we can to having universal standards where it is able to apply. Is that the point that you were getting at?

Ms. WILENSKY. Yes. What we tried to balance was the recognition that in different designs, precisely how you got someplace, might be forced to differ or might in common sense wish to differ, but the fundamental issues like solvency and protecting the seniors, those are issues that were as important for new plans as for old plans. Some might even say more important, but certainly as important.

Mr. STARK. The risks that a beneficiary would face, the limit of their liability, so that it is clearly defined to how much they might be at risk, is an issue that should apply, so that whichever plan you go into, you understand as a beneficiary what your contribution or risk might be.

Ms. WILENSKY. The answer is yes, to the extent the design was consistent. To some extent, in some of the designs, it allowed outside of the traditional barriers. In that case, we wanted to be sure that the seniors understood that if they chose a medical savings account, there may be higher prices that could be charged and, therefore, different liabilities. But it was extremely important, then, to be sure the information to the senior was as clear as we knew how

to make it; otherwise, within the Medicare benefit package, to keep the same standards.

Mr. STARK. A topic that we have heard a lot about is the medical savings account. Your analysis is interesting. If I read it correctly, you are saying that they are a good deal for anyone with less than $1,000 in medical expenses and that for each person who joins, it will cost Medicare about $2,400 a year more than would otherwise have been spent.

Do you want to lead me through that? I think I know the answer is why you say it is a good deal if you expect less than $1,000 in expenses. Go ahead. I will let you say it. I won't.

Ms. WILENSKY. Let me start by saying all of our analyses of medical savings accounts are by their nature highly speculative. We don't have anyplace to turn to, although PPRC has spent a lot of time looking at the issue of risk selection and trying to bring it up to date.

Our concern had been, in part, with a notion of a medical savings account that had an annual selection and, in part, with a particular construction that a medical savings account had in legislation, not necessarily any medical savings account that might be devised. Therefore, it was the staff's estimate that the current construction would have a risk selection problem associated with it, and therefore, it costs Medicare more if it maintained an annual selection.

Mr. STARK. Did the $1,000 relate to the fact that that is about what a Medigap policy that is fairly generous costs, or is that just a coincidence?

Ms. WILENSKY. I don't think that it related to the Medigap, but I will check that with the analyst who did the estimate.

Mr. STARK. Let me try this on you as an economist. Wouldn't it make sense as a businessperson? Let's do this a minute. You are running a business and you have got 100 employees. You are going to put them in a medical savings account. Let's say it is $1,000, just to pick the number, that you are going to give each employee, and they can either spend it until their policy kicks in, or if they are not sick, they can save it. The employer has got to pay $100,000 for his 100 employees.

Let's assume for 1 minute that the standard idea that only 20 percent of the population ever uses their health insurance in any 1 year and 80 percent don't need it or somewhere in there. Why wouldn't the employer say wait 1 minute, I'll buy the high deductible, but I will only pay the copays for people who get sick? The employer is not giving these people something to save in their account, but the employer is only putting $20,000 out if you assume, in fact, that 20 percent will use their insurance. He gets the same deduction. The people who get the $1,000 actually have to run it through their tax, but that might not bother them if they were sick and needed the money.

As a small business person or a medium sized business person, why wouldn't that be a more attractive way to go on the theory that the remaining $80,000, if you followed the MSA plan, is almost just a gift, although it is randomly distributed? So, if you really wanted to be an efficient employer and use that savings even for a better policy, why wouldn't that be a more economic approach?

Ms. WILENSKY. That is a fairly complicated example for me to think about, but it strikes me that one of the problems that you raise is that if you have the employer paying the copay, you now have no reason on the part of the insured to care about what is being sent.

Mr. STARK. On the other hand, you take away the incentive for people, maybe, not to get treatment because they want to keep the money in the savings account, which people have suggested is one of the downsides. People might not go for that initial doctor's appointment when they ought to.

Ms. WILENSKY. I have a section 125 provision at Project Hope which lets me put aside money that is not covered by my insurance. So, in some ways, that aspect of a medical savings account is very common if it is not a big employer, and I have that ability.

It has a terribly perverse aspect. It is called use or lose. At the end of the year, any money that I have set aside, if I haven't spent it, it just goes away.

Last year, I made the mistake, and I had $250 that I didn't spend. I am sure this year that I will go to visit my ophthalmologist or my dentist or something, so I am not going to let that happen.

Chairman THOMAS. You are beginning to sound like a bureaucrat again.

Ms. WILENSKY. It was my money, and I was going to do the use-it-or-lose-it, and I didn't want to lose it anymore. It is really taking an idea that actually has been around for years and saying that the way it is now is very perverse, and we let people roll it into the future, so that they can keep it aside in case they have a catastrophic illness. It is taking something that we actually are quite familiar with and saying we want to make it better.

So, while there are concerns about risk selection that are very real, and I don't want to downplay them, I think that we sometimes talk about medical savings accounts as though they were an animal with four heads. Whereas, in fact, the section 125 is really a medical savings account that many of us have access to.

Mr. STARK. Thank you.

Chairman THOMAS. A medical savings account with term limits.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman.

Dr. Wilensky, I think you answered the gentleman from California's question quite well regarding medical savings accounts, but in fact, your report only looks at MSAs in the context of Medicare. Is that right?

Ms. WILENSKY. Yes. That is what the Commission's charge is, and that is the only thing we looked at.

Mr. MCCRERY. In your report, you suggest a number of safeguards that might be enacted by the Congress in order to reduce the risk of adverse selection. Is that correct?

Ms. WILENSKY. That is correct.

Mr. MCCRERY. Based on your general knowledge of the health care system, is the potential problem of adverse selection more in the Medicare population than it is in the rest of the population?

Ms. WILENSKY. That is actually a hard question. The Medicare population uses a lot of health care. So, if you miss, it can cost you

more money, but actually, the concentration of spending is greater in the under 65 population, in part, for that very reason.

Mr. MCCRERY. In a relative sense.

Ms. WILENSKY. Right, in a relative sense. In a relative sense, risk selection may be even greater in the under 65 population. In absolute dollars, the impact that not adjusting for risk selection could have is high just because so much money is spent on older people. It is something we have to acknowledge.

Mr. MCCRERY. I am not sure I follow you. Let me rephrase my question, and then you can go on. It seems to me that in the Medicare population, you are going to have a higher percentage of beneficiaries knowing that they have adverse health conditions compared to the below 65 age population.

Ms. WILENSKY. Right.

Mr. MCCRERY. So it doesn't compute up here right now that the problem could be worse, even in a relative sense, or especially in a relative sense in the under 65 population.

Ms. WILENSKY. The concentration of spending in the under 65 is even greater. That is slightly a smaller percent that account for an even larger number of dollars in the under 65.

If you don't make adjustments for where that concentration is, then it could cause you in a relative sense even greater difficulty in the under 65.

The over 65 has high averages. It is slightly less concentrated, and the reason is because lots of people have some health care needs. But please understand, risk selection ought not to be regarded as an excuse for not doing things. We need to look at risk selection as something that we have got to fix so we can give people choices.

Mr. MCCRERY. I understand we would all like to fix the risk selection problem. Nobody has figured out a way to do it yet.

Again, if the bad result from adverse risk selection is higher premiums for everybody else——

Ms. WILENSKY. Right. It is a bigger problem in the Medicare population.

Mr. MCCRERY. That is what I am trying to get at.

Ms. WILENSKY. Yes. In dollars, it will have a bigger impact in the Medicare population.

Mr. MCCRERY. So, if that is the problem, if we want to avoid that problem, then we would more likely not provide MSAs in the Medicare population than not provide it in the general population of the under 65 population because, then, in that population, the insurance system has a much broader universe of people to spread that risk to. So that is what I was getting at.

Ms. WILENSKY. Yes. I think that that is correct.

I think by having a slightly longer decision period as one of the possible ways, it is possible to do this for the Medicare population as well. I didn't want you to drop that idea for the Medicare population because I think it is something that you can try to respond to imperfectly by, for example, having a slightly longer selection period.

Mr. MCCRERY. I don't want to drop the idea of MSAs for the Medicare population. I think you have given us some very constructive suggestions to maybe make offering MSAs to the Medicare

population. Since the gentleman from California got into MSAs in the general population, I wanted to make it clear that the risk involved, if we think the risk is increasing what everybody else pays, is much less with the under 65 population than it is for the other Medicare beneficiaries.

Ms. WILENSKY. Right. In the dollar amount, it definitely is much less.

Mr. MCCRERY. Thank you.

Mrs. JOHNSON [presiding]. Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chairman.

Gail, it is very nice to have you in the Committee.

Ms. WILENSKY. Thank you.

Mr. CARDIN. I was very pleased to see in the Commission's report the recommendation that a prudent layperson's perspective should be considered as one of the factors in determining when a health plan that participates in Medicare should pay for initial screening and stabilization, if necessary, in an emergency.

Ms. WILENSKY. That is correct.

Mr. CARDIN. I have filed that legislation here in Congress. With the expectation that there will be more managed care options available to our seniors within Medicare, it seems to me that it becomes even more important for us to move toward the reasonable layperson standard for emergency care.

I was curious what precipitated this recommendation and whether you are experiencing more complaints within the Medicare population.

Ms. WILENSKY. This is an issue that PPRC has taken up before. As we open up choice, we do expect more of the seniors to go into traditional managed care, as well as any of the new varieties; that any of our concerns that have been in the past get moved forward. It was why we were very specific about having some of the marketing safeguards that have been in past legislation be moved into the future legislation. I am not sure if there has been an increase, but it is an issue we have raised in the past.

We think the growth of managed care makes it even more important in the future because of the larger numbers of who would be at risk.

Mr. CARDIN. I applaud you for that. We are finding that the States that have adopted this standard, including my own State of Maryland, that it has worked rather successfully. We have very few complaints from health care plans. It seems to me that this is one area where there is a developing national consensus that we should use that standard within Medicare and develop it nationally as well. So I look forward to working with you in that regard, and hopefully, we can implement that recommendation.

If I might, let me move on to a second area where you talk about giving the option to beneficiaries to disenroll at any time and then having the ability to go into a plan that would offer at least a point-of-service option or choice to the beneficiary.

My question is, should we be considering requiring all the managed care programs that want to participate in Medicare, to offer the beneficiaries at least a point-of-service option?

Ms. WILENSKY. This is not an issue that the Commission raised.

My personal view is we should not put such a requirement in place because I think that you ought to allow plans that want to offer only a traditional staff or group model HMO and to price accordingly between benefits and whatever premium charges they make, to have that as an option. The only hesitation I would have is if in any marketplace it was observed that there were no point-of-service options available. Then I think you could decide whether or not there ought to be a role of government to make sure that there were some there.

I think to require that is just not the best way to make plans available to seniors. It will cost plans money they may or may not be able to capture, all of the costs associated with a point-of-service. So I would not do that unless it was clear that there were markets where you just didn't develop point-of-service.

Mr. CARDIN. There are several ways you could implement it. My concern is that if you are going to permit disenrollment, you are going to then find that a plan that does not offer the point-of-service option may be at an advantage of trying to get some of its higher risks out of their plans into other plans that offer the point-of-service.

Whereas, if the plan offers the choice of the point-of-service option, they are staying within the same plan. It seems to me it may promote more competition rather than less if all HMOs have to operate under the same standards.

A good HMO, with its marketing strategy, is not afraid of offering the point-of-service, even if it doesn't want its beneficiaries or enrollees to go out of network because they will have satisfaction within the plan. But, if they are permitted to offer without point-of-service where someone else has the point-of-service, it may not be fair competition.

Ms. WILENSKY. I have two points. One is, I actually think the plans that offer point-of-service will, in fact, be in a better place in the marketplace because I think that is actually what people are more likely to choose. So I think that plan that didn't do that would find themselves at a competitive disadvantage.

I wanted to be sure it was clear that what we were saying is that while, in general, annual enrollment was a model that the Congress was at least considering and we had some comment about it, we thought it was important that if an event occurred during the year that changed the nature of a plan that, in that case, if it was significant, enrollees be allowed to make a different choice. We were not taking a position that, in general, people ought to be able to disenroll in 30 days as they do now. That is a decision that Congress has to make as to whether or not it wants to proceed.

Even if you went to an annual choice, as is prevalent in the private sector, it will be important to have an allowance if a plan changes in a major way which needed to be defined in regulation as to what constituted major. At that point, you would need to allow individuals to make a second-round choice.

Mr. CARDIN. I thank you and look forward to working with you on these issues.

Mrs. JOHNSON. Thank you very much, Dr. Wilensky. In looking over some of the parts of your testimony that you didn't get to, I notice that you do have some recommendations regarding Medigap

insurance reform, and that is an issue that I am working on. I look forward to talking with you at another time about those recommendations. Thank you very much for your testimony today.

Ms. WILENSKY. Thank you.

Mrs. JOHNSON. It has been very helpful.

Finally, we will hear from Janet Shikles, the Assistant Comptroller General of the Health, Education, and Human Services Division of the GAO.

Welcome. You have been very, very helpful to this Committee and many, many others, you and your GAO colleagues, and we welcome you here today.

STATEMENT OF JANET L. SHIKLES, ASSISTANT COMPTROLLER GENERAL, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY EDWIN P. STROPKO, ASSOCIATE DIRECTOR, AND TOM DOWDAL

Ms. SHIKLES. Thank you very much. I would like to introduce Ed Stropko on my right and Tom Dowdal on my left.

We are very pleased to be here today to discuss strategies to curb escalating Medicare spending. Over the past few years, we have reported in some detail on several of Medicare's flawed pricing and reimbursement policies and weak controls over utilization.

Today, I would like to summarize these findings and outline several steps that would lead to a better-managed, less costly health care program.

Two areas that illustrate problems due to ineffective reimbursement and utilization controls are home health and skilled nursing facility services. In the case of home health care, Medicare pays home health agencies on the basis of cost, but uses few tools to determine whether the costs are reasonable.

For example, physicians are not required to see patients for whom they sign plans of care. Medicare does not require home health agencies to provide beneficiaries or physicians with information on the home health services that are billed. Only about 3 percent of the home health claims are reviewed before they are paid, and even when reviews are done, Medicare contractors rarely visit home health agencies or beneficiaries to verify that services were actually provided or needed. These minimal controls have resulted in significant inappropriate cost to the Medicare Program.

Turning to SNFs, skilled nursing facilities, this represents another area in which Medicare's reimbursement policies have been exploited. Under Medicare's provisions for reimbursement, providers can bill Medicare directly without the SNF or attending physician affirming whether the items were necessary or provided as claimed.

In January of this year, we reported that a wide array of provider types, including physicians, optometrists, psychiatrists, labs, and medical equipment suppliers, fraudulently or otherwise inappropriately billed Medicare for unnecessary or undelivered services.

We believe that the reimbursement and utilization problems facing Medicare in home health care, skilled nursing facility services, and other services confront private insurers as well, but private in-

surers are equipped with a larger and more versatile inventory of health care management strategies than HCFA currently has.

In stark contrast to private payers, HCFA and its contractors generally cannot use such utilization controls as prior approval or case management to coordinate and monitor expensive services and specialist care, encourage the use of preferred providers who meet utilization, price, and quality standards, negotiate with select providers for discounts, promptly change prices to match those available in the market or competitively bid prices.

If similar approaches were also available to Medicare, the government might be able to avoid spending substantial sums unnecessarily.

In conclusion, helping to move Medicare in the direction of becoming a more prudent manager of health care costs by giving it the tools it needs to pull this off will entail several steps. We believe that Congress should enact funding and contractor reform provisions, similar to those contained in H.R. 3103.

Second, we believe that HCFA needs to target Medicare's high cost, high utilization areas, such as home health and SNF services, for running demonstrations to apply such strategies as the use of case management and contracting with companies specializing in utilization review.

Third, the Congress should give HHS the flexibility to make prompt adjustments to fee schedules when overpriced services and supplies are identified.

This is the recommendation that Congressman Shays was also talking about at the beginning of this hearing.

This concludes my testimony, and we would be pleased to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF JANET L. SHIKLES
ASSISTANT COMPTROLLER GENERAL
HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss strategies to curb escalating Medicare spending. There is no shortage of numbers to illustrate the importance of controlling federal outlays for this program. On average, Medicare spending has grown by over 10 percent a year since 1989--twice the rate of the national economy. Medicare's part A trust fund, which pays for hospital and other institutional services, is projected to run out by mid-2001--a year sooner than projected last year.[1]

Over the past few years we have reported in some detail on several of Medicare's flawed pricing and reimbursement policies and on weak controls over utilization. We have noted how these problems amount to bad business practices and that aspects of the Medicare program must be modernized in today's highly competitive health care market.[2] Today, I'd like to summarize these findings and outline several basic steps that would lead to a better managed, less costly health care program.

In brief, we believe that while the Congress considers long-term restructuring efforts, immediate efforts to improve Medicare's traditional fee-for-service program could bring about much needed savings. This program currently serves about 90 percent of beneficiaries and with better management could run more efficiently while continuing to serve well the nation's elderly. This means allowing Medicare to use tools similar to those used by private payers to manage health care costs. Negotiated discounts, competitive bidding, preferred providers, case management, utilization review--these and other tools enable private payers to use market forces to control health care costs, but most are not authorized for general use by the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which administers Medicare. This results in a publicly financed program that pays higher than market rates for certain services and supplies, and sometimes pays without question for improbably high levels of services. Recent HCFA initiatives and pending legislation passed by the House of Representatives,[3] however, offer promise for making some program improvements. In addition, HCFA should test the feasibility of applying management strategies in high-cost, high-utilization areas. Finally, the Congress needs to give HHS the flexibility to make prompt price adjustments.

BACKGROUND

Medicare is the nation's largest single payer for health care. In 1995, it spent an estimated $177 billion, or 12 percent of the federal budget, on behalf of more than 37 million elderly and disabled people. CBO projects that, under current program law, program spending will almost double in the next 6 years to an estimated $332 billion by 2002. Approximately 90 percent of Medicare beneficiaries obtained services on an unrestricted fee-for-service basis; that is, patients chose their own physicians or other health care providers, with bills sent to the program for payment. This set-up mirrored the nation's private health insurance indemnity plans, which prevailed until the 1980s.

Since then, many changes have taken place in the financing and delivery of health care. Large health care purchasers have used leverage on hospitals and other providers to obtain lower prices. Private payers, including large employers, use an aggressive management approach to control health care costs. HCFA is

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[1]Based on CBO's March 1996 baseline projection for Medicare.

[2]A list of related GAO products is at the end of this statement.

[3]H.R. 3103, the Health Coverage Availability and Affordability Act of 1996, passed the House of Representatives on March 28, 1996.

Medicare's health care buyer. HCFA's pricing of services and controls over utilization have been carefully prescribed by interrelated statute, regulation, and agency policy.

HCFA contracts with about 70 companies--such as Blue Cross and Aetna--to handle claims screening and processing and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls in addition to those that have been established nationally by HCFA. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted when the program was established in the mid-1960s by concerns that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

The health care delivery system has become more complex since Medicare began 30 years ago. In addition to physicians and hospitals, a greater variety of providers bill Medicare, including multilayered corporations providing clinical laboratory services, home health care, rehabilitation therapy, and medical equipment and supplies. Even some of Medicare's claims processing contractors are investing in provider networks, which means that insurance companies responsible for reviewing the appropriateness of Medicare claims are also, through the medical networks they own, billing the program. At a time when the volume of Medicare claims has exceeded 800 million a year, Medicare is being billed increasingly by entrepreneurial entities rather than by medical professionals.

CATEGORIES WITH FASTEST GROWTH RATES COINCIDE WITH THOSE LEAST MANAGED IN MEDICARE

Although growth rates for inpatient hospital and physician services have moderated since the 1980s, Medicare spending remains high. Combined spending for these services amounted in 1994 to $120 billion--nearly three-fourths of total Medicare spending. The sheer size of these categories means that each percentage point of growth represents hundreds of millions of dollars.

Smaller categories of services, however, have displayed much more rapid growth through the 1990s, helping to drive total Medicare spending to double-digit inflation. Home health agency (HHA) and skilled nursing facility (SNF) services each grew at an average annual rate of 28 percent from 1990 through 1996.[4]

Table 1: Average Annual Growth Rates for Selected Categories of Medicare Spending

Numbers in percent

Years	Total	Inpatient	Physician	SNF	HHA
1980-89	10.2	9.5	13.8	27.3	14.0
1990-96	11.3	5.9	7.0[a]	28.0	28.4

[a]Percentage is based on data through 1994.

Private insurers and employer purchasers have sought to stem such health cost escalation by shifting from their role as passive payers to become more prudent managers of health care costs. Some 90 percent of health plans--from fee-for-service to managed care--

[4]This is based on the latest CBO baseline projections for 1995 and 1996, since actual data are not yet available. From 1990 through 1994, the growth rate was even higher--over 35 percent per year.

actively manage costs through price competition and negotiation and utilization monitoring techniques. By contrast, Medicare's reimbursement policies and claims payment activities have not been adapted to the contemporary marketplace and today's demands for fiscal discipline in public programs.

SNF AND HHA CATEGORIES ILLUSTRATE COST CONSEQUENCES OF UNMANAGED HEALTH SERVICES

The home health and SNF spending categories, in particular, illustrate the damaging effects of reimbursement policies that fail to incorporate effective pricing and utilization management techniques.

Inadequate Monitoring of HHA Payments

In the case of home health services, for example, Medicare pays HHAs on the basis of costs but uses few tools to determine whether the costs are reasonable. Also, physicians are not required to see the patients for whom they sign plans of care and are not held accountable if they approve inappropriate levels of service. Medicare does not require HHAs to provide beneficiaries or physicians with information on the home health services billed on their, or their patients', behalf. The Medicare contractors, moreover, pay 97 percent or more of home health claims without review.[5] Even when reviews are done, Medicare claims processing contractors rarely visit HHAs or beneficiaries to verify the actual and appropriate provision of services. One consequence of such neglect is the escalation of visits per Medicare beneficiary, which rose an average of about 20 percent a year from 1989 to 1994.

In July 1995 we reported that the largest privately held HHA in the United States, which was being investigated for fraud, obtained 95 percent of its total revenues from Medicare.[6] Current and former employees told us medical records were altered and forged to ensure continued or prolonged home health care visits. Services were provided to patients who were not homebound[7]--for example, one who routinely drove a vehicle to go grocery shopping and one who walked a few blocks alone daily to eat at the local senior citizens' center.

This company also visited patients more frequently than did most other HHAs. Although wide variation in utilization rates is a key indicator that an inappropriate level of services is being provided, Medicare contractors do not have the capacity to manage home health payments by scrutinizing agencies' claims in markets showing utilization outliers. Our March 1996 report on home health utilization shows huge variations in the level of services provided across geographic areas and provider types.[8] For example, in 1993 patients in southeastern states received on average more than twice as many visits as patients in northwestern states. Furthermore, diabetics received an average of about twice as many visits from proprietary HHAs as from voluntary or government-run agencies.

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[5]Because of limited resources, contractors' medical review of claims has declined from 62 percent of all claims in fiscal year 1987 to about 3 percent in 1995.

[6]Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

[7]42 U.S.C. 1395f(a) requires that, to qualify for home health services under Medicare, a beneficiary must be confined to the home.

[8]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Inadequate Monitoring of SNF and Ancillary Service Payments

Skilled nursing facilities represent another area in which Medicare's unguarded reimbursement policies have been exploited. In this setting, a population with extensive health care needs grouped together at a single location offers unscrupulous providers the opportunity for volume billing, and Medicare often does not look for warnings of egregious overutilization or rapid increases in billings. Under Medicare's provisions for reimbursement, providers can bill Medicare directly, without the SNF or attending physician affirming whether the items were necessary or provided as claimed. In other words, medical equipment suppliers, providers of rehabilitation therapy, and providers of X rays and other diagnostic tests can determine levels of services and bill Medicare with little or no oversight. In addition, Medicare's automated systems do not capture data in a way that would practically allow them to flag indications of improbably high charges or levels of services at individual facilities. This is in part because the data are not organized to report which beneficiaries are in nursing homes.

In January of this year we reported that a wide array of provider types--including physicians, optometrists, psychiatrists, laboratories, and medical equipment suppliers--have fraudulently or otherwise inappropriately billed Medicare for services and supplies furnished to nursing facility residents.[9] The wrongdoing has generally focused on billing Medicare for unnecessary or undelivered services, or misrepresenting a service to obtain reimbursement. The investigations we reviewed probed activities in over 40 states, with many providers operating in multiple states.

Not only are payments for the ancillary services provided to SNF patients poorly policed, payments to SNFs themselves are difficult to monitor. Medicare pays SNFs on the basis of costs. But as with home health care, Medicare has only limited tools to determine whether the costs are reasonable. This is particularly pertinent to rehabilitation therapy, services that account for 30 percent of SNF costs. Specifically, Medicare places no absolute dollar limits on reimbursements for occupational or speech therapy, and charges for therapy services are not linked through billing codes to the amount of time spent with patients or the treatment provided. In other words, Medicare has no easy way to limit the amount it will pay for occupational or speech therapy or to determine whether a charge is for 15, 30, or 60 minutes of treatment. Absent any benchmarks, and with limited resources available for auditing, it is largely infeasible for Medicare contractors to judge whether therapy providers have overstated their costs.

Last year we reported that Medicare had been charged as much as $600 for an hour of therapy services.[10] HCFA has acknowledged the problem and recently estimated that implementing salary equivalency guidelines for speech and occupational therapy, in conjunction with adjusting other salary guidelines, could save $1.4 billion over the next 6 years. To date, however, the salary guidelines have not been established. Although occupational therapists in SNFs earn on average $23 per hour, we recently found in one contractor's files that more than 25 percent of submitted charges for one unit (undefined) of occupational therapy exceeded $195 and some approached $1,500 per unit.

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[9]Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

[10]Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

Under Medicare rules for reimbursing SNFs, the problem of overpaying for rehabilitation therapy services becomes compounded. That is, Medicare pays SNFs a portion of their overhead expenses, based on the percentage of their total Medicare-related business. The higher the Medicare-related payments to rehabilitation agencies (or other outside contractors), the more Medicare business an SNF can claim, and the higher the percentage of its overhead that can be charged to the program. Further, as noted by the Prospective Payment Assessment Commission (PROPAC), SNFs may cite high use of ancillary services, such as therapy, to justify an exemption from routine service cost limits, thereby increasing their payments for routine (bed, board, nursing) services.[11]

MEDICARE'S RESPONSE TO
LONG-STANDING PROBLEMS TOO
SLOW TO BE EFFECTIVE

Allowing payment problems to continue unchecked results in billions of dollars of unnecessary spending. HCFA has been aware of the rehabilitation therapy overcharging problem since 1990. In 1993 HCFA began studies to develop averages for therapists' salaries. Its most recent analysis is expected to be completed some time this summer. Given the usual time involved in the federal notification and publication requirements for changing Medicare prices, salary equivalency guidelines--which are key to Medicare's determination of reasonable costs--are unlikely to be implemented before the middle of 1997 at the earliest.

This situation is consistent with HCFA's past experience of taking years to adjust excessively high payment rates. It took almost 3 years to lower the price of an item it paid up to 4 times more for than consumers paid at the local drug store. HCFA can adjust prices that are inherently unreasonable, but its authority to do so is very limited and involves a complex set of procedures that take a long time to complete.[12] Because of the time and resources involved, HCFA only occasionally uses this process. In an August 1995 report, we showed that Medicare paid higher than the retail prices for 44 types of surgical dressings.[13] Under the Omnibus Budget Reconciliation Act (OBRA) of 1987, however, even the unwieldy inherent reasonableness authority to change these prices was effectively eliminated. Before 1987, individual Medicare contractors had the authority to adjust prices to reflect local market conditions using a publication and notification process that could be completed in less than 90 days. In a letter to a congressional subcommittee, the HHS Inspector General last year characterized as "absurd" the situation limiting HCFA's ability to make timely adjustments to payment levels.[14]

MEDICARE PROGRAM
OVERDUE FOR CHANGE

Because of strict statutory constraints and its own burdensome regulatory and administrative procedures, HCFA is slow to address overpricing and overutilization problems. As we reported to the Congress last September, many of the tools Medicare's contractors

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[11]Report and Recommendations to the Congress (Washington, D.C.: PROPAC, Mar. 1, 1996).

[12]The relevant statutory provision is 42 U.S.C. 1395m(a)(10)(B).

[13]Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

[14]Letter dated July 25, 1995, to the Chairman, Subcommittee on Oversight and Investigations, Committee on Commerce, House of Representatives.

use to manage their commercial insurance plans are not authorized for use in the Medicare program.[15]

In stark contrast to private payers, HCFA and its contractors generally cannot

-- use such utilization controls as prior approval or case management to coordinate and monitor expensive services and specialist care;

-- encourage the use of "preferred providers"--those who meet utilization, price, and quality standards; or

-- negotiate with select providers for discounts, promptly change prices to match those available in the market, or competitively bid prices.

Not surprisingly, Medicare's ability to emphasize cost efficiency in its dealings with suppliers, physicians, and institutions that habitually provide excessive services is limited, and for certain services Medicare pays higher prices than its private sector counterparts. (See app. I for details on commonly used private sector strategies and their applicability to Medicare. See also chapter 11 of the Physician Payment Review Commission's (PPRC) 1996 Annual Report to Congress.[16]

The recognition that Medicare needs to change its role from largely a claims processor to prudent manager is beginning to take shape in HCFA itself as well as in pending legislation passed by the House of Representatives last month. For example, HCFA has planned, among several new initiatives,

-- a demonstration testing the concept of competitive bidding for certain supplies, such as oxygen, hospital beds, and urological and incontinence products;

-- an improvement on earlier case management experiments by which primary care physicians would, for example, provide comprehensive management for beneficiaries with specific diagnoses such as diabetes, hypertension, or congestive heart failure, for which Medicare would reimburse them with a bundled, capitated payment as is currently done on a monthly basis for end-stage renal disease patients; and

-- a demonstration in selected locations that allows beneficiaries to join preferred provider organization health plans, which are not currently available under Medicare.

HCFA has interpreted current law as precluding it from contracting with entities other than insurance companies. Certain provisions in the Health Coverage Availability and Affordability Act of 1996 would give HCFA the funding and flexibility to make its contractor network better managers of program dollars. In particular, HCFA[17] would have the authority to contract directly with companies specializing in utilization review and fraud detection to monitor and adjudicate claims. In essence, HCFA could contract with the companies best suited to perform medical, utilization, and fraud reviews; audit cost reports; revisit payment decisions and recover overpayments; provide education on payment integrity and benefit quality assurance issues; and provide more specific guidance on coverage of medical equipment and supplies.

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[15]Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

[16]Washington, D.C.: PPRC.

[17]Technically, the authority is granted to HHS, of which HCFA is a part.

Increased flexibility and an accompanying assured funding stream, such as that proposed in this legislation, would significantly enhance HCFA's ability to curb overutilization and inappropriate billings.

Despite these initiatives, however, important tools would still be unavailable to the Medicare program. For example, HCFA uses profiling--that is, statistical analyses--to identify "outlier" providers whose practice patterns differ markedly from those of their peers. While the private sector is free to use profiling results to provide financial rewards or penalties (in the form of exclusion from preferred provider networks), HCFA lacks the authority to do so. In addition, HCFA and its contractors have no viable statutory authority to require prior approval of select procedures. Most important, HCFA does not have the authority needed to promptly correct overpricing problems.

CONCLUSIONS

The problems facing Medicare confront private insurers as well, but they are equipped with a larger and more versatile inventory of health care management strategies than HCFA currently has. These strategies may not be deployable in every aspect, but in general they suggest ways to make Medicare more cost effective. Commercial contractors, which play a key role in administering Medicare, routinely employ management-of-care approaches in their capacity as private insurers. If they applied similar approaches to Medicare, the government might be able to avoid spending substantial sums unnecessarily.

Medicare needs to redefine itself from being a passive payer of claims to becoming a prudent manager of health care costs. Major reimbursement reforms may be an ultimate solution, but HCFA needs to begin immediately to manage Medicare's high-growth-rate areas, such as home health and SNF care. Reducing services and prices to appropriate levels is paramount before locking in existing cost structures through payment system reforms. This will entail several steps:

1. The Congress should enact funding and contractor reform provisions similar to those contained in H.R. 3103. Such reforms would give HCFA the flexibility to hire the private sector expertise necessary to apply the best health cost management practices.

2. HCFA needs to target Medicare's high-cost, high-utilization areas for running demonstrations to apply such strategies as the use of case management and companies specializing in utilization review. For example, HCFA could identify, as the focus of the demonstrations, geographic areas with particularly high home health or SNF costs per Medicare beneficiary.

3. The Congress should give HHS the flexibility to make prompt adjustments to fee schedules when overpriced services and supplies are identified. For example, Medicare should be able to reduce fee schedule prices for surgical supplies within 90 days, similar to what was customary before OBRA 1987.

We have included as appendix II a list of GAO recommendations recently made to correct specific Medicare payment problems.

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Mr. Chairman, this concludes my statement. I will be pleased to answer any questions.

For more information on this testimony, please call Edwin P. Stropko, Associate Director, at (202) 512-7119. Other major contributors included Audrey Clayton, Patricia Davis, Hannah Fein, and Barry Tice.

COMMON PRIVATE SECTOR STRATEGIES AND APPLICABILITY TO MEDICARE

Private sector strategy	Description	HCFA's current practice	HCFA explanation
Prompt reaction to market prices	Change prices quickly when paying more than competitively necessary	Prices generally not adjusted for declines in the price of product or service[a]	Pertinent statute generally permits appropriate adjustments only after a complex administrative process[b]
Negotiate with select providers	Selectively contract with providers to deliver certain services, such as hip replacements, at a specific price	Same payments generally made to any provider selected by beneficiary to provide services	Statute does not permit providers to be excluded unless they engage in certain prohibited practices[c]
Competitive bidding and negotiations	Set prices for services or service packages based on competitive process	Prices are set under complex formulas, but demonstration involving competitive procedures is proposed	Statute generally provides only for all area providers to be paid the same amount for service;[d] legislation prohibits proposed demonstration[e]
Preferred provider network	Promote use of a network of select providers meeting price, practice style, and quality criteria	Payments generally made to any provider selected by beneficiary to provide medical services	Statute guarantees beneficiary freedom to choose providers;[f] statutory authority to contract with health maintenance organizations (HMOs) only[g]
Prior authorization	Require prior approval of select procedures	No prior approval of hospitalizations or other procedures	No viable statutory authority for requiring prior approval; statute prohibits interference with practice of medicine[h]
Case management	Assist high-cost patients in selecting appropriate services efficiently	Assistance not provided to patients in selecting services efficiently	Statute prohibits interference with practice of medicine[i]
Contract with utilization review companies	Use companies specializing in utilization review to monitor and adjudicate claims	HCFA contracts with private entities--generally insurance companies--to process claims[j]	Statute provides no specific authority for contracting with utilization control organizations[k]
Greater use of commercial technology to detect billing abuses	Use off-the-shelf software that flags billing problems and automatically adjusts payments	HFCA directs contractors to develop system capabilities, without guidance on use of specific technologies	HCFA concerned about adaptability and relevance to Medicare

[a]For example, although 42 U.S.C. 1395u(b)(8) and (9) provide HCFA with authority to adjust payments when the established rates under a fee schedule are found to be inherently unreasonable, detailed procedures are mandated that include a lengthy notice and comment period.

[b]For example, 42 U.S.C. 1395m(a)(10)(B) provides HCFA with authority to adjust prices for durable medical equipment, excluding surgical dressings, but only after completion of a cumbersome administrative process. The one time this process was used, it took 3 years to complete.

[c]42 U.S.C. 1320a-7 provides for mandatory and permissive exclusion of providers who are, for example, convicted of certain program-related crimes.

[d]42 U.S.C. 1395f establishes conditions of and limitations on payment for services.

[e]In 1985, HCFA started the process to perform a demonstration of competitive bidding related to laboratory services, and it was set to begin in 1987. That year and in several subsequent years, however, provisions were included in the respective budget reconciliation laws specifically prohibiting its implementation. Eventually, HCFA abandoned plans for the demonstration, but has since requested authority to introduce competitive bidding, without success.

[f]42 U.S.C. 1395a, the so-called freedom of choice provision, expressly provides that beneficiaries may obtain health services from any willing provider.

[g]42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances.

[h]42 U.S.C. 1395.

[i]42 U.S.C. 1395.

[j]These companies may arrange for utilization review to be done under subcontract.

[k]42 U.S.C. 1395h provides detailed authorization for HCFA to contract with private entities without competitive procedures to handle part A claims, and 42 U.S.C. 1395u provides similar authority for part B claims.

SPECIFIC RECOMMENDATIONS MADE IN RECENT GAO REPORTS

Cited below are our recommendations and matters for congressional consideration addressing specific reimbursement system and payment control problems.

MEDICARE: HOME HEALTH UTILIZATION EXPANDS WHILE PROGRAM CONTROLS DETERIORATE (GAO/HEHS-96-16, Mar. 27, 1996)

Matters for Consideration by the Congress

The emphasis of Medicare's home health benefit program has recently shifted from primarily posthospital acute care to more long-term care. At the same time, HCFA's ability to manage the program has been severely weakened by coverage changes mandated by court decisions and a decrease in the funds available to review HHAs and the care they provide. The Congress may wish to consider whether the Medicare home health benefit should continue to become more of a long-term care benefit or if it should be limited primarily to a posthospital acute care benefit. The Congress should also consider providing additional resources so that controls against abuse of the home health benefit can be better enforced.

FRAUD AND ABUSE: PROVIDERS TARGET MEDICARE PATIENTS IN NURSING FACILITIES (GAO/HEHS-96-18, Jan. 24, 1996)

Recommendation to the Congress

To curtail the practice of giving providers unauthorized access to beneficiary medical records, the Congress should authorize HHS OIG to establish monetary penalties that could be assessed against nursing facilities that disclose information from patients' medical records not in accord with existing federal regulation.

Recommendations to the Secretary of HHS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

-- establish, for procedure billing codes by provider or beneficiary, thresholds for unreasonable cumulative levels or rates of increase in services and charges, and to require Medicare carriers to implement automated screens that would suspend for further review claims exceeding those thresholds and

-- undertake demonstration projects designed to assess the relative costs and benefits of alternative ways to reimburse nursing facilities for part B services and supplies; these alternatives should include such options as unified billing by the nursing facility and some form of capped payment.

MEDICARE SPENDING: MODERN MANAGEMENT STRATEGIES NEEDED TO CURB BILLIONS IN UNNECESSARY PAYMENTS (GAO/HEHS-95-210, Sept. 19, 1995)

Recommendations

We recommend that the Secretary of HHS direct the HCFA Administrator to

-- develop policies and revise practices so that Medicare can (1) price services and procedures more competitively, (2) manage payments through state-of-the-art data analysis methods and use of technology, and (3) better scrutinize the credentials of vendors seeking to bill the program;

-- examine the feasibility of allowing Medicare's commercial contractors to adopt for their Medicare business such managed care features as preferred provider networks, case management, and enhanced utilization review; and

-- seek the authority necessary from the Congress to carry out these activities.

Matters for Congressional Consideration

Given the urgency for expediting Medicare program changes that could lead to substantial savings, the Congress may wish to consider directing the Secretary of HHS to develop a proposal seeking the necessary legislative relief that would allow Medicare to participate more fully in the competitive health care marketplace. Such relief could include allowing the Secretary of HHS to set maximum prices on the basis of market surveys, or, if the formal rulemaking process is preserved, allowing the Secretary to make an interim adjustment in fees while the studies and rulemaking take place.

The Congress may also wish to consider options for granting relief from the funding declines in Medicare's anti-fraud-and-abuse activities.

MEDICARE: EXCESSIVE PAYMENTS FOR MEDICAL SUPPLIES CONTINUE DESPITE IMPROVEMENTS (GAO/HEHS-95-171, Aug. 8, 1995)

Recommendations to the Secretary of HHS

The Secretary should direct the Administrator of HCFA to

-- require that bills submitted to fiscal intermediaries itemize supplies;

-- develop and implement prepayment review policies as part of the process of implementing any new or expanded Medicare coverage; and

-- establish procedures to prevent duplicate payments by fiscal intermediaries and carriers.

Matter for Congressional Consideration

The fee-schedule approach to setting prices provides a good starting point for setting appropriate Medicare prices. HCFA, however, needs greater authority and flexibility to quickly adjust fee-schedule prices when market conditions warrant such changes. To allow Medicare to take advantage of competitive prices, the Congress should consider authorizing HCFA or its carriers to promptly modify prices for durable medical equipment (DME) and other medical supplies. For this to work effectively, however, HCFA or the carriers must devote adequate resources to routine price monitoring.

MEDICARE: TIGHTER RULES NEEDED TO CURTAIN OVERCHARGES FOR THERAPY IN NURSING HOMES (GAO/HEHS-95-23, Mar. 30, 1995)

Recommendations to the Secretary of HHS

The Secretary should direct the Administrator of HCFA to (1) set explicit limits to ensure that Medicare pays no more for therapy services than would any prudent purchaser; (2) strengthen certification requirements to better ensure that those entities billing Medicare are accountable for the services provided to beneficiaries; and (3) define billable therapy service units so they relate to the time spent with the patient.

RELATED GAO PRODUCTS

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

Fraud and Abuse: Medicare Continues to be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7, Nov. 2, 1995).

Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

Medicare: Antifraud Technology Offers Significant Opportunity to Reduce Health Care Fraud (GAO/AIMD-95-77, Aug. 11, 1995).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (GAO/T-HEHS-95-227, July 31, 1995).

Medicare: Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995).

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

Mrs. JOHNSON. Thank you very much.

I understand that toward the back of your testimony there is a chart that lays out these private sector strategies that you believe could be adopted to Medicare. In reviewing that chart, I wonder which strategies HCFA could do on its own through its administrative power and which ones would require changes in the law.

Ms. SHIKLES. We think that case management or most of these except perhaps the top one on changing market prices, they could certainly do on a demonstration authority. We have been pushing HCFA for some time, and I know this Committee has, to move out in a more aggressive way and certainly look at some of the activities used by private companies that are managing the indemnity side of the insurance business.

PPRC also just did a survey of Blue Cross plans to look at the same issue, and we believe that HCFA could have been running demonstrations particularly in these very high-growing areas, the postacute services on part A, testing case management, the utilization review strategies, perhaps PPOs, and then learning from those efforts and they could then come to this Committee and say these worked, these didn't work, and then ask for legislative relief.

On the first one, on changing prices quickly, they need legislative action. Back in 1987, Medicare used to be able to, on the basis of a quick market survey that alerted that it was paying at high rates when everybody else was paying at lower rates, in a period of 90 days, they could change prices in that market.

After 1987, it is really not possible for Medicare to do that quickly. They have to now take the whole Administrative Procedures Act, follow it through, and it can take up to 3 or more years to make a change on a price for a particular item.

So what we have recommended is that Congress consider at least giving the Medicare Program authority to at least make an interim change when it identifies really egregious prices, and then if the Congress wanted, they could follow through on the long procedures and issue a final rule. This would restore public confidence that Medicare is not overpaying for a particular item.

Mrs. JOHNSON. What was the cause of that change in 1987? Was it a change that went on for other reasons and simply affected this price-setting capability of HCFA?

Ms. SHIKLES. Yes. I believe that at that time a set of fee schedules were put in place nationally, and I think the thinking was that you would have uniform fee schedules and that somehow that would take care of the problem. So I don't think it was intended to cause the problems it subsequently did.

Mr. DOWDAL. Yes, that is correct. The restriction on changing prices came into being mainly with the fee schedules when there was feeling that prices would be national and not modified locally. Although there are authorized variations, the law didn't recognize that there could be pricing problems that arise.

On your first question, the only one of those strategies in our list that HCFA would definitely have legal authority to do now is the last one related to the claims processing systems and using different kinds of software. The rest of them, there would need to be legislation of some kind.

Mrs. JOHNSON. Which ones would you have the greatest confidence in, in the sense of urging clear legislative authority now rather than going through the demonstration process, or would you recommend legislative authority for all of them?

Ms. SHIKLES. Do you want to answer that?

Mr. STROPKO. I certainly think changing prices to market prices is pretty clear cut and should be dealt with very quickly from HCFA's perspective. They have the infrastructure to do it, and they have a large contractor network that could provide the information necessary to do it if authorized by law.

Certainly, prior authorization has been done in the past, and that is an area where, when abuse is apparent, it seems to me HCFA could very easily be given the discretion to allow prior authorization certainly on a geographic-specific basis. So those seem to be the most direct.

Competitive bidding, preferred provider networks, and case management get HCFA into a degree of management that it is not necessarily accustomed to providing directly, and that is where demonstration authority might be most appropriate.

Mrs. JOHNSON. Thank you.

Mr. McCrery.

Mr. MCCRERY. Thank you.

I appreciate the work that you did and the conclusions that you have drawn. They make a lot of sense. Would it make sense to you to adopt reforms in Medicare that would allow senior citizens to choose private sector plans that already have these kinds of enforcement tools or cost-saving tools available to them?

Ms. SHIKLES. I think it would. In fact, our second recommendation here, in terms of even absent larger legislation, we believe that HCFA now using its demonstration authority could go into the Los Angeles market and contract with a lot of private companies out there to offer preferred provider panels, home health services, case management, or any of these activities. That is what we are strongly pushing HCFA to do using the demonstration authority.

If you are an individual in a private indemnity plan, you are subject to most of these different types of activities. It is Medicare that the fee-for-service side is basically less managed right now.

Mr. MCCRERY. Thank you.

Thank you, Madam Chairman.

Mrs. JOHNSON. Thank you.

Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chairman.

I, too, appreciate the work that you all have done in looking at ways in which HCFA can save money in the administration of Medicare.

I agree that HCFA needs more flexibility in pricing on one of your recommendations, as also our colleague, Congressman Shays, has pointed out.

I hope that goes both ways. Let me just give you an example. It was brought to our attention by a person who needed an implant that automatically releases drugs into your system. Medicare would pay for the procedure, which was very expensive, about $30,000 if I remember correctly, and that if it didn't work, they would pay for the removal of the implant. But, they wouldn't pay

for the test to see whether it would work or not because that wasn't covered, which was one-tenth of the cost of the process for the implant itself.

So I would hope that as we look at flexible pricing that that type of discretion would be given to HCFA to be able to look at more cost-effective ways of dealing with costly procedures in an effort to save money for Medicare. Is that what you are intending to do?

Ms. SHIKLES. Absolutely, and I should have said that. We think that the program needs to have more flexibility, and you can't run with these very rigid rules that end up in situations like the one you just described that are just terribly wrong.

We would agree that if you could go in and do a quick survey of market prices, in some cases, Medicare may need to raise its prices. I think you want to be certain that beneficiaries have access to the very best care, and I don't think you want Medicare to be the lowest price payer in an area either, because you want to be able to pay enough to buy good quality care and comprehensive care.

Mr. CARDIN. It is sometimes very sad that you find Medicare will overpay in some costly areas, but will not pay an adequate amount in less costly procedures, forcing people into the more costly options in order to get reimbursed rather than more cost-effective options.

I hope that it would be balanced, and I appreciate your response on that. I hope that we can develop recommendations that will give HCFA this ability and that it will use it appropriately in order to save money for our system.

Thank you.

Ms. SHIKLES. I remember we did study, and I don't know if it is still true, where Medicare would pay for the cataract surgery, but we wouldn't pay for the glasses after the surgery.

Mr. CARDIN. Right.

Ms. SHIKLES. So you couldn't see, then.

Mr. CARDIN. We all hear about those in our congressional office. We are wondering if someone is looking at this, and every once in a while, we find they don't have the legal authority.

Ms. SHIKLES. That is the problem.

Mr. CARDIN. I would hope that Congress would give our administrator the necessary discretion in order to have a more cost-effective system.

Thank you.

Mrs. JOHNSON. Thank you.

Actually, I was interested in your explanation that HCFA lost that flexibility when we put in the national fee schedule. Now we desperately need the ability to adjust for aberrations that develop.

I think some of the things that we are proposing already will give us more money for both contracting for utilization review companies and greater use of commercial technology to detect billing abuses, but I think probably the utilization review is amongst the most important.

Ms. SHIKLES. I think I would agree with that.

Mrs. JOHNSON. We have little less management experience in the other areas, and we in the end are not going to be the ones who develop these networks.

I appreciate your testimony. It was very, very helpful today.

On the home health reimbursement issue, perhaps you could enlarge on your specific recommendations in that area because we are having a terrible time pricing out the savings of proposals, and I think most Members are getting a very different picture from their providers out there in the field versus CBO and other estimators of these proposals. So any comments that you might have on that, I would appreciate.

Ms. SHIKLES. We have just issued a report on the home health care whole benefit, and it has jumped from about $3 billion in 1989 to about $13 billion in 1994. CBO predicts that it will now increase to $30 billion in the year 2002. I think that and the other nonhospital services in part A are contributing to some of the stress in the part A fund.

Mrs. JOHNSON. To that point, does your study look at what portion of that increase is associated with a reduced number of dates in acute care hospitals?

Ms. SHIKLES. No.

Mr. DOWDAL. No. The conclusion we came to is that home health has become more of a long-term care benefit than it used to be when it was primarily a posthospital, acute care-type benefit. So the number of visits per beneficiary receiving home health care has gone up by factors of three, four, five, and even more than that.

Mrs. JOHNSON. The difficulty with that is looking at it in isolation isn't very helpful when we sought to reduce the number of acute care days. We knew we would increase the number of home care visits. So one of the things I need to know is how many of those home care visits represent reducing health care costs because they are bringing people out of the hospital earlier, and then what percentage of those longer term home health visits are also reducing costs because they are keeping people out of nursing homes.

I do actually see that in my daily life. So does your research go to either of those two points?

Ms. SHIKLES. We will get you the information that will show you how many people are using home health who didn't have a prior hospitalization, but we can't tell from the data that it would have prevented a nursing home admission.

Mrs. JOHNSON. Even in States where they have a very sophisticated program—I know in Connecticut, we have a very sophisticated organization called CCCI, Connecticut Community Care Inc.

Ms. SHIKLES. I am familiar with that.

Mrs. JOHNSON. I think their data ought to be pretty good about the extent to which they have been able to keep people out of nursing homes because that was their mission.

They don't get people. They don't get clients until they are at risk of going into nursing homes.

Ms. SHIKLES. Right.

Mrs. JOHNSON. I don't think this number-of-visits issue can be looked at in isolation.

Did you have further comment?

Mr. DOWDAL. No.

Mrs. JOHNSON. So, if you could help me look at that, I think we are having a terrible time dealing with this area because we aren't able to interpret the data relative to savings in other areas. I think

your comment about the number of services that are not physician-authorized or physician-overseen raises some questions.

Also, how much do you want to pay for physician time because, under managed care plans for the most part now, they don't pay for this. How much physician time do we invest in reviewing a care plan, or are there triggers that can be put in place so that when the time comes there is the review? It is those kinds of issues I would be interested in.

Ms. SHIKLES. I am a little familiar with your program in Connecticut and some similar programs, and we would love to see a demonstration at least for the Medicare benefit on home health care because that is when these services are really used either from a posthospital experience or to prevent nursing home admission or help somebody maintain independence at home.

We will come up and meet with you and show you the data we have that some of the utilization you are not certain whether it is really more just the fact that home health agencies now are competing with each other just to offer more and more services.

Mr. DOWDAL. Yes. When I thought about it a minute, what you are saying, Mrs. Johnson, is similar to what we were saying. Home health has become more of a long-term care program than posthospital acute care, and when you are taking care of people over protracted periods of time, whether it is related to nursing home programs or home- and community-based care and all of that, that is one of the points that we are making in the report. It has become more of a program for long-term care.

Congress didn't do anything specifically to say go ahead and do shift toward long-term care, and one of the things we are pointing out in the report is that Congress may want to consider whether that is the direction they want Medicare to move in for the home health benefit.

Mrs. JOHNSON. Certainly, we need to be clear about that. We also need to be clear on whether there is a better way of seeing whether services that are being provided are necessary.

Mr. McCrery, do you have any further comments?

Mr. MCCRERY. No.

Mrs. JOHNSON. Thank you very much for your testimony. We appreciate it. We look forward to working with you.

Ms. SHIKLES. Thank you very much.

Mrs. JOHNSON. The hearing is adjourned.

[Whereupon, at 5:03 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

HIAA
Health Insurance Association of America

Bill Gradison
President

April 26, 1996

The Honorable Bill Thomas
Chairman, Ways and Means Health Subcommittee
United States House of Representatives
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Bill:

On Tuesday, April 30, the Ways and Means Health Subcommittee will be holding a hearing on the Annual Report to Congress of the Physician Payment Review Commission (PPRC). The Health Insurance Association of America (HIAA) is extremely concerned about the direction the PPRC is taking in their study of the Medicare Supplemental Insurance market. While the Commission has not made any formal recommendations on policy changes to the Medicare Supplemental market, HIAA is concerned that the assumptions being used by the PPRC would set a course that could eventually eliminate or adversely impact the availability of private Medicare Supplemental insurance to millions of consumers.

Medicare Supplemental products offer consumers needed security and choice, and protect them from unforeseen medical expenses. Currently, approximately sixty-six percent of seniors eligible for Medicare have some form of private Medicare Supplemental insurance policies. Obviously, any public policy recommendations that would adversely impact these consumers are of great concern.

HIAA submitted its concerns about this matter to the PPRC in a letter dated February 21, 1996. We would like to submit the enclosed copy of that letter for the hearing record.

HIAA will be following this issue closely, and we look forward to working with you and others on the Ways and Means Health Subcommittee and the Physician Payment Review Commission to provide a better understanding of the importance of Medicare Supplemental insurance policies for seniors.

Sincerely,

Attachments

555 13th Street, NW Suite 600 East, Washington, DC 20004-1109 202-824-1623 Fax 202-824-1719



Health Insurance Association of America

Bill Gradison
President

February 21, 1996

Gail R. Wilensky, Ph.D.
Chair
Physician Payment Review Commission
2120 L Street NW Suite 200
Washington, D.C. 20037-1527

Dear Gail:

Enclosed please find HIAA's comments on draft chapter 16 of the Commission's upcoming report to Congress: "Secondary Insurance for Medicare Beneficiaries." We appreciate having the opportunity to comment on these matters of extreme importance to Medicare beneficiaries, Medicare supplemental insurance carriers, and Medicare replacement plan contractors.

We look forward to ongoing dialogue on these issues with you and the Commission during 1996. Please contact me if I can help facilitate the Commission's studies in this area. If your staff has questions related to the enclosed comments, they may contact Marianne Miller in HIAA's Policy Development and Research Department at 202-824-1693.

Sincerely,

Bill Gradison

555 13th Street, NW Suite 600 East, Washington, DC 20004-1109 202-824-1623 Fax 202-824-1719

PPRC 1996 Report to Congress - Chapter 16
"Secondary Insurance for Medicare Beneficiaries"

HIAA Comments on February 13, 1996 Draft
February 21, 1996

HIAA is deeply concerned about the underlying premise of this chapter, which is that Medicare supplemental insurance is somehow illegitimate. The Commission's health economists appear to have decided that there is a "right" level of health care use by Medicare beneficiaries, and that this "right" level is the one that would result if all beneficiaries had to pay the statutory Medicare deductibles and co-insurance out of their own pocket. We find no such limitation in the statute. Rather, the only statutory test for Medicare payment that we are aware of is that the care rendered to an eligible beneficiary be medically necessary. As the chapter points out, the available research finds that imposing beneficiary cost-sharing reduces use of necessary, as well as unnecessary, care.

Moreover, the benchmark for this "right" level of utilization appears to be the claims experience of the 10% of Medicare beneficiaries who have no secondary coverage of any kind. The results of the multivariate analysis are not presented, so we cannot critique them. But one is left with a nagging sense that the 10% must be unusual in some way, most likely with respect to income. Surely the Commission does not want to argue that Medicare should be responsible only for the level of utilization demanded by beneficiaries who are too poor to see a doctor until their need is urgent.

Another general concern relates to the chapter's discussion of Medicare supplemental product rating and underwriting practices. The chapter throughout seems to favor "equivalent" rules for Medicare supplemental and Medicare replacement (risk contract) policies. This stance, if translated to requirements for guaranteed issue and community rating of supplemental policies, ignores the implications for Medicare program costs of the inevitable adverse selection against Medicare supplemental insurers and traditional Medicare which would result. We are convinced that these costs would be significant. (See the enclosed HIAA Legislative Issue Brief #4.)

Additionally, we take issue with the chapter's discussion of rating practices. Indeed, several rating approaches are available in the marketplace. We believe this variety serves the public well by letting them decide for themselves which approach best serves their needs. To eliminate one or more of the current alternatives (on the grounds that the presence of the alternatives is "too confusing") displays Washington hubris of the worst sort. Rather than eliminate rating alternatives for

Medicare supplemental plans, perhaps we should expand them for risk contractors.

We particularly take issue with the allegation that attained-age rating is more costly to beneficiaries over a lifetime. A recent actuarial analysis by Blue Cross of California (attached) demonstrates that, under assumptions which reflect the current marketplace, attained-age rating actually results in a lower lifetime rate than either community rating or entry-age rating.

Specific Comments

1. p. 7, l. 20. Should "insurers" be "employers"?

2. p. 8, l. 24. Should read 14 percentage points.

3. p. 10, l. 20-25. See general comments. If there is legislative history that refers to this "purpose" of Medicare cost-sharing requirements, please cite it.

4. p. 12, l. 5-10. See general comments.

5. p. 12, l. 18-19. See general comments.

6. p. 13, l. 14-18. See general comments regarding attained age rating.

7. p. 13, l. 24 footnote. See general comments. We believe this line of argument is greatly exaggerated, especially in the current environment.

8. p. 14, l. 12-16. This comment has nothing whatever to do with rating practices and should be deleted.

9. p. 14, l. 19-21. Medicare supplemental carriers must offer all Med Supp products they sell on a guaranteed issue basis during a beneficiary's initial 6 months of eligibility for Medicare Parts A and B.

10. p. 14, l. 23-25. This comment appears at odds with the chapter's suggestion elsewhere that risk contracting managed care plans are experiencing favorable selection.

11. p. 14, l. 25-29. There is no problem for ill beneficiaries who purchase Medicare supplemental insurance in their initial eligibility period. The issue for poor beneficiaries is one of income and has nothing whatever to do with rating practices.

12. p. 15, l. 7-11. The larger problem here is that community rating and open enrollment would create severe adverse selection for Medicare supplemental products, raising premiums and making supplemental coverage unaffordable for many beneficiaries. This would occur because beneficiaries would now be able to defer purchasing a med supp product until they become ill enough to really need the benefits it provides (e.g., prescription drug

coverage). The implications for Medicare may be equivocal (in our view), but the implications for supplemental coverage are absolutely clear: higher premiums for all purchasers.

13. p. 16, l. 26-33. The existence of supplemental coverage is not inconsistent with use of financial incentives to affect utilization. Supplemental products could be designed that would pass through financial incentives from the underlying Medicare program, if the regulatory regime permitted it. The larger difficulty is the political one of attempting to reduce the flow of public dollars to particular providers.

14. p. 19, l. 13-14. Though obviously shorthand, this sentence is inaccurate and offensive - betraying the commission's bias on the issue. See general comments.

15. p. 19, l. 15-19. The first two "other options" deserve more discussion. As noted above, use of financial incentives to affect utilization is not incompatible with supplemental insurance.

16. p. 21, l. 1. Our understanding is that, under current law, Medicare risk contractors may not charge beneficiaries for Medicare benefits but only for supplemental benefits.

17. p. 21, l. 17-18. Pooling of risks does not lower costs; it shifts or shares them. Greater bargaining leverage over providers is another issue.

18. p. 21, footnote. There is a fundamental difference in the methods used for determining MIG capitation rates vis-a-vis risk contractor payments (based on the AAPCC). The former are based on the claims experience of enrollees in that arrangement; the latter are derived from the claims experience of beneficiaries remaining in traditional Medicare.

19. p. 22, l. 8 +. The chapter should introduce the discussion of "unified insurance" more deliberately, by defining it and describing the origin of the concepts and the extent of public discussion which has taken place about it.

20. p. 23, l. 18-21. It strikes us as a false premise that Medicare reform must maintain parity between coverage options available in the public vs. the private sector, or that private sector competition is somehow diminished when public sector options are restricted. We believe the notion of "unified insurance" needs considerably more public airing.

21. p. 24, References. We appreciate your citing Mr. Gradison's letter (in footnote 8), but it should then be listed in the References.

STATEMENT OF MARIANNE CZOCH
PRESIDENT AND CEO
VISITING NURSE SERVICE SYSTEM
ON BEHALF OF THE
VISITING NURSE ASSOCIATIONS OF AMERICA

Introduction

Mr. Chairman, I am pleased to submit before this subcommittee the views of the Visiting Nurse Associations of America (VNAA) on how we believe the Medicare program can take a positive direction in the area of home health care. VNAA is the national membership organization and economic alliance for Visiting Nurse Associations (VNAs). Our mission is to support and advance VNAs in their individual communities. By strengthening their role at the community level, VNAA helps VNAs continue to add significant value to the American health care system.

VNAs are freestanding, non-profit and Medicare-certified home care agencies. They represent 46% of all non-profit home health agencies in the United States. Together, they serve over eight million patients annually. Their mission is to provide innovative, cost-effective, and high-quality health care to their patients regardless of their ability to pay. While VNAs are united in mission, they are by nature individually unique in that they tailor services to meet the particular needs of their communities. Governed by voluntary boards of community leaders, they are in tune with community resources and, therefore, can respond quickly to crises. Following the tradition of Florence Nightingale, they spearheaded some of the nation's very first wellness programs. VNAs were well established accross the country before the turn of the century.

For over 100 years, VNAs have helped patients overcome illness and injury, and cope with disability and death, in the comfort of their own homes. Their history places them in the forefront of the home health care field with their ability to meet comprehensive and specialized needs. Today, VNAs provide basic home health services, including skilled nursing and rehabilitative therapy. They also provide non-medical long-term care services, including social services, personal care and housekeeping. High-tech services traditionally only provided by hospitals, including chemotherapy, ventilator care, blood transfusions, pain management and renal dialysis, are now routinely provided by VNAs. VNAs' specialty services include adult day care, Meals on Wheels and hospice.

Medicare's future is significant to VNAs and their patients. VNAs serve Medicare's oldest and sickest home health patients. Seventy percent of VNAs' received revenue is from Medicare, which reflects VNAs' patient population, of whom over 71 percent are persons over age 65. We are the safety net for some of the nation's most vulnerable populations, including poor women at risk of delivering premature infants, children with congenital disabilities, and HIV/AIDS and other terminally-ill patients. We care for those who are denied services, either because they are not poor enough to qualify for Medicaid, because Medicare or Medicaid do not fully cover the services they need, or because they have exhausted their private insurance. Volunteers and charity support from philanthropic sources allow VNAs to provide unreimbursed care. Our capacity to serve is limited only by restraints in available funding.

We, therefore, are deeply concerned about recent reports that the Medicare Part A Trust Fund, which primarily funds Medicare home health care, is in serious financial trouble.

According to HCFA, Part A accrued a deficit of $4.2 billion during the first half of fiscal year 1996. This report has lead to speculation that the Part A Trust Fund will go broke by 2000. This situation, combined with decreasing Medicaid expenditures and charitable contributions, threatens VNAs' future ability to provide health and long-term care to the elderly, persons with disabilties, and the poor. We would very much would like to work with Congress to help resolve these issues and appreciate this opportunity to share our policy recommendations.

Recommendations

VNAA believes that the Medicare home health prospective payment system (PPS) recently presented to key congressional committees by the home health industry will help keep the Medicare Part A Trust Fund solvent. We joined the other three national home health associations in developing this PPS plan and we enthusiastically endorse it. This plan, titled, "Revised Unified Proposal for a Prospective Payment System for Medicare Home Health Services," is a modification of the original PPS plan submitted to Congress in 1995. The modifications were made to the original proposal to respond to HCFA's concerns about implementation feasibility. We believe that the revised PPS plan incorporates the best elements of the home care PPS provisions in HR 2491, which was passed by Congress, and HR 2530, which was introduced by the Administration. It represents months of work and refinement by the home care industry.

This plan calls for three steps to achieve the PPS. Phase I creates an interim PPS plan that incorporates existing cost and utilization data. It accounts for agency case-mix variation by basing aggregate payment limits on an agency's base year performance. Phase II incorporates episodic payment caps based on 18 case mix categories to control utilization. It incorporates data from HCFA's Phase II per episode PPS demonstration project. Phase III moves to a pure per episode PPS with a refined case mix adjuster to reliably and accurately predict variation in costs by case mix. Growth rates would be set below projected spending to assure Medicare savings. Home health agencies that are able to keep their payments below the limits will share the savings with the government up to a maximum of 10% of payments. The attached fact sheet goes into more detail about this revised PPS plan.

VNAA particularly supports the plan's utilization controls. We believe that controlling over-utilization, not cost of care, is the key to producing significant savings in the Medicare home health program. Congressional Budget Office (CBO) analysts generally agree that controlling use is the key to the next generation of Medicare cost containment. An August, 1995, *Eli's Home Health Care Report* discussed findings of the HHS Office of the Inspector General (OIG) report, entitled, "Variation Among Home Health Agencies in Medicare Payments for Home Health Services." The article stated, "Medicare's costs for home health care are being driven by a small number of home health agencies that are providing up to seven times as many visits per patient as low-cost HHAs..... While the average reimbursement per visit was similar among all four groups of HHAs, varying no more than $2 from the national average of $58.06, 'the number of visits varied widely,' the OIG reports."

VNAs are proud of their legacy of cost-efficiency and quality care. The following information demonstrates our ability to meet patients' needs at a reasonable cost to the government and patients. If enacted, we believe that the industry's revised PPS plan will be the catalyst to bringing all home health agencies within the same pattern of cost-efficiency -- providing only the necessary number of visits, providing quality of care, and connecting the patient with community resources that enable them to remain at home. The average number of visits per beneficiary receiving home health services in 1993 from voluntary agencies (i.e. VNAs, Easter Seals Societies) was 46.1, compared to 56.7 for all home health agencies combined; yet we maintain high quality services as demonstrated in our patient satisfaction survey results (95-100% of patients report satisfaction) and percentage of patient goals achieved VNAA members are Medicare-certified and 82 percent are nationally accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Community Health Accreditation Program (CHAP).

A 1996 Abt Associates, Inc., study, using a sample of HCFA claims data from 1994, compared VNAs with other home care agencies on the following measures: 1) mean visits and reimbursement for episodes ending within 120 days and for episodes extending beyond 120 days; 2) mean visits for episodes ending within 120 days and for episodes extending beyond 120 days by census region; 3) mean number of episodes by census region; and 4) mean visits per episode by admission diagnosis.

The Abt study demonstrated that, on average, total reimbursements to VNAs for episodes of care that extended beyond 120 days were $1,876 less than reimbursements to non-VNAs for such episodes. And, total reimbursements to VNAs for all episodes of care (those that end within the first 120 days and those that extend beyond 120 days) were $896 less than reimbursements to non-VNAs for such episodes. In terms of utilization, VNAs were also favorably compared. By census region, VNAs provide fewer visits per total episode than do non-VNAs by every census region except the Mid Atlantic. They also have two-three times more episodes by region that do non-VNAs. Finally, VNAs provide fewer visits per episode in 41 out of 44 diagnosis categories than do non-VNAs. This latter finding demonstrates that VNAs' efficiency is not due to a lighter caseload. In fact, the March 1996 U.S. General Accounting Office (GAO) report, entitled "Medicare: Home Health Utilization Expands While Program Controls Deteriorate," points to VNAs' cost-efficiency when treating similar types of chronic and acute cases (described below).

The GAO report addresses that there are justifiable reasons for the growth in the home health benefit; for example, the lawsuit filed in 1988 (Duggan v. Bowen) that struck down HCFA's interpretation of benefit coverage requirements. "As a result of the suit, HCFA revised the Medicare Home Health Agency and Medicare Intermediary manuals in 1989 so that the criteria for coverage of home health visits would be consistent with 'part-time or intermittent care,' as required by statute, rather than 'part-time and intermittent care,' as HCFA had been interpreting it," states the report. Following those manual changes, the percentage of Medicare beneficiaries receiving home health services and the number of home health visits received per year per home health user have increased signficantly.

However, while changes in Medicare law, regulations, and policy have affected all home health agencies similarly, there is still stark contrast in utilization patterns between types of home health agencies (e.g, non-profit VNAs, hospital-based agencies, for-profit proprietaries). To learn about the cause of these different patterns, the GAO conducted an episode-of-care analysis for four diagnoses: diabetes, heart failure, hypertension, and hip fracture. What they learned from this analysis is that when different types of agencies treat the same severe diagnoses, a contrast in number of visits provided per beneficiary still exists between types of agencies even when case mix is controlled. There were differences in episode length as well. For diabetes, voluntary agencies' average visits were 30.5, compared to 38.2 for all home health agencies combined; and length of episode was 55.3 compared to 59.0, respectively. For heart failure, hypertension, and hip fracture, average number of visits per beneficiary and lengths of stay were less for voluntary agencies than all agencies combined. "Some HHS Office of Inspector General and intermediary officials further believe that the nonprofit HHAs are being forced to offer increasingly more services in order to stay in business," states the GAO report.

The savings generated by PPS and the changed incentives for providers mean that Congress does not need to consider a Medicare home health copayment. VNAA believes such a copayment would be bad public policy because it would:

o **Essentially create an unfunded mandate to the states.** Under current law, states are required through their Medicaid programs to cover coinsurance costs for poor Medicare beneficiaries under the Qualified Medicare Beneficiary (QMB) statute. States would then be required to pay the Medicare home health copayment for QMB beneficiaries. Imposing additional costs on state governments would conflict with S. 1, the unfunded mandate legislation that Congress passed last year.

o **Fall heaviest on Medicare's poorest and oldest beneficiaries.** For example, individuals over age 75 account for less than 50% of the total Medicare population, but comprise nearly 75% of home health beneficiaries. In addition, nearly 50% of home health recipients have low income and already spend an average of 17.1% of their income on health care. One-fourth of all home care recipients have incomes between 100% and 150% of the federal poverty level. Most home care patients will have been recently discharged from the hospital, and on the average will have paid $1,700 or more in the preceding 12 months for Medicare premiums, deductibles, and copayments even before the first home care copay comes due. A 20% copayment would mean average copays of over $900 in 1996 for these individuals, according to the National Association for Home Care.

o **Deter utilization among poor beneficiaries to the point that they might not seek medically-necessary care.** VNAs' experience has been that patients who can't afford cost-sharing forgo care in order to buy groceries or other necessities. While we would provide care to a patient regardless of his or her ability to pay, our experience has been that many of these individuals choose to hide a serious health condition rather than admit to not being able to afford the care. In 1994, the Office of Technology Assessment found that making patients responsible for copayments will keep them from seeking necessary care and could be especially harmful to those with low income.

o **Not deter utilization among those who could most afford to pay a copay.** According to Stuart Altman, chair of the Prospective Payment Commission, beneficiaries with Medicare supplemental insurance policies would have coverage for copayments.

o **Create a disincentive for patients to seek appropriate, less-expensive, home health care services.** Home health was exempted from the Medicare Part B coinsurance in 1972 in order to encourage utilization of less costly services. Reimposing a coinsurance would undermine that effort and create a financial incentive for institutional care. In addition, because there is no Medicare copayment for the first 60 days of inpatient hospital care, a home health copayment might result in longer hospital stays. Hospital patients can also stay within a hospital's transitional care unit beyond the 60 days without having to pay a copayment.

VNAA is also opposed to bundling post-acute care Medicare payments into hospital DRG payments. We believe such bundling would compromise the quality and accessibility of home care available to beneficiaries in the following ways:

o Hospitals have limited experience in determining cost for non-hospital, post-acute care; therefore, home care payments based on DRG rates would most likely not match patients' needs;

o Bundling would increase the administrative burden on home care providers by requiring multiple payment systems for home care -- one for post-hospital patients and one for patients entering home care from the community; home care agencies would be required to bill any number of hospitals for the care they provide to post-hospital patients rather than using the current single-billing system.

Finally, VNAA also urges you to oppose the Administration's proposal to limit Medicare Part A coverage of home health to the first 100 visits following a hospital stay and shift the rest of the benefit to Part B. VNAA opposes this "Part A to Part B shift" because it does not achieve true savings or target over-utilization as a per-episode PPS would do.

Conclusion

VNAA believes the industry's revised PPS plan will go a long way toward reigning in over-utilization. It will preserve access to high quality home health care while providing incentives for that care to be furnished in a cost-effective and efficient manner. By replacing cost reimbursement, prospective pay will create an incentive to providers to help a patient reach his or her highest level of wellness with the fewest visits and lowest cost. Quality, not quantity, will be emphasized, which will make home health services a better value for the beneficiary, the Medicare program, and the people of our country.

Revised Unified Proposal for a Prospective Payment System for Medicare Home Health Services

March 28, 1996

Attached is the Industry's Revised Unified Plan for a Prospective Payment System (PPS) for Medicare Home Health Services. It was developed jointly by the National Association for Home Care (NAHC) and the PPS Work Group.

This plan is a modification of the original unified plan submitted to Congress in 1995 which was presented as an alternative to a Medicare home health copay and proposal to bundle home care payments into payments to hospitals. The modifications were made to the original proposal to respond to concerns about implementation feasibility raised by HCFA.

This plan incorporates the best elements of the home care PPS provisions in HR 2491 passed by Congress and HR 2530. It represents months of work and refinement by the home care industry. The plan calls for a three-phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case mix adjuster.

PPS is a more efficient, cost-effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety, or increasing out-of-pocket costs.

We invite your careful review of this proposal. If you have any questions or would like additional information, please feel free to contact the organizations listed below.

National Association for Home Care
Dayle Berke/Lucia DiVenere 202-547-7424

PPS Work Group
Jim Pyles 202-466-6550

3-28-96

Home Care's Plan to Implement Prospective Payment for Medicare Home Health Services

I. Home Care's Goal

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. PPS is a more efficient, cost-effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety.

PPS will be phased in over time, resulting in an episodic prospective payment system plan that should:

- be developed cooperatively by HHS, the industry, and Congress
- be acceptable to the industry
- include extended care
- be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation
- be approved by Congress
- include adjustments for new requirements (such as OSHA) or changes in technology or care practices
- be based on a case mix adjustor that reflects the differences in cost for different types of patients

II. An Interim PPS Plan

An interim PPS plan incorporating certain elements of the Congressional and Democratic proposals (HR 2491 and HR 2530) should be implemented commencing within 6 months of enactment and continue until it can be converted to a pure episodic prospective payment system (Phase III). The interim PPS plan should be based on the industry's design and set forth in legislative language. The interim plan is implemented in phases to provide HCFA sufficient time to collect necessary data and to develop required processes and procedures. Current coverage criteria for Medicare Home Health services should be maintained with no coverage shifted to Part B.

III. Time Line for PPS Phase-In

Enact Legis.	Begin Data Collec	Begin Phase I Interim PPS	Begin Phase II Interim PPS	Report to Congress on Episodic PPS	Expected Implementation Phase III Episodic PPS
0	2mo	6mo	24mo- 30mo	48mo	60mo

IV. PPS Specifications

A. Data Collection

HCFA is mandated to begin immediately to develop a data base upon which a fair and accurate case mix adjustor can be develop and implemented. The data base must be able to link case mix data withcost (and utilization) data.

The data base must include a sample sufficiently large to support the development of statistically valid estimates of payment rates and limits for the geographic area used (e.g., MSA/nonMSA, national, census region).

The data base must contain at least:

- items for the 18 category Phase II case mix adjustor
- HCFA form 485
- UB-92
- additional data items that may contribute to a more accurate case mix system, developed with industry participation (such as items from OASIS)

Payment rates and limits shall be adjusted to reflect cost of data collection.

B. Phase-In of PPS Beginning with the Interim Plan

Phase I

Prospectively set standard per visit payment (as in HR 2491) with an annual aggregate per patient limit that applies to all visits (as in HR 2530).

Effective date: 6 months after enactment

All currently allowable costs related to nonroutine medical supplies will be included in the data base for calculating the per visit rate, per visit limit, and aggregate limits.

Per Visit Payment

- standard per visit rate for each discipline calculated (as in HR 2491) as follows:
  the national average amount paid per visit under Medicare to home health agencies for each discipline during the most recent 12 months cost reporting period ending on or before 12-31-94 and updated by the home health market basket index, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located

- amounts in excess of the per visit rate, up to a limit as defined below, may be paid if:
  1) a HHA can demonstrate costs above the payment rate, and
  2) quarterly reports demonstrate that total payments will not exceed the agency aggregate limit

- the payment rates and limits are calculated initially from the base year costs and cost limits and updated by the home health market basket index to the date of implementation; they are updated annually by the market basket index

- base year for payment rates and cost limits - 1994 (using settled cost reports)

Agency Annual Aggregate Per Patient Payment Limit

- base year for aggregate payment limit - 1995 utilization data for each agency

- the blended annual per patient limit is based on the reasonable cost per unduplicated patient in the base year (1994 cost per visit - updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 75% on agency data & 25% on census region data, then 50% agency data & 50% census region data

- the blended annual aggregate per patient limit is equal to the number of unduplicated patients served in the year multiplied by the per patient blended limit

- census region: the 9 census region geographic areas (New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central. West South Central, Pacific)

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate per patient cap and below 125% of the census region cost/utilization experience shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limit. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

- Phase I in place 18 months (no longer than 24 months)

Phase II

Prospectively set standard per visit payment with an annual aggregate episode limit for days 1-120 (as in HR 2491) and an annual aggregate per patient limit for visits after 120 days.

- continue per visit payment as in Phase I

- an episode is 120 days; post 120 day care is paid per visit with an annual aggregate per patient blended limit for the post 120 day period that is separate from the 1-120 day annual aggregate episode limit

- the HHA is credited for a new episode limit if there is a period of 45 days without Medicare covered home health care services following the 120 day episode (if a patient is readmitted before a new episode can be started, the agency is paid per visit subject to the aggregate episode limit if within the first 120 days, or the separate post 120 day aggregate per patient blended limit if after 120 days).

- the 18 category Phase II case mix adjustor is applied to the first 120 days, or a more accurate one if available

- the per episode limit (as in HR 2491) is equal to the mean number of visits for each discipline during the 120 day episode of a case mix category in an area during the base year multiplied by the per visit payment rate for each discipline

- the annual aggregate episode limit (as in HR 2491) is equal to the number of episodes of each case mix category during the fiscal year multiplied by the per episode limit determined for such case mix category for such fiscal year

- the region for the episode limit - MSA/nonMSA area

- the annual post 120 day per patient blended limit is based on the reasonable cost per unduplicated patient receiving care beyond 120 days in the base year (1994 cost per visit updated, multiplied by 1995 utilization) and updated by the home health market basket index: calculation based 50% on agency data & 50% on census region data

- the annual aggregate post 120 day per patient blended limit is equal to the number of unduplicated patients receiving care beyond 120 days in the year multiplied by the per patient blended limit

- the current certification and coverage guidelines continue

Sharing Saving

HHAs that are able to keep their total payments for the year below their annual aggregate episode and post 120 day per patient caps; and the post 120 day per patient payments below 125% of the census region cost/utilization experience, shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limits. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

Phase III *(as noted under the goal in Section I)*

Per Episode PPS

- developed cooperatively by HHS, the industry, and Congress

- acceptable to the industry

- includes extended care
- must be submitted to Congress one year in advance of implementation and within 4 years of enactment of legislation
- approved by Congress
- adjustments for new requirements (such as OSHA) or changes in technology or care practices
- case mix adjustor that reflects the differences in cost for different types of patients

C. Additional Specifications that Apply to All Phases

1. Exceptions: The Secretary shall provide for an exemption from, or an exception and adjustment to, the methods for determining payment limits when extraordinary circumstances beyond the home health agency's control including outliers and the case mix of such home health agency, create unintended distortions in care requirements not accounted for in the case mix adjustor payment system. The Secretary shall develop a method for monitoring expenditures when they are found to decrease total Medicare expenditures.

2. Quality: Any prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing quality. The Secretary will ensure that the quality of services remains high by implementing a revised survey and certification process that emphasizes patient satisfaction and successful outcomes.

   Home heath agencies will be required to provide covered services to beneficiaries to the extent that those services are determined by the beneficiary's physician to be medically necessary.

   There will be established a means for beneficiary due process to challenge care and coverage determinations first through internal provider grievance procedures, then through external PRO review.

   There will be established a mechanism for quality review for instances of significant variation in utilization by providers (this can address both visits and admissions).



TEACHING HOSPITAL AND OTHER ISSUES RELATED TO GRADUATE MEDICAL EDUCATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

JUNE 11, 1996

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TEACHING HOSPITAL AND OTHER ISSUES RELATED TO GRADUATE MEDICAL EDUCATION

TUESDAY, JUNE 11, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 12:17 p.m., in room B–318, Rayburn House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
June 4, 1996
No. HL-19

CONTACT: (202) 225-3943

Thomas Announces Hearing on Teaching Hospital and Other Issues Related to Graduate Medical Education

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on recommendations regarding Medicare's financing of Graduate Medical Education (GME). **The hearing will take place on Tuesday, June 11, 1996, in room B-318 Rayburn House Office Building, beginning at 12:00 noon.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare has reimbursed teaching hospitals for the program's share of the cost of training physicians and other health professionals, and the generally higher costs of operating teaching hospitals since the inception of the program. With the advent of the Medicare Prospective Payment System in 1983, Medicare hospital payment for graduate medical training and certain teaching hospital service costs has been separated into direct and indirect reimbursement for GME.

Medicare compensates teaching hospitals for costs directly related to the training of certain health professionals; payment includes resident salaries and fringe benefits, salaries and fringe benefits of supervising faculty, and allocated overhead costs. Medicare pays direct costs based on a prospective, capitated payments which is based on a hospital-specific per resident amount. In 1996, Medicare is expected to reimburse teaching hospitals $2.0 billion for direct costs of GME. The Medicare indirect medical education adjustment compensates hospitals for the costs of additional tests and procedures which occur in those hospitals related to the training of medical residents, as well as the fact that these hospitals tend to treat sicker, and generally poorer, elderly patients who require more intensive services. In order to cover these extra costs, teaching hospitals receive a higher payment per case than other institutions. This per case add-on is currently set at approximately 7.7 percent for each 10 percent increase in the ratio of full-time interns and residents to the number of beds in the hospital. Medicare is projected to spend $4.3 billion on the indirect medical education adjustment in 1996.

The Medicare Trustees are expected to release their report this week on the solvency of the Medicare Hospital Insurance Trust Fund -- the fund which finances Medicare's share of GME. Indications that Medicare's Part A Trust Fund is deteriorating more rapidly than was anticipated in the April 1995 Report of the Board of Trustees raise serious concerns about Medicare's ability to finance GME at current levels. The Balanced Budget Act of 1995 included major reforms in Medicare payment for teaching hospitals and GME as well as the establishment of a new trust fund to subsidize these activities.

Despite President Clinton's veto of the Balanced Budget Act of 1995, the Subcommittee remains committed to these reforms and is interested in receiving recommendations on perfecting these provisions. The Subcommittee also received testimony from the Pew Commission and the Institute of Medicine at an earlier hearing and expects to receive further comments on their recommendations at this hearing.

(MORE)

In announcing the hearing, Chairman Thomas stated: "Because of the deteriorating condition of the Medicare Part A Trust Fund and its relationship to the funding of teaching hospitals, it is essential that the Congress look at ways to reform this subsidy. The advice and recommendations of these witnesses provide an important opportunity to continue a dialogue in the Subcommittee on needed reform."

FOCUS OF THE HEARING:

The hearing will focus on the recommendations of the witnesses concerning Medicare's ability to finance GME and recommendations on GME provisions included in the Balanced Budget Act of 1995 and those presented by Pew Commission and the Institute on Medicine.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, June 25, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. The Subcommittee will come to order.

I want to welcome all of you to the Health Subcommittee's second hearing this year on the Medicare policy on payment of teaching hospitals and funding for graduate medical education.

In April, we heard from the Pew Health Professions Commission and the Institute of Medicine that the traditional role of the teaching hospital is threatened by both the challenges in the evolving health care marketplace and questions about the best role for these institutions in the future.

We also learned that the number of residents is growing, despite the oversupply of physicians, and that this growth is primarily due to the number of international medical graduate residencies.

Today, we will hear from representatives of various health care providers and from physicians and other health care professionals on their recommendations for the future of teaching hospital payment and funding for graduate medical education.

Last year, we included in the Balanced Budget Act of 1995 provisions which reformed payment for teaching hospitals and graduate medical education. In order to promote broader-based financing for both these important hospitals and for GME, we established a separate trust fund, which included funding both from Medicare and from general revenues. These reforms were, unfortunately, vetoed by the President. However, the Health Subcommittee remains committed to developing on an ongoing basis these specific reforms.

We are interested in recommendations today on how we could modify payment for teaching hospitals and graduate medical education through the kind of concept included in the balanced budget amendment, i.e., a trust fund funded from general revenues or any other ideas that you might offer this Subcommittee. We look forward to hearing from you and your suggestions in the face of unprecedented change.

Before we turn to the witnesses, I want to recognize the Ranking Member, the gentleman from California, Mr. Stark, for any comments he may wish to make.

Mr. STARK. Thank you, Mr. Chairman.

I look forward to your hearings today. I thank you for calling them. It is a topic about which I must say I am ambivalent. I have never quite decided whether we ought to legislate in this area or leave it alone.

In the last hearing on GME, both the Pew Health Professions Commission and the Institute of Medicine gave us recommendations to reduce the international medical graduate residents, but neither one really talked to us about how to help the hospitals who depend on them. And as I say, I do not think that I have an answer. There have been a few concrete suggestions. Maldistribution of physician services exists. It is like, the situation when some days there are too many English professors and not enough Political Science professors. I do not know whether we could pass a law to change that.

I do hope today's witnesses can tell us how to attract more U.S. doctors to underserved areas, expecially if we are going to limit those physicians who traditionally have taken less money to fill jobs that may or may not be more—less desirable.

According to the IOM, Institute of Medicine, report, teaching hospitals provide about 44 percent of all charity care. Both the Republican and Democratic budget plans have offered changes in graduate medical education. Some might undermine the viability of those hospitals, and I would like your comments on that. I was planning to talk about MSAs and MEWAs, but, this is such a good hearing that you have called that I will just leave it at that. I hope the witnesses can make some suggestions on which we might come together and be of any help, or if you say, just leave well enough alone and let nature take its course.

Thank you.

Chairman THOMAS. I thank the gentleman, and that is precisely why we have brought these panels together. They are, I think, quite prestigious.

Our first panel consists of Timothy M. Goldfarb, director of Healthcare Systems, Oregon Health Sciences—and there are a lot of interesting things going on in Oregon, Portland, to be specific, but Oregon in general.

We have Leo P. Brideau, general director and chief executive officer of the Strong Memorial Hospital, Rochester, New York, and chairman of the board of trustees, Healthcare Association of New York State. And, we want to hear from not only the State of New York, but also the city of New York.

Larry Wickless, who is D.O., vice chairman, Council on Federal Health Programs, American Osteopathic Association.

Dr. Spencer Foreman, president of the Montefiore Medical Center in Bronx, New York, and you might anticipate some specific questions that would help us understand the role of international medical students, particularly at New York hospitals, where there seems to be a predominance.

If any of you have written statements, we will incorporate them as a part of the record, and you may inform us as you see fit in terms of information that this Subcommittee needs to know.

Why don't we just start with Mr. Goldfarb and go down the panel? Thank you.

I would tell you beforehand these microphones are very unidirectional, and you need them right in front of you to be able to discuss. And we have four people and three microphones, so you do the math.

STATEMENT OF TIMOTHY M. GOLDFARB, DIRECTOR, HEALTHCARE SYSTEMS, OREGON HEALTH SCIENCES UNIVERSITY, PORTLAND, OREGON, ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. GOLDFARB. Mr. Chairman, distinguished Members of the Subcommittee, my name is Tim Goldfarb. I am the director of Healthcare Systems at OHSU, Oregon Health Sciences University in Portland, Oregon. AAMC, Association of American Medical Colleges, appreciates the opportunity to offer testimony concerning the funding of graduate medical education.

I would like to leave you with a few points: One, to emphasize how important DME, direct medical education, and IME, indirect medical education, funding is to OHSU specifically and major teaching hospitals in general; two that any cut in IME funding and

DME funding is a real cut for my institution, not just a cut in the rate of growth of funding; and, thru, to emphasize there are some short- and long term ways to help major teaching institutions in our country and my institution in particular, those being the AAPCC carve-out for IME/DME, and the trust fund concept that you spoke about in the beginning, Mr. Chairman.

With respect to the work force issues and the IOM and PEW reports, AAMC offered a statement at your April 16th hearing and I will not be responding to that in my oral presentation.

I would like give a face to the policy issues that AAMC has presented to you and that face Oregon Health Sciences University. Perhaps an accident of birth, we are the only health profession school in our State. We are the only major tertiary institution in the State. And as such, we are an illustration of what can happen in a very dynamic managed care marketplace.

A little bit about my institution: We have a university hospital, a children's hospital, Dornbecker Children's Hospital, a medical school, as well as schools of dentistry and nursing, and research institutes, and a lot of dedicated men and women being educated and working there.

We have all the academic missions, and we are a significant player because of our solo nature in our market. Twelve percent of all the inpatients in our market come to OHSU. Our teaching program clearly is the largest in the State; over 90 percent of the residents and fellows in our region are affiliated with our institution, and most are educated at our institution.

Indigent care has long been part of our mission. In fact, before we went fully managed care in our State for Medicaid, one out of every five dollars was spent at OHSU for treating the poor. And, of course, we maintain our mission as a laboratory for clinical and basic research, since we are the primary recipient of peer review dollars in the State.

The market in Oregon is, frankly, something to behold if you are in our industry. Over 80 percent of the population in our metro area are in managed care plans of some type. I know you are specifically interested in Medicare. Fifty-two percent of the population in our metropolitan area are in a Medicare risk plans, which is the highest market penetration in the country.

As an aside, the second highest community is about 45 minutes to the south, Salem, the capital of our State, with 42 percent of the Medicare eligibles being enrolled in some risk plan.

Eighty percent of the Medicaid population are in capitated plans today, and there are plans to increase that level during the next 24 months. Over 60 percent of those that are covered by commercial insurance are in risk plans. So, I am painting a picture for you, I hope, of a very dynamic, competitive managed care marketplace, one in which an academic medical center has few places to maintain funding for graduate medical education. You, in fact, through Medicare, are the primary payer.

I want to emphasize that because of the pressure of managed care, our margins have been significantly reduced. In fact, my total margin at this point is about 1 percent, and the need for IME/DME funding is greater than ever before. In the short term, a carve-out for the AAPCC is critical for our institution, and in the long term,

the shared responsibility concept of the health trust fund is critically important not only for us but for other academic centers in the country.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF TIMOTHY M. GOLDFARB
ON BEHALF OF
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman, and distinguished members of the Subcommittee, I am Timothy M. Goldfarb, Director, Healthcare Systems at the Oregon Health Sciences University in Portland, Oregon. The AAMC welcomes the opportunity to testify on recommendations regarding the Medicare program's financing of graduate medical education (GME). The Association represents all of the nation's 125 accredited medical schools, approximately 400 major teaching hospitals, including 75 Veterans Affairs medical centers, the faculty of these institutions through 89 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents.

I come before the Subcommittee today to express the Association's concern about the future financing of teaching hospitals' and medical schools' special missions in a market-driven, competitive health care delivery system. This includes addressing the future role of the Medicare program in the financing of GME. The transformation of the health care system to a competitive, price conscious structure poses at least two problems for academic medicine. This change threatens:

- the fiscal stability of teaching hospitals and medical schools; and
- their ability to maintain an environment for education, research and innovation.

Before presenting our concerns about the future, however, I'd like to describe the functions and diversity of teaching hospitals and how they currently support their missions, including the importance of Medicare's participation in these activities.

The Characteristics and Roles of Teaching Hospitals

Teaching hospitals, in addition to all hospitals' mission of providing basic health services to community residents, have the responsibilities of clinical education for all types of health professionals, provision of an environment in which clinical research can flourish, and highly specialized patient care. These responsibilities are combined in many different ways in individual teaching hospitals, depending upon a hospital's mission, its role in the community, the resources available to it, its past history and its view of the future. As a result, a vast continuum of diverse teaching hospitals exists.

Graduate Medical Education. Participation in graduate medical education programs is the characteristic that, by definition, separates teaching from non-teaching hospitals. Upon completion of medical school, physicians continue their medical education by completing at least three years of training in residency programs. While some residencies are based outside the hospital, most graduate medical education is sponsored by hospitals. Medical schools and teaching hospitals have devised a range of relationships for the conduct of graduate medical education. At one extreme, the "freestanding" residency is established, staffed and controlled by the individual hospital. At other end of the continuum, the residency program is offered jointly by the medical school and one or more hospitals. Along the continuum are a variety of relationships tailored to the needs, resources, and opportunities available. In 1995, nearly 1,025 short-term, non-federal hospitals provided the training sites for over 88,000 residents and clinical fellows in graduate medical education programs. The Veterans Health Administration also supports almost 9,000 filled residency positions, or 8.7 percent of filled residency training positions in the United States.

Undergraduate Medical Education. Prior to residency training, medical students complete four years of medical school. The "hands-on" clinical education of medical students consists of clerkships in hospitals and other clinical settings during which medical students spend a fixed amount of time under the supervision of faculty and residents in various specialties. Residents contribute substantially to the education of medical students, and their presence is often critical to the success of undergraduate programs. In 1995, over 33,000 undergraduate medical students received clinical training at teaching hospitals or their affiliated educational sites.

Nursing and Allied Health Education. Hospitals also remain the primary sites for the clinical training of nurses and other allied health professionals. While classroom training for nurses is now more likely to take place in a college or university, nurses still receive the major portion of their clinical education in hospitals. More than 25 other training programs in allied health fields are widely supported by teaching hospitals, including programs for physical therapists, respiratory therapists, and emergency medical technicians.

Provision of an Environment for Clinical Research. The nation's teaching hospitals and medical schools are the backbone of innovation in American medicine because they provide the environment for the conduct of clinical research and the introduction of new life-saving drugs, devices, and procedures into clinical practice. What is now commonly accepted medical care, such as treatment of infectious disease, came from laboratory and clinical research in academic health centers. Open heart surgery and life-saving organ transplantation were pioneered at teaching hospitals. From the use of ether in performing

"painless" surgery 150 years ago, to the development of neonatal intensive care units, and the promise of gene therapy in curing inherited genetic disease, medical schools and teaching hospitals serve as locations for experimentation and development of new knowledge that benefits the world. Many of these advances began in basic research laboratories of universities and their affiliated hospitals; most of the advances were transferred to patient care as clinical research programs at teaching hospitals. After rigorous evaluation in major medical centers, many of these innovations are adopted in other provider settings. Teaching hospitals offer a natural setting for the advancement and early application of medical knowledge by bringing together seriously ill patients and research-oriented faculty physicians.

Provision of Patient Care Services. In addition to their education and research missions, teaching hospitals are, first and foremost, providers of a broad range of health care services. They provide all levels of patient care--from preventive to tertiary services. They are local institutions providing basic hospital care in their neighborhoods and communities. They also are referral institutions providing tertiary care to statewide and regional populations, as well as community service institutions caring for patients from all economic and social backgrounds. Because of their research activities, teaching hospitals house the newest and most advanced services and facilities and with residents and supervising physicians available around-the-clock, teaching hospitals often care for the nation's sickest patients.

Why COTH Member Hospitals are Different

All teaching hospitals share three common objectives: education, research and patient care. However, while teaching and non-teaching hospitals operate in the same general organizational, social and financial environment, academic medical center hospitals, defined as short-term, nonfederal members of the AAMC's Council of Teaching Hospitals and Health Systems (COTH), have distinctive organizational and service characteristics. Membership in COTH requires hospitals to sponsor or participate in at least four approved residency programs and have a signed agreement with an accredited school of medicine. Thus, COTH member hospitals, which include 75 Veterans Affairs medical centers, are the backbone of graduate medical education, training about 75 percent of all residents in the U.S.

Comparing the 276 short-term general, non-federal members of COTH that reported data to the American Hospital Association in 1994 with the 828 other teaching hospitals and 3,853 non-teaching hospitals reveals striking differences about the characteristics of COTH members. Nearly two-thirds of COTH hospitals, but less than one-half of other teaching hospitals, are located in metropolitan areas of over one million population. In contrast, over one-half of non-teaching hospitals are located in rural areas. COTH hospitals are significantly larger than other hospitals. Over one-half of COTH hospitals have more than 500 beds; in comparison over one-half of non-teaching hospitals have under 100 beds. More than two-thirds of other teaching hospitals have between 100 and 400 beds. As large organizations with multiple responsibilities, COTH members also employ many personnel, often serving as economic engines in their local communities or regions. COTH members are primarily sponsored by non-profit organizations. About one-quarter are state university hospitals or major inner city municipal hospitals. Only three COTH members, or 1 percent, are investor-owned hospitals, while 7 percent of other teaching hospitals and 15 percent of non-teaching hospitals are owned by for-profit entities.

COTH members are major providers of patient care services and offer a wide range of hospital services. In 1994, while comprising only 6 percent of all hospitals, COTH members accounted for 20 percent of all admissions; 21 percent of all births; 23 percent of outpatient visits; and 18 percent of all surgeries performed in short-term, non-federal hospitals.

COTH members' unique responsibilities compel them to serve the needs of their communities differently than other teaching and non-teaching hospitals:

- Seventy-one percent of COTH members operate certified trauma centers, compared to only 29 percent of other teaching hospitals and 13 percent of non-teaching hospitals;
- Sixty-three percent of non-federal COTH members provide organ transplant surgical services compared to only 16 percent of other teaching hospitals and 3 percent of non-teaching hospitals;
- Ninety percent of all COTH hospitals provide both inpatient and outpatient AIDS services, while 69 percent of other teaching hospitals and only 33 percent of non-teaching hospitals provide similar services;
- Ninety-four percent of COTH members provide cardiac catheterization services compared to 68 percent of other teaching hospitals and 33 percent of non-teaching hospitals, and COTH hospitals provide similarly disproportionate amounts of open heart surgery and angioplasty services.

Teaching hospitals provide a disproportionate share of health care services to the most disadvantaged members of our society. Non-federal COTH members have 18 percent of the nation's beds, but 24 percent of all Medicaid inpatient days. In addition, COTH members provide a disproportionate share of uncompensated care. In 1993, COTH members wrote off 45 percent of the charity care ($4.9 billion) incurred by non-federal hospitals, and 27 percent of all bad debt expense.

The Current Financing Structure of Teaching Hospitals and Medical Schools

It is important to understand that in academic health centers, patient care, research and education occur simultaneously. Patients may receive care for complex medical problems or diseases that require state-of-the-art treatment and in that role may become subjects of clinical research trials. At the same time, physicians educate and involve residents, medical students, and other health professionals in caring for patients, who may also be enrolled in clinical research protocols.

Providing an environment in which health professional education and clinical research can flourish adds to the cost of patient care services at teaching hospitals and medical schools. Both teaching hospitals and medical schools have traditionally relied on a complex and delicate web of clinical revenue support to finance their additional missions.

The Current Financing of Teaching Hospitals. Teaching hospitals have long relied on revenues from patient care to cover most of the costs of the many services or products they provide for society. Patient care dollars have enabled teaching hospitals to support specialized services that are particularly expensive but vital community and regional resources. Patient care revenues also help cover the cost of treating those who cannot pay for their care and the cost of training health professionals. Teaching hospitals traditionally have financed their education and research activities with revenues from patient care. However, in the newly price-competitive market, private insurance companies, businesses, and some government purchasers of health care want to pay the lowest possible price for only those services that their enrollees receive.

Teaching hospitals are experiencing increasing difficulty in maintaining their educational and other social missions, which add to their cost structures, because they must meet the price competition from nonteaching hospitals when negotiating with nongovernment managed care contractors. State Medicaid programs are retreating from making special payments to teaching hospitals for their education and other societal missions. In addition, state Medicaid programs are increasingly entering into risk-based contracts under which teaching hospitals are forced to be price competitive with nonteaching hospitals.

At present, only two purchasers of services--the Medicare program and, in many states, Medicaid programs--recognize the additional costs of teaching hospitals. Since the focus of this hearing is the Medicare program, I will not address in detail Medicaid's participation in GME financing, except to note that most state Medicaid programs, but by no means all, include payments under their fee-for-service systems for the equivalents of Medicare direct graduate medical education payments and Medicare indirect medical education payments.

The Direct Graduate Medical Education (DGME) Payment. The Medicare program makes explicit payments to teaching hospitals for the costs of physician clinical training through the direct graduate medical education (DGME) payment. These payments are for the added direct costs of physician training, including salaries and fringe benefits for trainees and the faculty who supervise them; classroom space; the salaries and benefits of administrative and clerical staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for electricity and maintenance.

When Congress established the Medicare program in 1965, it acknowledged that educational activities enhanced the quality of care in institutions and recognized the need to support residency training programs to help meet the public need for fully-trained health professionals. In drafting the initial Medicare legislation, Congress stated:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (Senate Report. Number 404. Pt. 1. 89th Congress. 1st Sess. 36 (1965) and House Report, Number 213. 89th Congress. 1st Sess. 32 (1965)).

Similarly, in the regulations governing the Medicare program, the Secretary of Health, Education and

Welfare stated:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities (42 C.F.R. Section 413.85 [formerly Section 405.421(c)]).

Thus, since its inception the Medicare program has assumed some responsibility for graduate medical education costs, making separate payments to teaching hospitals. If there was ever an assumption that the "community" would take responsibility for its share of these costs, it has not occurred in the past thirty years and seems even less likely to happen in the current competitive environment.

Medicare support of direct graduate medical education costs is not open-ended, but the program imposes no limit on the total number of residents it will support. Today, the Medicare program pays its proportionate share of a hospital-specific per resident amount based on audited costs from a 1984 or 1985 base year and updated for inflation rather than on the basis of DGME costs actually incurred. A hospital's DGME payment is calculated by multiplying the hospital's fixed amount per resident by the current number of residents and then multiplying that result by Medicare's share of inpatient days at the hospital.

The Medicare program places limits on the number of resident trainee years for which full Medicare payment applies. Full support is restricted to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. Payments for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent. The five-year count is suspended, however, for a period of up to two years for training in a geriatric or preventive medicine residency or fellowship program.

The Indirect Medical Education (IME) Adjustment. Since the inception of the prospective payment system in 1983, the Medicare program also has made payments for the higher operating costs of teaching hospitals through the indirect medical education (IME) adjustment. While its label has led many to believe that this adjustment compensates hospitals solely for graduate medical education, its purpose is much broader. Both the House Ways and Means and Senate Finance Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

Thus, the IME adjustment is not to be confused with DGME payments, which are completely separate from the prospective payment system and serve a different purpose. It also should be noted that the Medicare program does not pay for a portion of the costs of clinical research or undergraduate medical education.

The Current Financing of Medical Schools. Medical schools support their education and research activities through tuition, endowment income and gifts, state appropriations, and federal and private grants and contracts. These are supplemented, however, by a complex system of clinical revenue support, primarily from faculty practice plan revenues.

Tuition and fees accounted for only 4 percent and state appropriations 10 percent of total medical school revenues in 1993-94. Faculty practice plan revenues represented 33 percent of total medical school revenue in that year; by contrast, in 1980-81, they contributed only 16 percent of the total. A portion of faculty practice plan revenue is used to cover the costs of uncompensated care. Faculty practice plan revenues also support academic programs in several ways. First, a portion is directly transferred to the medical school, its departments, and other research institutes and centers. This is discretionary money available to deans and department chairs to underwrite important teaching programs and a range of scholarly research activities. Second, the revenues are used to compensate clinical faculty for time spent in teaching and research. If clinical faculty were not engaged in these academic activities, their clinical productivity and the generation of patient care revenue would be far higher. Finally, some faculty

practice plan revenues provide direct support for residents and fellows, and indirect support for academic programs by paying the operating expenses of clinical practices in which these programs are intermingled.

The AAMC recently conducted a study, which estimated that a total of $2.4 billion of faculty practice revenue in 1992-93 was used to support academic programs. This represented 28 percent of the $8.3 billion of faculty practice revenue reported by U.S. medical schools that year. The academic program benefitting the most from faculty practice plan support was research, at an estimated level of $816 million. This amount is notable because it is a sum equivalent to one-fifth of the revenues medical schools received that year from the National Institutes of Health. While the division of this support between research in the basic or clinical sciences is not known, there is evidence to suggest that the bulk of the support was for clinical research and scholarly activities of the clinical faculty. Undergraduate medical education was the next largest beneficiary of faculty practice plan support, at $702 million, followed by graduate medical education at $594 million.

Research at academic health centers is supported by a variety of public, private, and institutional sources in addition to faculty practice plan revenue. The federal government, especially the National Institutes of Health, has been and remains the cornerstone of research support at academic health centers. However, institutional cost-sharing has been a growing factor in federally-sponsored research. Similarly, research sponsored by philanthropic and industrial sources rarely pays the full costs borne by the institution.

The shortfalls caused by uncompensated research costs are offset by significant institutional support, usually from funds derived from clinical practice. These funds also provide seed money for innovative faculty research projects prior to demonstration of their competitiveness for external funding, support for investigators during temporary periods in which funding is not available, information technology, renovation of research facilities, major research equipment, faculty recruitment, administrative compliance with state and federal regulations, and assorted overhead expenses not reimbursed through other mechanisms. In addition, the research environment reduces clinical productivity because research activities command faculty time that would otherwise be available for patient care. As more clinical research and care move from the inpatient to the outpatient settings, this problem will become more acute. To a large degree, clinical research in ambulatory settings is more complicated to accomplish.

The Future Financing of Teaching Hospitals and Medical Schools

As complex institutions with multiple and varied funding streams, teaching hospitals and medical schools are subject to many different environmental pressures, but their dependence on clinical revenue to support their education and research missions makes them extremely vulnerable to changes in the delivery system. The shift to a price-driven and more explicit financing system threatens the fragile nature of teaching hospitals and medical schools and their ability to fund research and education.

Academic medicine is adapting to a market-driven health care delivery system, but is concerned about proposals that would jeopardize its ability to fulfill its core missions. There are three fundamental principles which the AAMC believes should guide changes in the delivery system and the Medicare program:

Principle 1. The AAMC believes in a "shared responsibility" approach to financing the special missions of academic medicine. The AAMC has consistently supported a policy that graduate medical education and other societal missions are the shared responsibility of all entities that pay for hospital and health-related services on behalf of their enrollees. In September 1995 the AAMC endorsed the concept of a trust fund as a means of assisting teaching hospitals in meeting the special costs associated with their education mission.

This trust fund concept was part of H.R. 2491, the Balanced Budget Act of 1995, as adopted by the U.S. House of Representatives on October 19, 1995 and by the U.S. Senate on October 28, 1995. This legislation would have created a Teaching Hospital and Graduate Medical Education (THGME) Trust Fund consisting of five separate and distinct accounts. Three of the five accounts would have been funded by appropriated general revenue, and the Medicare program would have contributed funds to the two other accounts. The AAMC believes that the creation of a trust fund is an important transition toward re-establishing the principle of shared responsibility and creating a societal approach to financing the societal missions of teaching hospitals in the new competitive delivery system.

Some policy makers believe that the creation of a trust fund would serve as replacement funding to ameliorate the impact of reductions in Medicare DGME and IME payments. However, the AAMC hopes that, to a significant degree, the creation of the trust fund, which includes non-Medicare revenue, can

be viewed as a transition toward establishing the principle of shared responsibility. We believe that the designated general revenue funds would have replaced in part the dollars which Medicaid and private payers have provided for these purposes traditionally through higher payments to teaching hospitals. A trust fund would create a framework for all parts of the health care delivery system to participate in the financing of clinical education. The Association is anxious to work with the members of this subcommittee to enact a trust fund for teaching hospitals.

The AAMC also notes that H.R. 2491, the Balanced Budget Act of 1995, included additional study of graduate medical education and its funding. Among the issues identified for further study was the "financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and the method of financing used for the MedicarePlus program." The legislation directed the Prospective Payment Assessment Commission (ProPAC) to study this issue in addition to federal policies on international medical graduates and the dependence of schools of medicine on service-generated income.

The AAMC believes that medical school dependence on clinical income is a particularly pressing issue. While current data from 1994-95 (forthcoming in JAMA) indicate that the majority of U.S. medical schools are performing increased volumes of clinical work, practice plan revenues on average are barely holding steady on a per clinical faculty member basis; for many schools this measure is declining. Schools have substantially expanded their clinical faculties to remain competitive and to maintain their market share, but it appears that reductions in units payments related to managed care and increased competition have put pressure on financial margins.

The Role of Medicare Managed Care in a Shared Responsibility Approach. The AAMC believes that the Medicare program should contribute to the mission-related activities of teaching hospitals on behalf of all its beneficiaries, both those who remain in traditional fee-for-service plans and those who opt to enroll in risk-based plans. Under the proposed trust fund, the Medicare program would have continued to make IME and DGME payments on behalf of its fee-for-service beneficiaries, but not on behalf of its enrollees in risk-based plans.

The AAMC believes that the Medicare program should contribute to a trust fund on behalf of its beneficiaries enrolled in risk-based plans. To do this, the methodology used to calculate the Adjusted Average Per Capita Cost (AAPCC), the rate that the Medicare program pays to its risk-based plans and that was not addressed in H.R. 2491, the Balanced Budget Act of 1995, should be modified. The AAMC believes that payments for DGME costs and for patient care costs attributable to the special roles of teaching hospitals (IME and DSH) should be preserved for their intended purposes. Modification of the AAPCC methodology is needed to ensure that the Medicare program meets its obligation for its beneficiaries in risk-based plans under the shared responsibility principle.

After considerable study, the AAMC has concluded that the current method of calculating the Medicare AAPCC results in a payment system that creates an uneven playing field between teaching and non-teaching hospitals. The AAPCC calculation incorporates all Medicare expenditures, including the DGME, IME and DSH payments. Once these payments have been included in the AAPCC and paid to a risk contractor, there is no assurance that these dollars are used for the purposes intended by the Congress. Thus, teaching hospitals are at a competitive disadvantage when they attempt to contract with risk plans because the risk contractor receives the same AAPCC amount regardless of with whom the risk plan has a contract.

The AAMC recommends that both near-term actions to address the immediate issue at hand, as well as longer-term actions to resolve issues surrounding the current Medicare payment methodologies (DGME, IME, DSH, and AAPCC). In the long term, initiatives should be undertaken to identify and study potential alternative contracting mechanisms to the AAPCC methodology. For the near term, DGME, IME, and DSH payments should be removed prior to the calculation of the AAPCC rates and paid directly as intended by Congress to teaching and non-teaching DSH hospitals that incur the costs of these activities. These "carved-out" mission-related payments should be made to teaching institutions when Medicare risk contract enrollees utilize their services. The AAMC recommends that separate payment methodologies, which mirror the current Medicare regulations and are administratively feasible, be applied to each component of the DGME, IME and DSH payments. This approach could be accomplished through direct payments to the providers by continuing to use the current Medicare payment methodologies and settlement process with some relatively minor technical changes.

The AAMC urges the Congress to address this methodological issue in an urgent manner as part of its package of proposals to reform the Medicare program. The Association recognizes that while this problem is more prevalent in some parts of the country than in others, it will be increasingly difficult to resolve as national enrollment in Medicare risk-based plans grows. As Medicare beneficiaries increase

their participation in managed care plans, or exercise other options, such as Medical Savings Accounts (MSAs) and fee-for-service payments decline, the mission-related dollars lost by teaching hospitals will increase substantially. Additionally, the same issues will arise under proposals to increase enrollment in Medicaid managed care programs. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding risk-based contracts among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Principle 2. The AAMC believes that teaching hospitals and teaching physicians should not bear more than their "fair share" of reductions in the rate of projected Medicare spending. The AAMC recognizes that unrestrained growth in Medicare spending threatens the long-term solvency of the Federal Hospital Insurance (HI) Trust Fund, and supports reforms to align trust fund income and outlays, but the proposed changes in the Medicare and Medicaid programs would have profound effects on the nation's health care system, and especially on teaching hospitals and medical schools. Teaching hospitals serve large numbers of the poor and elderly and depend heavily on Medicare payments for DGME, IME, and disproportionate share (DSH). Many teaching hospitals also serve large segments of the Medicaid population. For COTH members, Medicare and Medicaid payments on average constituted nearly one-half of all their net patient revenue in 1994. In the absence of a marketplace where all insurers or sponsors of patient care programs share responsibility for supporting the academic missions, these historical, explicit payments to teaching hospitals take on critical importance.

Any reductions proposed for DGME and IME payments are not reductions in the rate of increase of program spending, but are real cuts for teaching hospitals. Coupled with private sector losses, reductions in Medicaid spending and other cuts in projected Medicare payments, reductions in DGME and IME payments will force teaching hospitals to bear an unfair burden of Medicare payment reductions, making it more difficult for them to sustain their additional missions.

The Medicare Indirect Medical Education (IME) Adjustment. The AAMC believes that the IME adjustment should be maintained at a level that will allow teaching hospitals to fulfill their missions. As the Congress contemplates adjustments in the annual growth rate of the Medicare program, payments for hospital services are principal targets.

Proposals to slow the growth in PPS operating payments have centered on three specific elements: the annual increase in the basic PPS price for all hospitals, called the update factor, and two add-on payments, the IME and DSH adjustments. All hospitals' Medicare payments are affected by changes in the update factor, but only certain types of hospitals experience the effect of changes in IME and DSH payment policy. While teaching hospitals recognize the need to control Medicare expenditures to protect the long-term solvency of the program, these institutions would be affected not only by IME reductions, but also by reductions in the update factor and DSH payments. At the levels being proposed by some policy makers, these would be real cuts in payments that would endanger the ability of teaching hospitals to fulfill their core missions of patient care, education and research.

While policy makers regard the $4 billion in IME funds as a source from which to obtain budget savings, it must be remembered that IME payments, while a relatively small proportion of total Medicare spending, are absolutely vital to a relatively small number teaching hospitals. Work done by ProPAC has shown that IME funding is concentrated in relatively few teaching hospitals: about 140 teaching hospitals receive one-half of all IME payments. If the level of the IME adjustment is reduced, it would have a significant negative impact on the hospitals at the very high end of the continuum of teaching intensity.

Principle 3. Any changes in Medicare payment policy should be implemented gradually with an annual evaluation of their impact on the financial viability of different groups of hospitals. The AAMC believes that Congressional decisions on Medicare payment policies should be made in the context of their impact on the entire health care system. Non-federal COTH members account for 6 percent of the nation's hospitals, but nearly 2 million, or almost 20 percent, of all Medicare discharges. For many COTH member hospitals, Medicare payments comprise from one-quarter to one-third of all their revenue. Clearly, changes in Medicare payments will have a profound impact on these institutions.

The Financial Viability of Teaching Hospitals. In recent years, Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, ProPAC has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care for all Americans.

Historically, teaching hospitals have had higher PPS inpatient operating margins--the excess or loss of

revenue attributable to PPS patients expressed as a percentage--on average than non-teaching hospitals, but teaching hospitals' total margins--the financial margins from all patients--have remained consistently lower than other hospitals' total margins. This relationship between PPS and total margins and teaching status persists in the most recent financial data available.

Recent Medicare IME payment policy has recognized the importance of IME payments to teaching hospitals' financial viability. In that regard, the AAMC believes that any changes in payment levels should be made gradually with periodic monitoring of their effect on the financial viability of teaching hospitals. Reductions in these payments could substantially harm the ability of teaching hospitals to fulfill their numerous and complex missions.

Proposals to Change the Size and Distribution of the Physician Work Force

For more than a decade, the AAMC has analyzed issues of physician work force supply and the mechanisms necessary to support the education of physicians. A review of the Association's efforts in this arena and our comments on the recommendations recently made by the Institute of Medicine (IOM) and the Pew Health Professions Commission were submitted in detail to this subcommittee on April 16, 1996. The AAMC endorses the recommendations set forth by the IOM Committee on U.S. Physician Supply, which are consistent with many of our current positions and activities. Both the AAMC and the IOM call for a closer alignment of the number of entry level residency positions with the number of U.S. medical school graduates. In addition, both organizations call for the development of funding mechanisms to assist hospitals that depend on residents who have graduated from non-U.S.-accredited medical schools to provide care to the poor in reconfiguring the delivery of health care.

The AAMC also agrees with a number of the recommendations made by the Pew Health Professions Commission. However, the Association takes strong exception to the Commission's recommendation that U.S. medical schools be closed to decrease enrollments by 20 to 25 percent. While the medical education system is indeed producing more physicians than are needed for the nation's medical care, data do not show that the number of U.S. medical school graduates entering residency training is excessive. With more than 25,000 entry-level residency positions and only some 17,000 U.S. medical school graduates, efforts should be made to reduce the number of first-year positions.

The American medical education system has developed an accreditation process for U.S. medical schools that requires vigorous peer review and continuous quality improvement. All accredited residency programs must meet the minimum standards established by the Accreditation Council for Graduate Medical Education (ACGME) and the specialty-specific Residency Review Committees (RRCs). While it is clear that improvements in the measurement of the quality of residency training are necessary, one measure of high quality might be programs that attract graduates of LCME- and AOA-accredited medical schools.

Reductions in the number of residency positions, or "right-sizing" the graduate medical education enterprise, should begin with those programs that do not attract graduates of U.S. medical schools. This process will require difficult decisions. Hospitals that cannot reduce positions due to service demands by the populations they serve must get adequate financial assistance to maintain their patient care mission. However, after the process is complete, the quality of graduate medical education training and the size and compositions of the physician work force will be better aligned.

Medicare Payments with an Educational Label. Proposals to reform Medicare DGME and IME payments have been stimulated by both the need to limit the growth in Medicare expenditures and the need for an appropriately-sized and -trained physician work force. Some proposals seek to achieve a more appropriately configured physician work force by shifting the balance of generalist and nongeneralist physicians, or placing limits on the total number of physicians-in training, or encouraging residency training in non-hospital settings. The AAMC offers three suggestions for changes in the Medicare program that would improve the educational environment for physicians.

1. The AAMC supports changes in Medicare DGME funding to encourage residency training in non-hospital, ambulatory sites, such as private physicians' offices, freestanding clinics, or nursing homes and believes that Medicare DGME payments should be made to the entity that incurs the cost. Current law regarding Medicare DGME payments explicitly states that DGME payments may be made only to hospitals. Recipients of payments could be teaching hospitals, medical schools, multi-specialty group practices or organizations, such as GME consortia, that incur training costs. However, the AAMC does not support payments being awarded directly to training programs, since ultimately the organization in which the program functions must determine the institutional commitment to graduate medical education.

2. The AAMC believes that the current rules for counting residents for purposes of IME payments should be changed to remove barriers to training physicians in non-hospital, ambulatory settings. In making this change, the Congress could allow hospitals to count residents in non-hospital ambulatory training sites for purposes of calculating the resident-to-bed ratio in the payment formula, as long as the total number of residents counted by the hospital did not exceed the number it counts currently. Hospitals could be required to use the ratio in effect for the 1995-96 fiscal year.

3. The AAMC supports limiting Medicare DGME funding to graduates of medical schools approved by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA). This change in Medicare funding must make provisions for appropriate transitional-and potentially permanent-mechanisms to address the impact on crucial patient care functions of hospitals that are adversely affected by a substantial reduction in the number of residents. Currently, Medicare provides support for medical school graduates regardless of whether they are graduates of U.S. or foreign medical schools. While the number of graduates of U.S. allopathic medical schools has remained relatively stable for several years, the number of IMGs receiving training in this country has increased substantially. Between 1988 and 1993, the number of IMGs in graduate medical education nearly doubled from approximately 12,000 to nearly 23,000. In 1993-94, nearly 27 percent of all first-year residency training slots in allopathic and osteopathic programs were filled by IMGs.

In response to concerns regarding overall physician supply, on June 22, 1995, the AAMC Executive Council adopted a policy position on the physician work force and the participation of IMGs in graduate medical education:

> That the Association of American Medical Colleges, in recognition of the growing oversupply of physicians in the United States, pursue and undertake initiatives to address the future supply of physicians consonant with legal restrictions and requirements. While the Association should consider all available options for addressing this oversupply, it should--first and foremost--pursue options to diminish the number of international medical graduates pursuing graduate medical education in the United States and remaining in the United States following the completion of their graduate training. Any options supported by the Association that would result in constraints on the number of international medical graduates receiving training must include mechanisms to mitigate the impact on hospitals that currently train IMGs and those hospitals that are highly dependent on IMGs for maintenance of their patient care programs.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for IMGs would cause substantial access and service problems for Medicare beneficiaries. One of the issues that policy makers would need to address in enacting such a change would be the implementation of a process and a time table so that patient access to services would not be reduced precipitously. Additionally, mechanisms would be needed to mitigate the impact on hospitals that currently train IMGs and on hospitals that are highly dependent on IMGs for maintenance of their patient care programs.

A variation of this proposal offered by some policy makers would limit Medicare DGME payments to a defined number of residents. One option could be to freeze the number of full-time equivalent (FTE) residents that the Medicare program would support at the current number of residents in the training system. A more aggressive option that has been suggested might be to impose an aggregate limit on the total number of positions, e.g., the number of U.S. graduates plus some add-on percentage for IMGs. It should be understood that these proposals could require the establishment of control or regulatory mechanisms.

Conclusion

The AAMC regrets that the possibility of establishing a "shared responsibility" fund for the special missions of teaching hospitals and medical schools apparently has been delayed. This approach to financing the special missions of academic medicine is an issue that continues to deserves the Subcommittee's attention. All evidence indicates that the health care delivery system will continue to emphasize price competition, challenging the financial viability of teaching hospitals and teaching physicians. The AAMC is deeply concerned that the fundamental structural changes now occurring in the health delivery system will undermine the ability of academic medicine to adapt to the new environment and to fulfill its unique missions.

Chairman THOMAS. Thank you very much, Mr. Goldfarb.
Mr. Brideau.

STATEMENT OF LEO P. BRIDEAU, GENERAL DIRECTOR AND CHIEF EXECUTIVE OFFICER, STRONG MEMORIAL HOSPITAL, ROCHESTER, NEW YORK, AND CHAIRMAN, BOARD OF TRUSTEES, HEALTHCARE ASSOCIATION OF NEW YORK STATE, ALBANY, NEW YORK

Mr. BRIDEAU. Thank you, Mr. Chairman and Members of the Committee, for the opportunity to speak with you on this very important matter. My name is Leo Brideau. I serve as the chief executive officer of Strong Memorial Hospital of the University of Rochester. It is its principal teaching hospital. I also chair the board of trustees of the Healthcare Association of New York State.

As the State that trains the largest number of physicians, New York certainly has a valuable perspective to bring on the topic of medical education. And before I begin, I want to thank you, Chairman Thomas and Ranking Member Stark for the attention you have paid to the very special circumstances of New York, and I do want to recognize also the fine work of Congressman Amo Houghton, who serves on this Subcommittee. He has earned the respect of all of us for his wisdom and integrity, as well as to acknowledge the work on the Ways and Means Committee of Congressman Rangel, whose leadership has meant better health care for all New Yorkers, and Congressman Mike McNulty, who also serves on the Ways and Means Committee.

What I would like to do is to begin by providing you with a brief synopsis of all that we do at Strong to underscore the enormous value of medical education as a key component of the service delivery of the region, and then comment on three areas: One being the appropriate role of government in medical education; second, the notion that we need to rely on the marketplace to adjust physician training and supply; and, finally, I want to talk about the value that international medical graduates bring to New York's health care system.

Strong Memorial is the largest acute care hospital in New York's third largest city, and we provide the tertiary set of services for Monroe County and the 10-county Finger Lakes region, which is largely a rural region, about 1.4 million people in total. In addition, we train 640 medical residents, over 150 fellows, and conduct about $100 million per year in sponsored research. We provide a good deal of the uncompensated care that is provided in Monroe County for a whole variety of services.

We serve as one of 30 bone marrow transplant centers nationwide and are designed as a Center of Excellence, one of 13 Spinal Cord Injury System hospitals.

We are one of only six sites nationally designated as an AIDS Vaccine Evaluation Unit and serve as a State-designated AIDS treatment center and are one of the eight Alzheimer's disease centers in New York and are the recipient of a Pepper Center grant.

In addition to those tertiary services, we also provide health care to a large rural population throughout the Finger Lakes region of New York.

Both directly and indirectly, Medicare contributes to our ability to fulfill our mission through these activities. And, we realize that you face a difficult task. The Medicare Hospital Trust Fund is spending more than is being collected, and there is a perception that Medicare pays more than its fair share of graduate medical education. That has prompted some policymakers to again suggest cutting what Medicare pays hospitals to treat Medicare patients. These proposals come at a time when our population is aging, has growing health care needs, and deserves improvement in the treatment of such debilitating diseases as Alzheimer's and others—improvement that will only come through rigorous biomedical research and through the educational program for physicians and allied health professionals that we depend on our academic medical centers to provide.

The Healthcare Association of New York State believes that any change in Medicare must be made within the context of the Nation's responsibility to both its current and its future elders. Viewed in that context, reform should be oriented to protecting the program's financial viability while preserving its goal of enhancing the quality of life for our senior citizens through the quality of health care. We should not only seek to moderate the program costs, but also expand options for service and align revenues with projected spending.

Consequently, cuts in Medicare indirect and direct medical education payments to hospitals should be minimized, and, furthermore, we believe that a trust fund should be established to provide non-Medicare support for financing medical education.

Investment in graduate medical education is an investment in improving the health of entire communities. Both public and private sources need to share in that investment. The funding base needs to be as broad as possible. We believe concentrating medical education in Centers of Excellence such as New York is a national benefit that should be financed as a national public good.

The Pew Health Commission's report, the subject of a prior Subcommittee meeting, calls for a broader sharing of costs of medical education, advocating the establishment of a private-public partnership for funding through insurance premiums.

At the same time, the report from the Institute of Medicine wisely recognizes the link between medical education and the provision of charity care for the poor and uninsured. It strongly recommends that State and Federal Governments take immediate steps to develop a mechanism to provide replacement funds as opposed to simply transition funds. Further, we also argue for the carve-out of the medical education funds from the AAPCC provided so it can go directly to those providing that education and not into the pockets of HMOs.

Finally, the notion of international medical graduates is one that I would like to address. It is one that really needs our attention because we simply can't solve the problems on the back of international medical graduates. They provide key services not only during the time that they are in training, but they also provide key services when they leave. And, I know in my region many of the rural hospitals' medical staffs are largely made up of these international medical graduates. If we don't have that pool of physi-

cians, we aren't able to staff those hospitals. That is not just an inner-city problem, though it is a serious inner-city problem.

Our view is that international medical graduates who pledge to serve in those regions that are underserved or serve in underserved disciplines should be permitted to stay in this country.

Mr. Chairman and members, I thank you for giving me the opportunity to speak today. The goal of reforming medical education should be one that is left to the system, to the marketplace, and, Congressman Stark, I agree with you that this is not an area that lends itself very well to dictating it through regulation.

Thank you.

[The prepared statement follows:]

STATEMENT OF LEO BRIDEAU
OF STRONG MEMORIAL HOSPITAL
AND HEALTHCARE ASSOCIATION OF NEW YORK STATE

Mr. Chairman and members of the House Subcommittee on Health, thank you for the opportunity to speak on this important matter. My name is Leo Brideau. In addition to being the Chief Executive Officer of Strong Memorial Hospital -- the 736-bed teaching hospital for the University of Rochester School of Medicine and Dentistry -- I chair the Board of Trustees of the Healthcare Association of New York State. I appear before you today with Daniel Sisto, President of the Healthcare Association of New York State.

As the state that trains the largest number of physicians, New York has a valuable perspective on medical education. New York States academic medical centers and teaching hospitals train approximately 15% of the nations future physicians.

Before beginning my testimony, I want to thank you Chairman Thomas and Ranking Member Stark for your recognition of New Yorks unique situation and for the attention you have paid to our special circumstances.

I also want to say that it is a pleasure to appear before one of my Western New York neighbors, Representative Amo Houghton who has been a tireless advocate for improving Medicare and the health care system. We are proud to have him represent our state.

I also would like to acknowledge Representative Charles Rangel of New York -- whose leadership on the Subcommittees parent Ways and Means Committee has improved health care for all New Yorkers -- and Representative Mike McNulty of New York who also sits on the Ways and Means Committee.

Lastly, I would like to acknowledge Representative Nancy Johnson who has worked tirelessly on graduate medical education issues. We appreciate her hard work and look forward to continuing to work with her.

I would like to begin by telling you a bit about what we do at Strong Memorial. Although our mix of services and programs is unique, Strong is *not* unique among teaching hospitals in having an integrated mission of care, education, and research. The opening sentence of our mission statement says it best: We improve health through caring, discovery, teaching and learning.

Strong Memorial is the largest acute care hospital in New Yorks third largest city and provides tertiary care for surrounding Monroe County and the rural Finger Lakes region to the south. All together, close to 1.4 million people depend on Strong Memorial for all or part of their care.

We provide $7 million a year in uncompensated care to persons with no or inadequate insurance and in unreimbursed services devoted to community health and wellness.

We are one of 30 bone marrow transplant centers nationwide to be designated a Center of Excellence by Blue Cross/Blue Shield and one of 13 Spinal Cord Injury System hospitals in the nation.

Along with the UCLA Medical Center, Mayo Foundation, and others, we formed the Academic Medical Center Consortium which is devoted to improving the quality, effectiveness, and outcomes of clinical practices while keeping costs to a minimum.

Since Monroe County has the highest cumulative number of reported AIDS cases in upstate New York, we serve as a state-designated AIDS Center. We also are one of only six sites nationally designated as a National Institutes of Health-sponsored AIDS Vaccine Evaluation Unit.

Strong Memorial also serves as a regional trauma center and are one of eight regional Alzheimers Disease Assistance Centers in New York.

We have a partnership with St. James Mercy Hospital in Hornell and Jones Memorial Hospital in Wellsville -- two small communities to the south -- to enhance care in rural areas. With Wyoming County Community Hospital in Warsaw, New York, we operate a family health care center. And we help area hospitals recruit physicians trained at the University of Rochester for the primary, emergency, acute, and continuing care services that their communities need.

Both directly and indirectly, Medicare contributes to our ability to fulfill our mission through these activities. In other words, a lot of caring and curing rides on the decisions made by this Subcommittee regarding funding of graduate medical education.

GOVERNMENT HAS AN OBLIGATION
TO ENSURE THE TRAINING OF FUTURE PHYSICIANS

We realize that you face a difficult task. The recent Medicare Trustees report found that the Hospital Trust Fund is already spending more than is being collected in payroll taxes. In addition, there is a perception that Medicare pays more than its fair share of graduate medical education costs. This situation has prompted some policymakers to once again suggest cutting what Medicare pays hospitals to treat Medicare patients and, specifically, reducing Medicare funds for graduate medical education. But that is a short-term solution at best.

The level of reduction in the rate of growth considered during the 104th Congress was greater than that necessary to either preserve the solvency of the Medicare Hospital Trust Fund or balance the federal budget. It would have reduced Medicare spending too steeply at a time when our population is aging and not only has increasing health care needs, but also deserves improvements in treatment of such debilitating diseases as Alzheimers. These improvements will only come from rigorous biomedical research and will only be made available through the education of physicians and allied health professionals.

The Healthcare Association of New York State believes that any change in Medicare must be made within the context of the nations responsibility to both its current ***and future*** elders. Viewed in that context, reform should be oriented to protecting the programs financial viability while preserving its goal of enhancing the quality of life of seniors by ensuring their access to quality health care. Such reform requires a multi-faceted approach that not only seeks to moderate program costs, but also expands options for service delivery and aligns revenues with projected spending.

Investment in graduate medical education is an investment in improving the health of communities, and both public and private sources should share in that investment. This is an approach we have advocated in New York, and it should be adopted on the national level, as well. If you believe that Medicare is paying more than its fair share for medical education, the answer isnt cutting Medicare, it is requiring others who benefit from the improvements in health that derive from medical education to share in the cost.

The Pew Health Professions Commission report appropriately calls for a broader sharing of the costs of medical education, advocating the establishment of a public-private pool for funding health professions education that is tied to all insurance premiums.

In short, cuts in Medicare indirect and direct medical education (IME and DME) payments to hospitals should be minimized. Also, a trust fund should be established to provide non-Medicare support for financing medical education -- as an addition to, not a replacement for, Medicare funding. Some features of the GME trust fund proposed in the Balanced Budget Act should be incorporated into future budget legislation.

We also strongly support carving out funds for graduate medical education and disproportionate share hospital payments from Medicare managed care rates. These funds should go directly to the hospitals that train physicians and treat uninsured patients, with none being used for deficit reduction.

WE SHOULD RELY ON THE MARKETPLACE TO ADJUST PHYSICIAN TRAINING AND SUPPLY

The reports of the Institute of Medicine (IOM) and the Pew Health Professions Commission regarding medical education and physician supply -- the focus of a prior Subcommittee hearing -- make a substantial contribution to discussions of medical education reform.

The IOM would place greater reliance on market forces than on regulatory approaches to reduce the number of students entering the health professions and to encourage generalist rather than specialist training. This is the right approach. The power of the market to encourage such corrections is underscored by the results of the 1995 and 1996 National Resident Matching Programs. In both years, more than half of U.S. medical school graduates chose training in one of the generalist disciplines. Steep declines were recorded in several specialties; for example, there was a 53.8% reduction in the number of graduates choosing anesthesiology training and a 20.3% decline in the number choosing diagnostic radiology residencies. The experience in New York mirrors this trend. Moreover, the percentages of New Yorks medical residents in primary care and other generalist areas exceed the national averages.

Furthermore, many of New Yorks teaching hospitals are responding to the market by adjusting their curricula, training sites, and student mix. It is crucial to keep in mind that although the current demand for specialty physicians is declining, the demand for generalist physicians and for certain allied health professionals is rising and that this demand trend will continue as the Baby Boomers age -- suggesting a need for more training in geriatrics -- and as managed care gains in popularity and enrollment -- suggesting a need for more primary care practitioners. Relying on regulation rather than the marketplace to adjust the supply of health professionals could result in a future undersupply of needed professionals.

At Strong Memorial, we are responding to these trends with a number of ongoing adjustments in our health education programs. Ive already mentioned our focus on Alzheimers research and treatment. In addition, Strong and the University of Rochester have developed a masters level nurse-midwifery education program. With Ithaca College, we train much needed physical therapists.

In physician training, in 1993, we began a residency program in emergency medicine -- an area where there continues to be strong need. Overall, an increasing proportion of our medical students clinical experience occurs outside the hospital. In 1993-94, two-thirds of our third-year class spent half of their medical clerkship in practice-based settings, both in Rochester and in 10 small communities across New York State.

We are not alone in undertaking such initiatives. For example:

> Albany Medical College has made primary care dominant in their graduate medical education program. Their residents rotate to health maintenance organizations, group practices, and family practice centers.
>
> Bassett Health Care in Cooperstown has a residency training program in rural primary care. Program participants do a substantial amount of their training in rural community primary care clinics.
>
> The State University of New York at Buffalo has developed a nationally recognized medical education consortia that gives students a wide range of experiences in treating patients in a variety of non-hospital settings.

With regard to physician supply and distribution, the IOMs recommendations are preferable to those of the Pew Commission. While Pew recommends closing and downsizing health profession training programs, the IOM makes the more cautious recommendation that no new medical schools be opened or expanded. Caution is well-advised given the difficulty of predicting what ailments and diseases may afflict our population in the future, as well as the difficulty of predicting improvements in medical treatment and practice patterns.

If legislative and regulatory steps to reduce the supply of physicians are taken, please be cautious not to underestimate the future demand for physicians or other health professionals.

Also, please heed the Institute of Medicines wise recognition of the link between medical education and the provision of charity care for the poor and uninsured. The IOM report strongly recommends that the state and federal governments take immediate steps to develop a mechanism to provide *replacement* funds to those hospitals that depend on medical residents for provision of care to the poor, and it underscores the difference between replacement funds, which are ongoing, and transition funds, which are time-limited. Reducing teaching support, without providing adequate replacement funding, would jeopardize our teaching hospitals ability to provide care to the poor and uninsured.

Medical residents provide valuable services in the communities where they train and contribute to New Yorks status as a leading international center of medical advancement and research. Concentrating graduate medical education in centers of excellence, such as New York, is a national benefit that makes both financial and programmatic sense and should continue to be financed as a national public good. For example, this system has enabled six states (plus two Canadian provinces and two Canadian territories)* to forego the creation of academic medical centers while benefitting from the ability to obtain well-trained physicians to meet their needs.

THE VALUE OF INTERNATIONAL MEDICAL GRADUATES MUST BE ACKNOWLEDGED

One of the most troubling proposals floated in the halls of Congress would reduce physician supply by limiting or eliminating residency funding for international medical graduates (IMGs). Both the Pew and IOM reports attribute the overall oversupply of physicians in the United States to the growth in the number of IMGs, and both call for changes in federal funding of IMGs and tighter immigration laws to ensure that non-citizens return to their home nations upon completion of their training.

We believe that assisting the medical education of citizens of other nations is important for world public health and is an appropriate role for the United States as the leader of the free world. Apparently House Speaker Newt Gingrich feels similarly, because in a January 1995 speech before the American Hospital Association, Speaker Gingrich suggested that we measure the total number of specialists against world demand, not against American demand.

Strong Memorial is not a high IMG hospital, but I cannot emphasize enough the importance of IMGs to the health care of the communities that we serve. IMGs benefit our communities both during training and after entering practice. For example, after caring for New Yorks low-income residents during training, many of the IMGs who remain in the United States practice medicine in otherwise under-served communities. This is certainly true in the rural communities with which Strong Memorial is familiar.

The Healthcare Association of New York State believes that the same mix of public and private financing should be provided for the medical education of IMGs in recognition of the benefits they provide in our communities during training. We also believe that those IMGs who agree to

As many members of this Subcommittee observed during your April hearing on graduate medical education, if the supply of these physicians is cut, there is no mechanism to replace this talent in countless urban and rural communities across the United States.

In summary, the goal of reforming medical education should be to achieve a system that is responsive to the marketplace. The goal of reforming Medicares role in medical education should be to achieve a system that is responsive to the current and future needs of Medicare beneficiaries. Unfortunately, the proposals under consideration as part of the Balanced Budget debate would set up a future crisis. Our parents -- and, ultimately, we -- deserve better. Thank you.

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* Alaska, Delaware, Idaho, Maine, Montana, and Wyoming in the United States. New Brunswick, Northwest Territories, Prince Edward Island, and Yukon Territory in Canada.

enter a medical field that is under-supplied or who agree to practice in medically under-served

Chairman THOMAS. Thank you.
Dr. Wickless.

STATEMENT OF LARRY WICKLESS, D.O., VICE CHAIR, COUNCIL ON FEDERAL HEALTH PROGRAMS, AMERICAN OSTEOPATHIC ASSOCIATION

Dr. WICKLESS. Thank you. Chairman Thomas and Members of the Subcommittee, thank you for inviting me to appear before you this afternoon. My name is Larry Wickless, D.O., and I appear today on behalf of the American Osteopathic Association.

For the record, my testimony has been endorsed by the American Association of Colleges of Osteopathic Medicine and the American Osteopathic Health Care Association.

Mr. Chairman, you stated last year that it is your intention to develop a policy which will encourage a better balance of generalists and specialists for our health care work force. I want to emphasize it is the osteopathic profession which, for the past century, has produced a work force in which primary and nonprimary care specialists are balanced in a way that more properly reflects the needs of our society. As a matter of fact, in your State alone there currently exists 154 osteopathic postgraduate training positions, including internships and residencies, positions which produce many of the physicians on which the citizens of the great State of California depend.

As is evident, we have a considerable amount at stake in how the Nation's GME system is reformed. The following are the AOA's recommendations:

First, the AOA believes that the Medicare beneficiaries directly benefit from GME and, therefore, because Medicare is a Federal program, the Federal Government should continue to be a major stakeholder in GME, but not the sole stakeholder. There are others who benefit from GME programs who need to step up to the plate, such as private insurers, pharmaceutical houses, medical equipment manufacturers, to name but a few.

The AOA also strongly supports the establishment of a national GME fund to which those who benefit from the GME would contribute. Once it is agreed that there should be multiple contributors to GME, there should exist standard payment principles under which all would have to abide.

Second, the AOA urges that the current DME payment methodology, which is based on hospital-reported costs in 1984, be revisited. The AOA strongly encourages the Subcommittee to establish a new reimbursement structure for the reimbursement of direct costs based on a national per-resident average. This would finally put all medical residents on a level playingfield.

Third, under current law, residents are counted as 1.0 full-time equivalents only up to the lesser of reaching initial board eligibility or 5 years. If the resident chooses to pursue additional subspecialty training, such a resident is counted as a 0.50 FTE. The AOA supports the current 50 percent rule.

Fourth, the AOA generally agrees with the Pew Commission's recommendation to reduce the number of GME training positions to the number of U.S. medical school graduates plus 10 percent. Any such methodology must specify that the number of funded

allopathic residency programs would be determined based on the number of graduates of allopathic schools, while the number of funded osteopathic programs, both internships and residencies, would be determined based on the number of graduates from osteopathic schools. This position has also been endorsed by COGME.

Fifth, the AOA supports a policy of gradually reducing the funds available for the training of international medical graduates to 25 percent of current levels. This position has also been supported by COGME.

Sixth, the current indirect medical education formula which is based on a training program's resident-to-hospital-bed ratio is unacceptable. The AOA believes that training in ambulatory settings must be specifically encouraged through any new IME reimbursement formula. The underlying concept is for training funds to be permitted to follow the resident and not for the resident to be constrained to follow the training funds.

Seventh, another of the Pew Commission recommendations is to redirect graduate medical education so that a minimum of 50 percent of the training programs are in primary care by the year 2000. We agree with this ratio. We point with pride to our history of meeting and even exceeding the primary care specialty ratio that has been identified as a national work force target. In fact, the College of Osteopathic Medicine of the Pacific, our osteopathic medical school in California, was recently ranked number one in the Nation among all medical schools according to the percentage of its physicians graduating in family practice and number three in the Nation by the percentage of graduates entering careers in primary care.

Eighth, the AOA also strongly encourages Federal support of educational consortia in graduate medical education. The AOA's accrediting program requires that by mid-1999 all osteopathic graduate medical education will be completed in osteopathic postdoctoral training institutions, OPTIs, comprised of at least one hospital and one osteopathic medical school. Integration of medical schools in graduate medical education will result in an integrated or seamless curriculum.

In conclusion, Mr. Chairman, thank you for hosting this important hearing here today. The AOA believes that only with the implementation of the aforementioned recommendations will we begin to prepare our Nation resident physicians and training sites for the next century in delivering quality health care for the public good, while generating significant savings in the Medicare Program.

Thank you.

[The prepared statement follows:]

STATEMENT OF
LARRY WICKLESS, D.O.
AMERICAN OSTEOPATHIC ASSOCIATION

Chairman Thomas and members of the Subcommittee, thank you for inviting me to appear before you this afternoon. My name is Larry Wickless, D.O., and I am the Vice Chair of the American Osteopathic Association's Council on Federal Health Programs. For nearly thirty years I have practiced osteopathic medicine, and am currently the Program Director for Gastroenterology at Botsford General Hospital in Farmington Hills, Michigan. The AOA recognizes that reform of the Nation's graduate medical education financing and workforce policies is a bold task. Based on the latest figures from the Medicare Trustees' Report, it is clear that some difficult decisions will have to be made immediately to ensure the solvency of the trust fund, and some of these decisions will have to focus on GME. Mr. Chairman, by providing this opportunity to discuss the extent to which these decisions will impact the system under which our Nations' medical residents are trained, you are demonstrating tremendous leadership. I am honored to have been called on to help the Subcommittee begin to identify a workable solution.

OSTEOPATHIC MEDICINE

Inviting me to testify before you today is certainly reflective of your appreciation that there are two separate and distinct branches of medical practice in the United States today -- osteopathic medicine and allopathic medicine. As you know, the majority of physicians in the country are allopathic physicians (M.D.s); however, osteopathic physicians (D.O.s) constitute more than five percent of all physicians practicing in the United States - almost 40,000 strong. However, osteopathic physicians represent more than 15 percent of all physicians practicing in communities of less than 10,000 people, and fully 18 percent of all physicians serving communities of 2,500 or less. Further, osteopathic physicians provide care to patients in all private health systems as well as public programs, such as the military, Public Health Service, Veterans Administration, and Medicare and Medicaid. The D.O. and M.D. degrees are the only recognized degrees leading to the unlimited licensure for the practice of complete medicine and surgery.

Osteopathic medical practice grew out of a concept developed over 120 years ago by Andrew Taylor Still, M.D. Dr. Still studied the attributes of good health so that he could better understand the process of disease. This ultimately lead to a philosophy of medical care, focusing on wellness, preventive medicine, and the ability of the body to regulate its own health, which emphasizes the unity of all the body parts as a key element of health. This philosophy is reflected in the osteopathic educational continuum, which has consistently produced more than 60 percent osteopathic primary care physicians who provide a complete range of services to patients of all ages. The success of the osteopathic profession in producing community-level primary care medical practices is the result of the profession's carefully crafted educational continuum that emphasizes primary care and the osteopathic philosophy throughout all levels of education and training. This continuum begins with four years of medical training, during which osteopathic medical students complete a curriculum of basic sciences and clinical studies, including the same subject matter taught in allopathic medical schools. In addition, osteopathic medical students receive training in the administration of manual medicine and complete significant course work in osteopathic principles and practice. This predoctoral program is followed by a unique osteopathic postdoctoral educational track. As I hope will be made clear upon the conclusion of my remarks, it is this continuum that must be preserved, and strengthened, for our profession to help the nation's health care delivery system produce the appropriate mix and distribution of physicians most in demand for the next century.

THE OSTEOPATHIC POSTDOCTORAL EXPERIENCE

Following graduation from one of the Nation's 17 osteopathic medical schools (in 1995 an estimated total of 1,843 graduated from these schools), osteopathic physicians generally embark on a course of unique graduate medical education. This postdoctoral training system is designed to build upon concepts taught during medical school. Entry into an osteopathic residency training program is contingent upon completion of a one-year internship. This internship includes mandatory rotations in the primary care areas of family practice, internal medicine, general pediatrics, and

obstetrics and gynecology, in addition to exposure in general surgery. This experience ensures that all osteopathic physicians are trained as primary care physicians first, even if they choose to specialize later in their careers in one of over 40 medical specialties and subspecialties. The osteopathic residency training curriculum includes the "utilization of osteopathic principles and practices relating to the specialty." This ensures that the concepts of osteopathic medicine continue to be cultivated following graduation from osteopathic medical school.

Mr. Chairman, you stated last year that "there is a growing consensus that the Nation needs more primary care physicians and fewer specialists," and that it was your intention to "develop a policy which will encourage a better balance of generalists and specialists for our health care workforce." As the Subcommittee continues to pursue the means to such an end, I want to emphasize that it is the osteopathic profession which for the past century has produced a workforce in which primary and non-primary specialties are balanced in a way that more properly reflects the needs of our society. As a matter of fact, in your state alone, there currently exist 154 osteopathic postgraduate training positions (including internships and residencies) - positions which produce many of the physicians on which the citizens of the great State of California depend.

My testimony today will concentrate on the recent graduate medical education recommendations of the Pew Health Professions Commission and the Institute of Medicine. As appropriate, I will include in my responses some specific recommendations on how to structure a more cohesive graduate medical education financing system that responds to the needs of both physicians and their patients.

As a clarifying note, all references in my statement to "physicians" and "medical schools" implies both osteopathic and allopathic physicians and both osteopathic and allopathic schools, as defined under existing Federal law.

CONTINUED FEDERAL PARTICIPATION IN FINANCING OF GME

In defining the parameters of the GME financing and resultant manpower debate, I believe that we must first decide on whether the Federal government should continue to have a role in the financing of GME. Since the advent of the Medicare Program, the government has channeled its GME monies through the Medicare service dollars and has been almost the sole financier of such programs. The AOA believes that Medicare beneficiaries directly benefit from GME and therefore because Medicare is a federal program, the federal government should continue to be a major stakeholder in GME....., but not the sole stakeholder. There are others who benefit from GME programs who need to step up to the plate such as private insurers, pharmaceutical houses, and medical equipment manufacturers, to name a few.

Once it is agreed that there should be multiple contributors to GME, there should exist standard payment principles under which all would have to abide.

CONTROLLING THE NUMBER OF FUNDED GME POSITIONS

This past April, this Subcommittee heard several recommendations on how to revitalize the health professions for the 21st century from the Pew Health Professions Commission and the Institute of Medicine. The Institute of Medicine recommended bringing support for the total number of first year residency slots much closer to the current number of graduates of U.S. medical schools. The Pew Commission's recommendation in this regard was to reduce the number of funded graduate medical training positions to approximately the number of U.S. medical school graduates, plus 10 percent. The AOA generally agrees with this recommendation, but we do have some concerns about how such a methodology will be implemented. Because osteopathic and allopathic residency training programs are operated under separate jurisdictions, any such methodology must specify that the number of funded allopathic residency programs would be determined based on the number of graduates of allopathic schools, while the number of funded osteopathic programs (both internships and residencies) would be determined based on the number of graduates from osteopathic schools. This position also has been endorsed by COGME.

As you know, the Federal government is now funding the equivalent of 140 percent of medical school graduates. Recognizing that the proposed 110 percent would allow for a 10 percent adjustment for international medical graduate slots, the intent of this proposal is two-fold: 1) to gradually reduce the number of Federally-assisted training positions; and 2) to exact greater control over the number of international medical graduates training in the U.S. If appropriately implemented, this new methodology would still offer U.S. medical school graduates the opportunity to secure training positions. The positions available for international medical graduates, however, would be gradually phased-down. However, this represents only half of the international medical graduate issue. Without appropriate reimbursement policy changes to complement this new methodology, its effect might not completely respond to the needs of graduating physicians.

Last year, as you will recall, this Subcommittee's graduate medical education reform proposal included a provision early on which would have gradually phased-out the funds available for non-U.S. citizens to train in the United States. Through changes in the direct medical education (DME) funding stream, reimbursement to teaching hospitals for the direct training of non-U.S. citizens would have been phased-out by Fiscal Year 1999. While there is the potential for some unintended consequences associated with a complete phase-out of funds for training international medical graduates (most notably the access to care in many of the Nation's rural and underserved areas most often served by international medical graduates), the AOA supports the policy of gradually reducing the funds available for their training to 25 percent of current levels. This position has also been endorsed by the Council on Graduate Medical Education.

You will recall that Congress, through this Subcommittee, last year proposed a similar policy to reduce the number of training positions. But rather than apply the 110 percent methodology, the proposal was to freeze the number of residency positions in a teaching facility based on the number of positions as of August, 1995. This freeze would have been intact for seven years. The AOA appreciates the Subcommittee's efforts in this regard, but would like to propose clarifying language should this proposal be revisited this year. The legislation did not specify whether the freeze would be applicable to "approved" positions or "filled" positions. The AOA strongly urges the Subcommittee to clarify that such a freeze would be applicable to "approved" positions. Under such a freeze, residency programs must be afforded the opportunity to fill those positions which have already been approved for funding, and not be constrained to operate under the number of those positions that just happened to be "filled" on a specific date. Without this clarification, there will be no margin in the policy to allow for fluctuations in residency assignments. Demand for different programs changes over time and the funding mechanism should be sufficiently flexible to allow for funding more positions in programs where more positions are required.

Another of the commission's recommendations is to redirect graduate medical education so that a minimum of 50 percent of the training programs are in the primary care areas by the year 2000. As was mentioned before, the osteopathic profession has always graduated a majority of its physicians into primary care areas of practice. We agree that there is a shortage of primary care physicians in practice today, and we point with pride to our history of meeting, and even exceeding, the primary care-specialty ratio that has been identified as a national workforce target. However, our profession can only survive if our training programs receive an appropriate proportion of available funds. We must be able to maintain our distinct educational program beyond the medical school level. The simple fact is that osteopathic education requires more than the medical school experience; complete training in the osteopathic approach to medical care requires continued application of osteopathic principles and procedures in osteopathic postdoctoral training programs.

Another central feature of this Subcommittee's graduate medical education proposal last year was to reduce the funds available for residents who have achieved their initial board-certification. Under current law, residents are counted as 1.0 full time equivalents (FTE) only up to the lesser of reaching initial board certification or five years. If the resident chooses to pursue additional subspecialty training, such a resident is counted as .50 FTE. Under your proposal last year, a resident who pursues additional training past their initial board certification would be counted as .25 FTE. It is clear that the intent of Congress in this regard was to create a disincentive for physicians

to train in subspecialties, or to force subspecialty training programs to re-engineer their curricula to be completed in five years or less. However, the question that needs to be asked is "Why cut the DME reimbursement level by another 25 percent over how much it was cut three years ago?" Recognizing that the current 50 percent payment rule was implemented just three years ago, it seems premature to cut it another 25 percent without having the opportunity to gauge the effects of the most recent set of cuts. The AOA supports the current 50 percent rule. Despite its negative impact on all subspecialties the AOA strongly encourages Congress to maintain that current level of reimbursement until such time that reliable data becomes available regarding the effect of the 1993 cuts.

ASSOCIATED REIMBURSEMENT ISSUES

As was alluded to previously, the AOA strongly urges the Subcommittee to revisit the current DME payment methodology which is based on hospitals' reported costs in 1984. This outdated system is nonresponsive and unappreciative of the current physician training climate. For the osteopathic profession specifically, the problems with the 1984 base year are further compounded. In the past, osteopathic graduate medical education was completed in osteopathic hospitals with a largely volunteer faculty, thus causing the "reported costs" of the training institution to be unrealistically low. In order to provide a more responsive and equitable payment methodology for the reimbursement of facilities' direct costs, the AOA strongly encourages the Subcommittee to establish a new reimbursement structure based on a National, per-resident average. Such a system could take into consideration necessary geographic adjustments without skewing its design. This proposal is not unique, as several legislative incarnations of GME reform over the years have included this policy recommendation. This would finally put all medical residents on a level playing field. As reflected in the Subcommittee's graduate medical education reform proposal last year, positive steps were taken to respond to these concerns, in that the historic payment method was replaced by updating the base year. However, several training programs which are training those physicians who are needed most in today's health care delivery system are still left at a significant disadvantage because the underlying reimbursement concept remains.

The indirect medical education (IME) funding is also flawed in that it does not take into account the importance of training residents in ambulatory care settings, and this system of training is one recommended most recently by the Pew Commission. The current formula is based on a training program's resident-to-hospital bed ratio. Maintaining this formula is a disincentive to moving graduate medical education to ambulatory clinics, community health centers, and managed care organizations. Larger academic health centers have the resources to maintain these ratios at a much higher level than their smaller osteopathic counterparts. Continuing to link IME payments to the resident-to-hospital bed ratio provides incentives to add residents based on hospital service needs rather than societal needs. The Subcommittee, in part, addressed this issue by establishing a formula based on hospitals' costs in a more recent base year. But the AOA strongly believes that training in ambulatory settings must be specifically encouraged through any new reimbursement formula. The underlying concept is for training funds to be permitted to follow the resident, and not for the resident to be constrained to follow the training funds.

The AOA also strongly supports the establishment of a National GME fund, to which all third party payers would contribute. Managed care capitation payments for Medicare are based on 95 percent of the average per capita rate of all Medicare costs, including costs for graduate medical education. Yet, most managed care entities do not incur any such costs. Private payers benefit from the graduate medical education system, and should contribute their fair share of the costs. An all-payer pool would ensure more stable funds for graduate medical education and, concurrently, realize significant savings for Medicare.

CONSORTIA MODEL FOR GRADUATE MEDICAL EDUCATION

The AOA strongly encourages Federal support of educational consortia in graduate medical education. In the Subcommittee's graduate medical education reform proposal last year, the Secretary of Health and Human Services was granted authority to fund such consortia for the purposes of training of residents. The AOA supports this provision. As was mentioned previously,

the old picture of osteopathic graduate medical education is changing. The AOA's accreditation program requires that by mid-1999, all osteopathic graduate medical education will be completed in Osteopathic Postdoctoral Training Institutions (OPTIs), comprised of at least one hospital and one osteopathic medical school. The new program will offer high quality postdoctoral training with the added resources of the osteopathic medical school. Integration of the medical schools into graduate medical education will result in an integrated or seamless curriculum. This concept will also allow some of the Nation's smaller rural hospitals to retain some role in training osteopathic physicians. This is significant recognizing that the physicians training in these smaller hospitals are more inclined to practice in the primary care disciplines. By becoming part of a consortium of training institutions that includes a large hospital, the osteopathic medical school, and some specialty hospitals, the small rural hospital can continue to have access to residents and their services. And the link between the medical school and the training sites under this OPTI structure will allow for the reinforcement of academic and didactic enhancements and osteopathic principles and practice, and their continued integration into a student's entire medical education and training.

ADVISORY PANEL ON GRADUATE MEDICAL EDUCATION

Mr. Chairman, I have identified several recommendations for reforming graduate medical education including changes in the reimbursement formulae, workforce recommendations, and ideal sites where training should be hosted. The issue of graduate medical education reform is complex, as you know having hosted this -- your third -- graduate medical education hearing in the 104th Congress. This is why it is imperative that your proposal from last year to establish a National Advisory Panel on Graduate Medical Education and Teaching Hospitals be reintroduced. Recognizing that osteopathic and allopathic graduate medical education systems are governed separately, it is equally important to have the AOA Council on Postdoctoral Training represented on any such panel. It is critical that experts in the field develop recommendations on whether and to what extent Federal policies regarding graduate medical education should be reformed.

CONCLUSION

In conclusion, the AOA believes that before any new payment methodologies are implemented, it must be decided who will be the payers of GME. These payors, who should include the Federal government, but not be limited to it, should agree on a standard set of financing methodologies which would include: 1) a policy under which the number of funded GME training positions would be based on the number of medical school graduates, plus 10 percent (this cap would be applied separately to graduates of osteopathic and allopathic medical schools); 2) a phase down of reimbursement for IMGS; 3) reimbursement for residents which would be based on a national per resident average; and, 4) dollars should follow the training, wherever it might occur.

In terms of program changes, the AOA strongly believes that GME should occur in consortia and that there needs to be an Advisory Panel on GME so that all the players and payors will have financing and program oversight responsibilities and opportunities.

Mr. Chairman, thank you for hosting this important hearing today. The AOA believes that only with the implementation of the aforementioned recommendations will we begin to prepare our Nation's resident physicians and training sites for the next century in delivering quality health care for the public good, while generating significant savings in the Medicare program.

Chairman THOMAS. Thank you.
Dr. Foreman, tell us about New York City.

STATEMENT OF SPENCER FOREMAN, M.D., PRESIDENT, MONTEFIORE MEDICAL CENTER, BRONX, NEW YORK, ON BEHALF OF GREATER NEW YORK HOSPITAL ASSOCIATION, NEW YORK, NEW YORK

Dr. FOREMAN. Thank you, Mr. Chairman. My written testimony addresses a number of issues concerning Medicare financing for graduate medical education, but I will focus my remarks mainly on international medical graduates.

Recently, interest has focused on ways to control the number of international medical graduates entering graduate medical education as a means of controlling the perceived national physician surplus, because many international medical graduates remain in the United States to practice after they complete their training. Though residents enter graduate medical education primarily to advance their own knowledge and skills, even while in training they are an extremely important part of the health care ecology, and they play a pivotal role in helping the hospitals in which they train meet the health needs of those communities. Nowhere is this more true than in hospitals in inner-city neighborhoods, neighborhoods which in general have not yet benefited from the Nation's growing supply of physicians.

New York City still has 125 federally designated health professional shortage areas. Graduate medical education programs often provide the only guarantee that individuals and families living in those communities have access to basic health care.

We know this Subcommittee has been concerned about the number of international medical graduates in the past and that New York accounts for a large proportion of them. In fact, 50 percent of all training positions in the New York City area are occupied by international medical graduates. And, nearly one-third of New York's 800 programs have 100 percent of their positions filled by international medical graduates.

Of particular importance is that these positions are concentrated in hospitals serving substantially poor populations. None are in academic medical centers.

We urge the Subcommittee to recognize that restrictions on international medical graduates will have a devastating effect on communities which have the greatest need for physicians since their hospitals which rely on IMGs lack the resources to replace their services. We urge Congress to move cautiously in formulating policies that will have a disproportionate impact on some of our Nation's most essential and most vulnerable hospitals and that substitute funding be made available for any reductions which are made.

Before closing, Mr. Chairman, I would like to offer two other recommendations. First, we urge Congress to maintain its commitment to graduate medical education not only for fee-for-service payments but for Medicare managed care. Health maintenance organizations now receive capitation fees which roll up Medicare payments for graduate medical education and disproportionate share adjustments into a single payment. There is no Federal require-

ment under current law that HMOs pass either of these public benefits payments on to the hospitals which provide the services or incur the costs. We urge Congress to enact provisions that would carve out these payments and pay them directly to hospitals that provide these services.

Second, we strongly support the establishment of an all-payer trust fund for graduate medical education, and we believe its funds should continue to flow, as they do now, directly to the institutions that incur the costs of training. While it has been suggested that consortia consisting of medical schools and their affiliated teaching hospitals serve as the vehicle for distributing funds, we believe it is more appropriate for the funds to flow as now, directly to the sponsoring hospitals or health systems which bear the cost and in whose venue graduate medical education is conducted.

Mr. Chairman and Members of the Committee, thank you very much for the opportunity to testify.

[The prepared statement follows:]

STATEMENT OF
SPENCER FOREMAN, M.D.
ON BEHALF OF
GREATER NEW YORK HOSPITAL ASSOCIATION

Thank you, Mr. Chairman and members of the House Ways and Means Subcommittee on Health for inviting me to testify before you today on the subject of graduate medical education (GME).

My name is Spencer Foreman, M.D., President of Montefiore Medical Center in the Bronx. Montefiore is the largest non-profit provider of health care and related services to the 1.2 million persons living in the Bronx, a community whose socioeconomic and health status indicators rank among the poorest in the United States. Today, Montefiore Medical Center includes two hospitals; three skilled nursing facilities; the nation's oldest and one of the largest hospital-based home health agency; eight community based comprehensive primary care centers (soon to grow to thirteen providing an estimated 325,000 visits to 120,000 users); a fourteen site multispecialty group practice; an over 500 physician faculty practice providing the full spectrum of specialty care; and a range of other community-based health services, including school health services, drug treatment, and dialysis. In addition, through contracts with New York City, Montefiore provides medical services to two public hospitals, North Central Bronx Hospital and Jacobi Medical Center, and health and mental health services at the 16,000 bed Riker's Island Detention Center. With its roughly 11,000 employees, Montefiore is the largest private employer in the Bronx.

Montefiore is the university hospital for the Albert Einstein College of Medicine and the principal education and training venue for 350 medical students and 1,200 resident physicians annually in its hospital and community-based facilities. I am testifying today on behalf of the Greater New York Hospital Association (GNYHA), a metropolitan hospital association representing 172 not-for-profit hospitals and long term care facilities, both voluntary and public, in New York City and surrounding counties. I am a member of the board and past chairman of GNYHA.

The focus of today's hearing -- Medicare's financing of graduate medical education -- is a subject of keen interest and importance to Greater New York Hospital Association member teaching hospitals. The nearly 800 GME programs sponsored by GNYHA member hospitals constitute the largest concentration of such programs in the U.S. Each year, these hospitals train approximately 13,000 residents representing 13% of all physicians-in-training in the country. As a consequence, New York is a vitally important part of the national infrastructure of academic medicine and is, therefore, particularly vulnerable to any changes in the financing of graduate medical education.

The New York Health Care Environment

New York is presently in the throes of the health care system transformation that is sweeping across the country driven principally by the rapid growth of managed care and resulting in the sharp reduction in both the demand for and the price of hospital services. Presently, approximately 3.1 million residents in the New York metropolitan region -- or 28% of the population -- are enrolled in managed care plans. This number is expected to reach 50% by 2000.

The squeeze managed care has put on New York's hospitals has been made significantly worse by sharp reductions in Medicaid financing in the State of New York. In 1995, the Medicaid hospital budget was slashed by $700 million, and this year the Governor has proposed well over $1 billion in additional cuts.

The movement toward a competitive marketplace is expected to accelerate rapidly with the anticipated expiration of the State's longstanding prospective hospital reimbursement scheme, the New York Prospective Hospital Reimbursement Methodology or NYPHRM. Under NYPHRM, the State establishes inpatient rates for all non-Medicare payers which are designed to contain hospital costs while assuring access to care for those unable to pay. It does this by tying commercial payers to rates paid by Medicaid, thus reducing cost shifting from public to private payers to the lowest level of any state in the country, and by creating innovative payment mechanisms for uncompensated hospital care.

NYPHRM has succeeded in containing costs far better than most observers had anticipated. Studies of health care inflation in the 1980s show New York had among the lowest hospital inflation rates of any state in that decade, an experience that continued in the 1990s. In 1994, New York's institutions had the third lowest net price per inpatient discharge (adjusted for regional differences in wages and illness severity) and the third lowest (wage-adjusted) net price per outpatient visit, of any state. Moreover, through rate setting and public benefit pools for bad debt and charity care and graduate medical education, New York succeeded in creating one system of care for all.

But to achieve and sustain a low rate of inflation and universal access, the State promulgated hospital rates so stringent that even well run institutions had revenues sufficient only to meet their barest costs. While total margins hovered around 4.5% nationally, New York's hospitals could scarcely post a surplus. In 1994, the weighted average total hospital margin was 0.4% for New York State. In New York City, hospitals had a weighted average total margin of -0.5%. Even the private, voluntary hospitals, including some of the best known institutions in the country, just broke even at 0.6%.

After decades of NYPHRM's rigid penury, most New York hospitals had little, if any, cash reserves. The emergence, now, of a competitive health care market has turned a chronic cash shortage into a cash crisis. When lawmakers and the Governor failed last week to enact emergency legislation in the absence of a State budget agreement, causing weekly Medicaid payments to be delayed by a single day, one major hospital missed making its payroll. A number of others would have followed with but a single additional day's delay.

The NYPHRM legislation expires at the end of this month, and State lawmakers are now debating what will take its place. While no final decision has been made with respect to when the new system will take effect, there is agreement that the current rate-setting system should be abandoned in favor of a market based health care economy.

The Role of Graduate Medical Education in the New York Metropolitan Region

America's graduate medical education system is inarguably the finest in the world and the envy of every other nation. With 13% of the country's residents training in member hospitals, the Greater New York Hospital Association community is extremely proud to play so major a role in that system. Moreover, two-thirds of last year's graduates from member hospital programs planned to remain in New York either for additional training or to enter practice; the remaining one-third went elsewhere, 60% to enter practice. Thus, this large health manpower pool supplies well trained physicians to meet the needs of the state and the nation.

But even while in training, residents play an extremely important role in the health care ecology of New York. These doctors are an integral part of the health care team and play a pivotal role in helping the hospitals in which they train meet the health needs of their communities. Nowhere is this more true than in hospitals serving inner city communities which, in general, have not yet become beneficiaries of the growing supply of physicians. New York still has 125 communities, population groups, or facilities designated by the U.S. Department of Health and Human Services Health Resources and Services Administration as health professional shortage areas. Graduate medical education programs in inner city hospitals often provide the only guarantee that individuals and families living in those communities have to access basic health care. Two corollaries are extremely important: such hospitals do not have the fiscal resources to substitute for these physicians; and a very high proportion of physicians in these programs received their basic medical education abroad.

International Medical Graduates (IMGs)

A number of reports in recent years have documented the growing physician supply in the United States. Many, noting this trend with concern, have suggested that the supply is now or soon will be a surplus that must be curtailed. Recently, interest has focused on ways to control the number of international medical graduates who enter graduate medical education as a means of controlling that so-called surplus because many IMGs end up remaining in the U.S. to

practice. It is important to note that IMGs are persons who graduate from medical schools that are not accredited by the Liaison Committee on Medical Education regardless of their citizenship. IMGs are both U.S. citizens and foreigners. In fact, more than half of the IMGs in training positions in the U.S. are either U.S. citizens or permanent residents. Medicare does not currently discriminate in its support of residency programs on the basis of whether the resident is an IMG or a U.S. medical graduate so long as the resident is enrolled in a program accredited by the Accreditation Council on Graduate Medical Education and has passed Parts I and II of the United States Medical Licensing Examination, a standard test administered by the National Board of Medical Examiners to U.S. and international medical graduates alike.

Mr. Chairman, we know that this Committee and other policy makers have been concerned about the number of international medical school graduates trained in the U.S. We also know that the New York metropolitan region accounts for a large proportion of these trainees. In fact, approximately, 50% of all training positions in New York City-area teaching hospitals are occupied by IMGs. Of the nearly 800 training programs sponsored by GNYHA member hospitals, nearly one-third have 100% of their positions filled by IMGS and more than 40% have at least three-quarters of their positions filled by IMGs. Of particular significance, however, is that these positions tend to be concentrated in public and private hospitals serving substantially poor populations. According to GNYHA, 24 high Disproportionate Share Hospitals -- more than half such hospitals in the membership -- have at least 80% of their training positions filled by IMGs. Virtually all of these hospitals are located in economically disadvantaged parts of New York City and none are academic medical centers.

Mr. Chairman, you will likely hear today from others who support proposals to control access to graduate medical education for international medical graduates by recommending, for example, that Medicare make Direct Medical Education payments to hospitals for residency positions only when they are filled by graduates of U.S. or Canadian medical schools, denying such payments in years when they are filled by IMGs. In fact, this Committee has proposed such a limitation in the past. The Institute of Medicine recently proposed replacing the current system of GME payments to hospitals with a voucher system under which vouchers would be given directly to students, with preference going to graduates of American medical schools.

We urge the Committee to recognize that restrictions on Medicare GME financing that specifically target IMGs would have a devastating impact on communities in New York that have the greatest need for physicians, since such hospitals rely on IMGs and lack the resources needed to replace their services. Even if Congress were to authorize a way to continue the flow of funds associated with residency training in order to provide monies for replacement staff, it will take some time to build the pool of staff needed to meet replacement requirements.

Looking to the Future

Congress, the Administration, and others are currently debating the future of Federal support for graduate medical education. Two recently published reports (*The Nation's Physician Workforce: Options for Balancing Supply and Requirements, Institute of Medicine, 1996* and *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century: The Third Report of The Pew Health Professions Commission, November 1995*) make a number of recommendations with respect to the size and funding of the GME system. As Congress debates this issue, GNYHA we would like to offer the following comments and suggestions.

First, we urge Congress to take no action with respect to Medicare funding that will disproportionately affect teaching hospitals. While we share the concern about the solvency of the Medicare Trust Fund, GME represents only a tiny fraction of the overall Medicare budget. We are prepared to accept a fair share distribution of the funding reductions that may be necessary to reduce cost growth in the Medicare program, but deeply oppose any approach that would rely upon disproportionate cuts in GME payments, because such cuts would have a devastating impact on teaching hospitals in New York and across the country.

Second, we urge Congress to maintain its commitment to GME not only for fee-for-service payments, but for Medicare managed care. This is a crucial component in preserving Medicare's support for high quality training and research nationwide. Health maintenance organizations (HMOs) receive monthly payments for each Medicare beneficiary enrolled in their plan; such payment is called the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is calculated under a formula that rolls up Medicare payments for GME, as well as for another crucial public benefit program, the Disproportionate Share Hospital (DSH) adjustment, which is made to hospitals serving extremely large numbers of low income patients. DSH payments are a critical financial support for teaching hospitals. In New York City, teaching hospitals receive almost all of the DSH payments, indicating the tremendous overlap between the hospitals' teaching mission and service to the poor. Nationally, teaching hospitals receive about two-thirds of the DSH payments.

There is no requirement under current law that HMOs pass these public benefits payments on to the hospitals that provide the services and incur the costs, and teaching hospitals around the country are ailing from the failure of HMOs to pay for GME services that are recognized by the Medicare fee-for-service system. Medicare managed care enrollment, while still relatively low in our area, is increasing at a rapid rate, growing in the past year by almost 30%. It is essential that the disappearance of GME and DSH payments into HMO coffers be stopped.

To accomplish this, we urge Congress to enact provisions that would remove, or *carve out* GME and DSH payments from the AAPCC and pay them directly to hospitals that provide these services. The Senate included a limited carve-out provision in its version of the Balanced Budget Act of 1995. We urge Congress to support a full carve-out of GME and DSH funds in future Medicare legislation.

Third, we urge Congress to refrain from attempting to control the supply of medical specialists by involving the government in the allocation of residency positions. If this idea ever made any sense, it was in a fee-for-service environment where many believed that physicians, in general, and specialists, in particular, were uncontrolled cost generators. Managed care has changed all that by providing very powerful incentives to control the inappropriate use of specialty services and sharply reduce the demand for specialists. This shift in the marketplace is already having a major impact on specialty choice among medical school students nationally. According to the National Resident Matching Program, record numbers of students are choosing to enter residency training in one of the generalist disciplines. This year, 54.4% of medical school seniors will be pursuing training in a primary care specialty. Moreover, each of the major primary care disciplines experienced a significant increase over the prior year in the numbers of students entering their programs (family medicine: 9.4%; internal medicine: 2.9%; pediatrics: 6.1%). The market is moving physician training in the direction that many want to see it go; regulatory intervention at this point would only prove disruptive.

Fourth, GNYHA strongly supports the establishment of a Trust Fund for graduate medical education, such as this Committee included in the Balanced Budget Act last year. This would guarantee that the responsibility for paying for the training of our nation's future doctors would be shared by all payers. Such a Trust Fund should be funded at levels adequate to ensure that we can maintain our preeminent training system. While the details of how this Trust Fund would operate need to be worked out, we believe funds should continue to flow directly to the institutions that incur the costs of training. While it has been suggested that consortia consisting of medical schools and affiliated teaching hospitals could serve as the vehicle for distributing funds, we believe that it is more appropriate for the funds to flow directly to sponsoring hospitals or to health systems, which bear the costs and in whose venue graduate medical education is conducted.

Fifth, while we recognize that many are concerned about the number of IMGs being trained in the U.S., we urge Congress to move cautiously in formulating policies that are directly targeted to IMGs. Such policies, by definition, will have a disproportionate impact on some of our nation's most essential, but most vulnerable, hospitals. Care should be taken to avoid actions that will create further financial hardship or jeopardize the ability of these facilities to meet their patient care obligations.

Finally, we support the notion of replacement funding for hospitals that voluntarily choose to downsize their training programs. Such funding would enable hospitals to replace residents with other staff who can provide patient care, but as the IOM report pointed out, the need for these funds will be ongoing and should not be viewed simply as transitional.

Mr. Chairman, members of the Committee, thank you very much for the opportunity to testify today. I would be pleased to answer any questions.

Chairman THOMAS. Thank you. To be honest, I am somewhat underwhelmed by the creativity in trying to figure out a way to deal with the current situation.

Mr. Goldfarb and Mr. Brideau, you both indicated that you weren't sure whether—you agreed with Mr. Stark; you weren't sure whether legislation really ought to go forward. And, Mr. Brideau, you urged us to legislate and make sure that the medical payments out of the AAPCC be carved out and sent directly. So, you are either going to legislate, or you are not going to legislate. It takes a lot of energy to get everybody focused on legislating. A long time ago, I said if we are going to spend that energy on legislating, simply carving out the AAPCC payment, we could spend it on some significant change like a general fund, a broad-based support for not only graduate medical education but perhaps some of the teaching hospitals or even hospitals that rely on certain kinds of products to meet their basic needs. I am hoping for a little more radical thinking, if you will.

Mr. Goldfarb, do you honestly believe that if we simply pass legislation that said the DME, the IME, and the DSH are going to be carved out of the AAPCC and that then will be funneled directly to the institutions, that that is going to solve our problem? I mean, obviously, it gives you an incremental change, but can teaching hospitals compete in the current marketplace?

Mr. GOLDFARB. Mr. Chairman, in answer to your two questions—first, can we compete, and second, will a simple carve-out of the AAPCC suffice—and maybe the second question first—it clearly will not suffice. I tried to characterize that as a short-term response. I believe it is critical to our institution that we have that short-term response because we no longer have the opportunity, if you will, to gain access to those dollars even if we do attract those Medicare managed care patients to our institutions.

Chairman THOMAS. Given your structure, it is especially significant in the percentage of folk——

Mr. GOLDFARB. Especially significant with the amount of managed care.

Chairman THOMAS. Yes.

Mr. GOLDFARB. The second question is an interesting one: Can we compete? The answer is yes, we can compete. But, we can not compete and offer the public good services, that are so unique to academic medical centers. We increasingly would be faced with dismantling the infrastructure that provides indigent care, the teaching programs, and so forth, if we simply competed on a flat plane surface with community hospitals.

Chairman THOMAS. Well, there was another analogy to whether we needed English teachers or political science teachers. I do know that this society made a commitment in the late fifties to try to emphasize sciences and that we created scholarships in an attempt to induce folk in a particular direction. I guess, Mr. Brideau, in your response that maybe we ought not to legislate in this area, should Federal policymakers have some concern about what happens? Should we really go Darwin here and let the evolving system determine how these people are going to be educated rather than to try to legislate and lock in a current system, albeit funded slightly differently? Maybe we just ought to let the whole thing evolve and sit

back with Mr. Stark and see what happens. And, that is not necessarily a bad option because it is the old business of what you do when you throw a football. You know, three things happen, two of them are bad. And, when we try to determine what the future is going to be, almost always all three of them are bad.

Mr. BRIDEAU. I think that is very wise, Mr. Chairman. Obviously, government does have a proper role in oversight of the distribution, both by specialty and geographically, of physicians in this country given that the government, both Federal and State, finance a large part of medical education in the country.

On the other hand, what we have seen even in the past 2 years is the marketplace really taking effect. As we look at the residency matches throughout the country, in 1995 and 1996, what we have seen is a significant increase in interest by medical students in primary care disciplines. There is now very significant competition for primary care residences. We have had our best matching years ever in our primary care areas, and we have had extreme difficulty finding residents in the areas of anesthesia, radiology, other specialties that are in oversupply at this point.

The medical students are pretty smart, and they figure out where the jobs are going to be in the future. Now, it takes a little while for the marketplace to adjust. The concern that I would have in any type of legislation around this whole question is that the factors are so dynamic that to predict them in advance is very difficult. And, in the short 25 years that I have been in health care management, we have gone through two eras of physician surplus and one of physician shortage. That pendulum tends to swing too far one way and then the other. So, it is a very tricky area in which to try to manage at the Federal level.

Chairman THOMAS. As we are coming to a consensus that we really do need more primary care folk, in part As case managers, it looks like some HMOs are responding that perhaps we skip that step and move directly to specialists and that we might need someone to make a determination when they come in holding their ear. You do not need a private care doctor, send him to an ear, nose, throat specialist, so you need the ear, nose, throat specialist. It is a very dynamic structure that is clearly going to change.

Dr. Wickless, thank you for your list of recommendations. I agree with a lot of them, and if we can come together as a community, it will help us to urge, where there is agreement across the board, that we move forward in those areas rather than try to hang on to the big bang theory in terms of making a lot of changes. Sometimes incremental change will get us where we need to go.

Dr. Foreman, New York City, we have had an evolving history of the way in which we have funded graduate medical education, some of it, I think, directed historically, especially on the DSH payments, to try to kill two or three birds with one stone, and some folks have utilized that significantly.

In looking at the geographic distribution of international medical students, you tend to be shocked, I think, one, at the concentration, the percentage concentration, primarily in New York and Chicago. Don't you think rather than the current tail wagging the dog, that if we can identify what the problems are, that are not currently being met through this structure, that it would be better to meet

those needs and not hold captive the entire funding mechanism? We need to suggest some fairly fundamental reform, either on the basis of a patient profile, or particular urban areas where we would make those changes, rather than to simply say, let's pass through the AAPCC and that might help us.

One, why does New York City seem to be an area that attracts such a high percentage? Second, maybe we should rethink the whole method of delivering health care in areas that at one time had the best medical delivery structure in the world and at the same time have perhaps some of the most glaring problems.

Dr. FOREMAN. Well, there are several reasons for New York City having such a high number of teaching hospitals. The first is that the hospitals in New York City tend to be very large, simply because everything in New York City tends to be very large. And, that means that they have had traditionally a large concentrated patient population with which to teach and train.

The second thing is that in the absence of adequate financing for the care of the poor and the generous financing historically for graduate medical education, you have the dynamics built right in for the building and maintenance of graduate medical education programs in areas which are surprising.

Your last question, of course, is the fundamental question, which is to say, what would happen to graduate medical education in the United States if we had universal entitlement to health care insurance? And the answer is, I believe that a very substantial number of the programs which we now see in urban areas which are being sustained, at least secondarily, as a means of providing care for poor communities would disappear. Furthermore, I believe that if an experiment which the New York community has been discussing with HCFA, which is to essentially uncouple graduate medical education payment from residency counts, you will see a substantial diminution in the numbers of physicians trained and the numbers of programs sustained, particularly in areas such as we have been discussing.

At the present time, as you know, Mr. Chairman and Members of the Sucommittee, each additional resident results in incremental funding to the program. That creates a very powerful disincentive for reducing programs. I need not point that out. And if one could disconnect that relationship, one could create the opportunity for doing two things: First, providing funds to institutions that are particularly vulnerable, and at the same time disincenticize the very large and complicated training programs that are now being supported.

Chairman THOMAS. Finally, it is not unfair of me, is it, to indicate that probably New York City's concerns would probably need to be dealt with at the city, then the State, and then the Federal level, in terms of the size and the number of the hospitals, the way in which the State assists, and then the Federal Government coming in? Or, do you think we should have the Federal Government step in and deal with the problem, notwithstanding the city and State levels?

Dr. FOREMAN. Well, that is a very difficult question for me to answer because it depends on what you mean by State, local, and Federal action. At the present time, the city of New York is under-

going a budget squeeze which is, if anything, causing a sharp reduction in their support for medical services to the poor. The Health and Hospital corporations have had continuous and rather dramatic reductions in their funding because the city feels that it is at its maximum in terms of its taxing authority, and yet still has a considerable social burden to bear.

The State is trying to cope with its own budget deficits. It seems clear to me, though, that the problem of sustaining care for the poor as well as sustaining payment for graduate medical education is a problem for all citizens and, therefore, needs to be tackled on as broad a base as we possibly can.

Chairman THOMAS. Thank you.

Mr. Stark, do you wish to inquire?

Mr. STARK. Well, I appreciate your testimony, gentlemen, you have pointed out the dangers in trying to define a system. We have defined a system and education, it was an afterthought. Because the system, not your work, is changing, the historic development of your funding stream is being changed.

For example, let's assume for a minute that some people prevail and all of Medicare were turned over to capitated managed care plans. You guys would be in real trouble if we suddenly corrected something now and then we change through other government action the way the government funds flow through the insurance world. When we originally designed Medicare, almost everybody was in a fee-for-service system, so that the money found its way, and you could attract some patients. In my example, you cannot do this. You have lost control, in effect, of your own population.

I do not know what the answer is, but it would seem to me that Medicare's being made responsible for funding about a third of graduate medical education was an afterthought. Perhaps if we are going to do anything at this point, we ought to start from ground zero. I have always felt that we should fund the students, if it is a Federal responsibility. It is a political decision. All of you could compete for the students. They would have the money from us, and they would have to pay us back. If you want them, you would have to charge them enough for your long-range costs.

My theory has always been to charge the graduates an extra point or two on their income for their earning period which would refund the trust fund. You would then have a system of funding the students that was divorced from the insurance plan or poverty plans or anything else.

I cite this example, not as something that I think you all might endorse, but to illustrate the idea of decoupling, When we need rocket scientists, we have in the past created grants to encourage that. If we need medical research in an area, we should fund that as grants. The problem that I see is trying to tie your future to the tail of a kite which has got an uncertain direction and is not apt to do you any good. I am not sure how we can deal with graduate medical education.

So, what I am hearing today are some fixes for a system that is in a real state of flux. I do not know which system we are going to end up with over the next 2 years to depend on for funding. I guess that is still my dilemma. I do not know what you are going to do.

One other thing, I am not much swayed by the idea that students end up with big loans, $100,000, roughly? It seems to me if you take the difference between their starting salary and the next highest profession's starting salary, and spread that over 20 years, you are talking about an education with a marginal increased value of $300,000 or $400,000. Think about that. If they earn $40,000 a year more than a lawyer, over 20 years that would amortize a $300,000 or $400,000. Now, that is a pretty good buy, $100,000 now for $300,000 or $400,000 in the future.

I am not so sure that students should not be funded, if we give them a reasonable way to repay it. You could be funded on tuition and research grants. Now, there may be other iterations of this. I think that is what Bill may have been referring to—I hesitate to put words in the Chairman's mouth—about creativity. I am just afraid that we are going to redo a system that now does not work. It is not what you have done. It is because, we are changing and we have left you sitting there hanging on this thing tied to Medicare fee-for-service payment, The latter is sort of changing and disappearing.

Dr. Foreman.

Dr. FOREMAN. Mr. Stark, it seems to me there are two principles here that would be helpful if we were to separate. The first is that we clearly need to establish a distance between funds which are intended to support medical education and funds which are intended to pay for health care. And that needs to be done across all——

Mr. STARK. That is not the case now, is it?

Dr. FOREMAN. Correct.

Mr. STARK. OK.

Dr. FOREMAN. It is true for Medicare fee-for-service. It is not true for Medicare capitated payments, and it is certainly not true for any of the other payments. So, the first thing, it seems to me—and it seems to a number of us—is that those funds need to be segregated.

Now, how they are applied to the system once they are separated depends on the philosophy that you take. One interesting suggestion you have just made about——

Mr. STARK. If we could just start from where you are and say let's support you while we decide and find——

Dr. FOREMAN. Right.

Mr. STARK. I think you are right on. I mean, I think that is——

Dr. FOREMAN. Well, this Subcommittee had that idea a year or so ago, and it proposed an all-payer trust fund, which I think the whole community of academic medicine endorsed enthusiastically. And, even those of us who were concerned about how the funds would be distributed and all the other issues——

Mr. STARK. Harry and Louise weren't jumping up and down over that. [Laughter.]

Dr. FOREMAN. Well, I don't think Harry and Louise appreciated how much benefit they get from well-trained physicians and how closely connected they were to graduate medical education.

Mr. STARK. My time has expired, Dr. Foreman. Somehow we have taken a system which has been fine—it has funded graduate medical education and the system has healed around it. The tree grew around the wire and it is working. Now, without prejudice,

the system is changing or being pushed to a change perhaps in some areas, and your system doesn't fit that anymore. I think you have hit the nail on the head. By saying that if you decouple payment for health care and medical education, we have to decide what our responsibility as a Federal Government is in funding your activities. That is the same as funding—whether we fund highways or whatever kind of research. There are pressures, and I am sure you will do fine. I have every confidence in your advocates who I see in the lobby. They are good and hard-working, and underpaid. [Laughter.]

Mr. STARK. So, they will work to support the funding. How we structure the next iteration is important, and I would love for the chance to see this Subcommittee work with you. That may not come quickly enough to resolve the problems. I will turn it over to the distinguished gentleman from Louisiana.

Mr. MCCRERY [presiding]. I thank the gentleman.

First of all, let me apologize for getting here after your testimony. I was here on time, which is to say early, and then I had to leave for another meeting, and now I am back. I am sorry I missed your testimony, but I do have some questions that we would like to have you explore. Let me start with Dr. Foreman with respect to foreign medical graduates and the question of foreign medical graduates.

Some say that while foreign medical graduates generally go into primary care residencies, they end up in specialties. If that is the case, then how are we increasing the number of primary care physicians or generalists? And, since most foreign medical graduates do not go home but end up staying here in the United States, or returning to the United States after a short stay back home to practice medicine, isn't the current policy helping to drive up the overall number of physicians in the country?

Dr. FOREMAN. Let us take the questions one at a time. It is very clear that we have had in the fee-for-service system very powerful incentives to encourage physicians to become specialists. As the market shifts to managed care, those incentives are disappearing. And, in fact, we have heard testimony today, some anecdotal, some direct, that there has been a massive shift in the preferences of all young physicians toward primary care specialties and away from the non-primary care specialties. In fact, highly complex specialty programs are now going begging for residents.

We believe that the major change that accounts for this is that information is now reaching students at a time when they are making decisions about specialty choice sufficiently to persuade them that the opportunities in the health care marketplace are in generalist positions, and we are now seeing massive increases in the applications to residencies and family practice, general internal medicine, and general Pediatrics. I do not believe—and I think much of the professional opinion has now changed on this subject—that we still have to worry about, at least in the near term, physicians opting for specialty practices as opposed to generalist practices in a way that would continue the imbalance that exists. So, we can put that to bed.

Now, with respect to international medical graduates, several things are true. They have historically behaved exactly like other

physicians in their specialty choices. Where they could get specialty training programs, they took them. Where they couldn't, they didn't. What they have done, however, is tended to migrate into communities once they were trained, whether as specialists or generalists, where other physicians have been reluctant to go. This is particularly true of isolated rural areas, and it is true in many areas of dense inner-city poverty. That is not an irrefutable fact, and their presence has been a great benefit to the country as a result of being available in places where physicians were hitherto not available.

There is a final question, which is, I think, the most critical one of all, which is whether it is in the Nation's benefit to have more or less physicians. In my view, having sufficient physicians to provide care to every part of the country appropriately is a national benefit that we ought not overlook. If we have more physicians now than we used to have, many of us see that as a very strong plus.

Mr. MCCRERY. Thank you. I will ask one more question and then, Jim, have you ask questions.

Mr. MCDERMOTT. No.

Mr. MCCRERY. To Mr. Brideau.

Mr. BRIDEAU. Yes, sir.

Mr. MCCRERY. Being from Louisiana, I had a little headstart on you there.

You recommend in your testimony that Congress develop a mechanism to provide replacement funds to those hospitals that depend on medical residents that serve high numbers of the poor.

Can you be more specific. Have you got some recommendation for a specific mechanism?

Mr. BRIDEAU. The concern that we have is some of the proposals we have seen are for transition funds, and the issue is that those hospitals will, over time, still need to provide that service.

Obviously, if the numbers of residents that they train actually do not drop, if the international medical graduate numbers stay the same, then those replacement funds are not needed. But otherwise, there does need to be some other funding for those hospitals. We do not have a specific proposal for how we do that, but that is a concern that I think needs to be addressed in terms of looking at the funding. Because if steps are taken to remove significant numbers of international medical graduates, especially from the inner city programs in New York and some other cities, we end up then with hospitals without care givers at that point.

Their ability to recruit and keep care givers, and pay care givers is a critical issue. The concern we have there is without replacement funds of some sort, those hospitals essentially are not able to provide service to the people of that region, and those people do not get service.

Mr. MCCRERY. OK. Anything that you come up with, we would appreciate your sharing with us.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

It is a unique opportunity to have you folks here, and we appreciate your spending the time with us. I think you recognize in the way this hearing has been conducted, how difficult it is to make

policy judgments off the back of a galloping horse, with one member running in and another one running out.

So, I am not sure if some of these issues have been raised already with you. But, I would like to pursue a couple of lines of questioning. One is that when I graduated from medical school in 1963 everybody had a 2 year obligation to this country. In our flurry over the Vietnam War, we got rid of the 2 year obligation for not only physicians, but everybody else in the process.

I have often wondered what would be the impact of having the Federal Government pay tuition for medical school, and then requiring 3 years of service some place.

I am curious, I mean, we are paying for medical education, but when I trained at the University of Illinois, I spent $800 a semester to get my medical education, and the day I finished my training at the University of Illinois, in Chicago, I left. I never paid a single dime back to the people of the State of Illinois.

I wonder, your response is to some kind of "this for that," that is, pay for tuition in exchange for some years of public service.

Dr. FOREMAN. That has been part of your tradition and mine for some time. The National Health Service Corps was enacted into law some time, as I recall, in the middle to late sixties and has been funded at various levels since that time.

It has been a very successful program. Generally speaking, it has attracted more interest among students than the government was willing to apply funds to. It has not been possible to get funding for all the people who wanted to enroll in that program.

Now, if what you are suggesting, Dr. McDermott, is that in exchange for receiving a medical education, in general, even if you have paid for it, you ought to be——

Mr. MCDERMOTT. No, only if your medical education has been paid for by the government, then you are required——

Dr. FOREMAN. If it has been paid for by the government, I think that there would be—no problem, so far as I know, in generating enthusiasm among students for the National Health Service Corps program as it now exists, and I think it would be a great benefit if more funds were available and such physicians were then given the opportunity to serve in health shortage areas as repayment for the support they received.

Mr. MCDERMOTT. What percentage of your students are able to pay their own freight in terms of their tuition?

Dr. FOREMAN. I do not have the numbers at my fingertips, but I would think that the overwhelming majority of medical students, one way or another, get some sort of support, either in loans or in scholarship——

Mr. MCDERMOTT. At the University of Washington, the average debt coming out is about $80,000 for 4 years of medical school. So, they have obviously had to borrow quite a bit to do it.

Dr. FOREMAN. Right.

Mr. MCDERMOTT. And you are saying that is about the same for you?

Dr. FOREMAN. Oh, the Association of American Medical Colleges has that data, keeps it on an annual basis, quite currently can tell you precisely what the level of debt is. I do not have it at my fingertips, but somebody in the room may be able to provide it.

Mr. MCDERMOTT. How about the rest of you? If you were to provide an education at government expense and then your graduates would have to go and spend 3 years some place?

Mr. GOLDFARB. Mr. Chairman, Mr. McDermott, I guess if I can answer the question a little different way, part of the problem with the National Health Service Corps and Public Health Service commitments, as you know, is the durability of the commitment of the student and young physician, once they get in a rural community, for example.

And, we found that programs like WAMI, from Washington, as well as the Area Health Education Program, has been a more durable program in placing students, as early as their first year in medical school, in homes in rural communities where they can establish some attachment to the culture there, and in fact we now see our students moving to those communities, staying because they have built ties there.

So, I am unsure that just a financial incentive, that in fact is short term, will solve the problem, if that problem is a durable relationship between a practitioner and a community.

Mr. BRIDEAU. My only addition to that, Dr. McDermott, would be to first agree, generally, that you do need both, but that it is not an either/or question. That is we have a number of programs where we place residents in rural areas, and place them—and medical students as well—for 3 and 6 months at a time, to get to know the community, understand what it is like to practice in the community, and get rid of some of the myths of what it is like practicing in smaller communities.

That coupled with a significant financial incentive to practice, especially to practice primary care in those communities, would be very effective, and would be enthusiastically received by graduates at our school.

Dr. WICKLESS. In our profession, the Osteopathic profession, our average graduate debt this past year was a little over $93,000. The thing that many people do not recognize is that this debt is after tax money, and with respect to Mr. Stark's comment, it may be a good value, but it is going to come to the point, I think, that as these debts go up year after year, as the years go by, that, you know, the debt is going to be unmanageable for students, and something will have to be done to change this.

The people have to have loan forgiveness funds, that are scholarship funds to go to an immediate area, be sponsored in a rural area, if that may be the case, or an inner city area. The National Health Service Corps is a good idea, but it probably needs some fine tuning.

One thing I would like to point out is that a lot of the money that NHSC participants get is just to set up a structure. The rest of it comes from moneys that get generated from Medicaid funds or something like that.

In talking to some of the people that were in the NHSC, it appears, some of their concern is if the block grants come forth, their costs will not be appropriately included in the allocated funds, as are currently recognized in the Medicare rate.

To answer the specific question about payback time for this, we need to have a lot of study done on this. We have a lot of facts and

figures right now about manpower data, if we apply this, we can come up with some solutions.

Changes are going to occur. We might as well make them controlled changes.

Dr. FOREMAN. We have had some considerable experience, now quite successful, in bringing highly qualified, fully trained physicians into practice in the most underserved communities in the Bronx on a permanent basis.

We now have over a 100 primary care physicians practicing in medically underserved areas in a variety of settings. We have 3 large community health centers, 10 community health center satellites, 12 school program centers, and 6 mobile units that provide care to homeless children throughout the city.

It is not as difficult as you think to get highly qualified physicians to work in settings like this. As a matter of fact it is no longer difficult at all.

What it takes, however, is a considerable amount of investment capital and the willingness to do it, and to sustain the early start-up costs until these programs break even.

Our commitment to this is based on our view that we have a particularly powerful social obligation to meet the needs of the community in which we are located.

But, it seems to me that looking at the whole notion of community health centers, how they are funded and how they are structured, would open a door to bringing well-qualified physicians back into urban inner-city areas in a way that has not been thought possible previously.

Mr. MCDERMOTT. If I may just follow up. Are the community health centers staffed by international medical graduates?

Dr. FOREMAN. No, sir. These are American graduates.

Mr. MCDERMOTT. These are American graduates.

Dr. FOREMAN. Yes, by and large. Our own graduates as a matter of fact. These are people who are making career commitments to this. This is not a 1 or 2 year obligation.

Mr. MCDERMOTT. So, they went to Cornell or New York University, or whatever, and how are they paying their debts back, and whatever, in that kind of setting?

Dr. FOREMAN. We are giving them a salary, and they are marrying rich spouses, I guess. I mean, one way or the other, they are paying their debts. [Laughter.]

Mr. MCDERMOTT. May I ask one other question.

Chairman THOMAS. After that answer, you go forward at your own peril.

Mr. MCDERMOTT. Well, this question is in a different area. The University of Washington's medical school is funded from 11 percent State money, 39 percent doctors' money, and 50 percent Federal money.

Now, why should not the States pick up a bigger chunk of that cost?

Why should it be 50 percent Federal money? Why not give 40 percent of what the Federal commitment is now, and ask the States to pick up the balance?

Mr. GOLDFARB. Well, Mr. Chair, Mr. McDermott, coming from across the river, I am actually envious of the State support provided by the State of Washington.

Actually, the percentage is a little bit higher, maybe 13, 14 percent for our medical schools. But, for an entire institution is that same 13 or 14 percent, for all of our health professions, across the board. So, some of those programs, let us say the School of Nursing, that are unable to generate as much clinical revenue, and peer review dollars to support their activities, have a much larger State component.

As you well know, the State of Oregon appears to be in no position at this point to provide additional dollars with the property tax law that was recently passed, and their commitment to the criminal justice system.

So, the answer is we are wagged by that tail, and that we do need a Federal commitment that spans the vagaries in State funding across the country.

Mr. MCDERMOTT. How about the rest of you? Could your States pick it up? How about New York?

Mr. BRIDEAU. We are a private university, University of Rochester, so we get essentially no State support on the medical school side. We rely very heavily, though, for our faculty salaries, on funding from the National Institutes of Health. We have about a $100 million in sponsored research. that is a very large part of it.

The tuition payments from students make up about 6 percent of the total medical school budget. So, the key pieces are the income earned by faculty from seeing patients and the research dollars that are received. But essentially, it is that coupled with our endowment income that finances all of the undergraduate medical education.

Obviously graduate medical education——

Mr. MCDERMOTT. So, your Federal support is 75 percent of your budget?

Mr. BRIDEAU. For the undergraduate medical school, essentially, yes, through research funding and Medicare/Medicaid revenues.

Dr. WICKLESS. In Michigan State University we have a College of Osteopathic Medicine. We have a retention rate, that is something over 60 percent of the graduates that stay within the State, and continue to practice in the State.

The number of people that stay there are primarily primary care. The State funds that go toward this initiative is well returned. The trouble with our society today is we have a very mobile society, and where people go to school and where they end up living later are two different things.

I think, historically, that people end up, you know, practice where they train, in residency programs more so than in medical schools. To lay it all on the shoulders of the State, is probably inappropriate, because the places where these people train—and I am a fine example of that, coming from the Midwest and ending up in Michigan—are not necessarily where they finally practice medicine.

It probably has to be a little bit broader based than a State-only initiative, though it is something they have to contribute more to.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman's time has expired, and I believe he said a little bit more of the load to be picked up by the State, rather than the State assuming the whole load. And, I apologize for not being here for this entire discussion, because you may find this is an area where there is a great deal of shared interest of the Subcommittee on some solutions that have been suggested.

I would say that rather than incentive, Mr. Brideau, or that idea might generate some enthusiasm, Dr. Foreman, my model is closer to the ROTC model, in terms of, a direct commitment, if in fact we do this for you, you will do this for us, for stated periods of time, and that there is nothing wrong with the sweat equity concept in terms of earning a very valuable ticket.

The other thing we are looking at is if in fact it is $80,000, or $100,000, there are an awful lot of people in small business who look at that amount of money in terms of going into business, given the resources that I am going to receive.

In other words, the asset debit sheet. That if you started off with that small amount on the debit side, given what you can do on the receipt side, that that is not a bad deal at all, in terms of simply creating a funding mechanism to work it off, not in a scholarship way but in a pure business sense.

Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank, you, Mr. Chairman.

Actually, some of my questioning will follow up with what Dr. McDermott was talking about, except with a little bit different twist to it.

That is, he was talking about undergraduate and medical education tuition being paid for. We already have a system that pays currently out of Medicare for graduate medical education.

One of the ideas that I have heard proposed, that is very promising, is the idea that the money obviously follows the physician in training, wherever they decide to go.

Coupled with that, if you say to that physician, that is fine, you can go wherever you choose to go; however, an obligation that you will have—what Chairman Thomas was talking about—is that these are the areas in the country that you have to choose from now for receiving that graduate medical education training, subsidized by Medicare. These are going to be the areas in the country that will owe us 3, 4, or 5 years.

I graduated from veterinary school at Colorado State, and we have a similar situation, where they actually paid for part of our training, and we had to go back to your State for 3 of the 5 years.

Very high compliance with that simply because you are looking at either paying back $50,000, or working 3 out of the 5 years in your State. And it works very well. You do not have to take it, but then, again, you have to pay. It is a good deal for the taxpayer, but it is also, a very good deal for making sure that underserved areas like, New York City, some of the rural areas, or whatever, are served, in a manner that, without coercing people, just lay it out to them.

Would any of you like to comment on that?

Dr. FOREMAN. I did my——

Mr. ENSIGN. Let me make one quick comment that you can follow up on.

You know, we have talked a lot about just hospitals here. First of all because of a voucher type situation where residents go where they want to go, are hospitals the best and the only place that we should have residencies?

Dr. FOREMAN. In answer to your first question, I would like to say that I did my training in Federal facilities or facilities under Federal sponsorship. Then I moved to private facilities, incurred a payback obligation, and ended up spending 11 years as a Public Health Service officer in uniform. So, I believe I can comment with some degree of personal authority on this.

It is a system that works, but what it does not, it seems to me, do, is get people reliably to stick in the areas in which you send them, after they have finished their training.

It seems to me that it is a terribly vital adjunctive policy. There are areas, quite frankly, that are so remote, and so difficult to attract people to work in, that the only way to get health services in there is to assign them.

I harken back to the comments I made earlier. I believe that you can attract quality physicians to move into at least urban underserved areas by creating practice environments which will draw them, and that the way that we ought to approach that problem, it seems to me, is to be certain that the facilities and organizations capable of building such systems have the means to do that and encourage these physicians to practice in underserved areas.

It is my sense that without that, we will have revolving door medicine.

Mr. ENSIGN. What is wrong with that? I mean, right now——

Dr. FOREMAN. It is better than nothing, but it is——

Mr. ENSIGN. Right now, we have graduate medical education and we have residents that basically are revolving door. That is an improvement from the current situation, but it is not incurring more cost.

As a matter of fact, the way I believe that we should do it—we talk about international medical graduates. Right now, if we want to pare those back, which I believe that we should, we could say to American graduates that these are available to you. That would still take care of the underserved, because New York City and Chicago, and a few other places, are the places that are telling us that they are going to be really hurt if we cut back on the number of international medical graduates.

But, if you had the voucher type system, they would be able to be served.

Dr. FOREMAN. I do not think there is any question that you would get a good many takers.

Mr. ENSIGN. Yes. OK. Mr. Brideau.

Mr. BRIDEAU. I would like to address your second question, if I could, on, are hospitals the best place to conduct graduate medical education?

The answer is yes, they are the best place through which to sponsor graduate medical education, but even today we obviously do not conduct a large part of medical education in the hospital setting itself. We all have a number of programs, either in inner city areas, rural areas, of ambulatory settings, a whole variety of settings.

So, less and less of medical education takes place inside the hospital today. More and more takes place in the ambulatory services that we all have and are establishing throughout the community and our regions as well.

But, to have the hospital as the base for the sponsorship gives you the wide breadth of services, wide breadth of educational experiences that residents need, that other organizations would have to then go out and find hospitals to contract with to get those.

I would say hospital sponsorship is still the key, but the site of training needs to be much more like the real world of the practice of medicine.

Dr. WICKLESS. Just a little bit different response. By the impact of managed care, what we have seen is the hospital sense of all institutions going down and the downsizing of institutions. And what we have seen is an increase in the people using outpatient facilities whether it be free-standing surgery centers, or what have you.

What we have to do is train people, residents, where the people are going to be. I do not think we can ever get away from academic health centers and we always should sponsor them, but there has got to be more money pushed over into the area of developing ambulatory health care center sites, and with the advent of technology today one of the better things that you do get out of a hospital setting is, you know, the conferences, the lectures, and so forth.

With telemedicine and things of that nature, you can be at a remote area, yet receive all the interactive and intercommunication that you need to keep up your skills and advance your skills.

Mr. ENSIGN. Mr. Chairman, just real quickly, based on the McDermott clock.

Chairman THOMAS. I would tell the gentleman that the more senior Member of the Committee was given a privilege which may or may not extend. [Laughter.]

If it is requested, it might be, but if it is demanded, it may not be.

Mr. ENSIGN. Mr. Chairman, I will not follow the ROTC approach here. I would beg a—humbly——

Chairman THOMAS. The gentleman may continue. [Laughter.]

Mr. ENSIGN. Just following up on this whole idea, because I think that it is such an important concept that we explore. We also have to look at the idea of residencies in hospitals, especially in the inner cities. That becomes the place where people get the primary care, which is also the most expensive care that they can possibly get, is in emergency rooms, which is where a lot of the residents end up treating these people.

The idea of ambulatory care in situations outside the hospital obviously needs to be addressed, but also the idea of perhaps that we have too many residencies funded in this country, and if you decrease those, but you incentivize people to go in and set up private practices because they are going to have the graduate medical education funded, those same people, if they go back to the inner city, set up a private practice. Perhaps there is more incentive there to get people treated, maybe in community-based clinics, that are much lower cost, overall, to the whole health care system, than the current system of treating most of those indigent type people in our emergency rooms.

Mr. GOLDFARB. Mr. Chair, or Mr. Ensign, I think the managed care wave in this country, in fact, incentivizes just what you describe. We are now financially incentivized to go to the community and not bring the community to us. And as a result, like many of my colleagues, our institutions establish what we call community health centers, and many of our best residents in fact end up at least initially practicing there, and then moving into the community.

What you are describing is in fact happening as the financial incentives in the system have changed to those that are more primary care based.

If I might also answer part of your question about placing students or young physicians in undesirable locations.

It has to be two part. It cannot, in my view, simply be at the graduate medical education level. At the undergraduate level, we also need to get the students into those environments. So, there is a better chance that they will stick, if they have an obligation, whether it is a PHS obligation or other in those communities.

Mr. ENSIGN. OK. I thank the Chair for the Chair's benevolent indulgence.

Chairman THOMAS. I would tell the gentleman from Nevada he is getting much better. [Laughter.]

Before I call on the gentlewoman from Connecticut, I just want to say, and acknowledge, that in this area we have tried to be creative, and I indicated I was a little underwhelmed by some of your solutions, since they were more the obvious ones, and we are looking for some responses in a real world context which will allow us to better understand.

No one has been more responsible for providing creative alternatives in dealing with graduate medical education than the gentlewoman from Connecticut.

Mrs. JOHNSON. I thank the Chairman, and I was interested that only one Member even mentioned some of the proposals that we have been making. This is a very big problem. We are going to have to have a far more dramatic series of presentations than we had this morning to get to it.

Many of you have talked with me personally, and had engaged at a different level, but I thank the gentleman from Nevada for really getting in there with some of the issues that have to be dealt with, as Dr. Wickless began to deal with them.

First, because there are a number of questions, and anyway, I might not be granted the liberal treatment of preceding Members, I need some information on a number of issues.

First of all, is managed care draining your education resources? Now, Mr. Goldfarb, you had managed care around you for a long time. We have not done anything. I mean, we tried in our preservation act, but we have not done anything to deal with the fact that managed care does allow resources that were supposed to support medical education to be diverted to other needs of the managed care system, including profit.

Have you seen any kind of diminution of resources for medical education?

Mr. GOLDFARB. Mr. Chairman, Mrs. Johnson, absolutely. The fact in Oregon is that half of those Medicare patients that formerly

had access to our institution, with the pass-throughs to support graduate medical education, attached to their State, are no longer available to us.

Yes, the patients do come, but we compete for managed care contracts for those, and the health plans retain those dollars themselves.

Mrs. JOHNSON. OK. Have any of you done any analysis? After all, we have kept DME money flowing. IME money go directly to you. DSH money go directly to you.

There are a lot of money that flow directly to you. The only little piece that does not is the piece of the AAPCC that goes through the actual reimbursement for that patient.

Now patient stays have diminished, so you would not be getting those anyway. Have you done any analysis of what percentage of your medical education dollars are being compromised by managed care? We need to know that, because if we do not have a good premium for managed care, we will not be able to buy the quality plan that seniors need.

So, if it is only a small percentage of your money, then let us deal with it through the trust fund, which is exactly what we tried to do. We put new tax dollars into the trust fund and kept the AAPCC high.

So, the logic was to put a good premium out there to buy a good plan, that would better serve seniors, so they can actually get more benefits than Medicare currently provides, and give hospitals the replacement dollars.

We do need to know from you a much more precise estimate of what the contractual negotiated loss is. Now, you have to in fact draw out what will be the estimated reduction in length of stay, because you would not have been able to count on that, whether it was managed care or not.

If you want to comment, and I do have other questions, so do not belabor it, if you do not have any information.

Mr. BRIDEAU. Go ahead.

Mrs. JOHNSON. Thank you. Consortium funding. But, do get back to me. I know I am asking for information you do not have.

Consortium funding. I am very interested in consortium funding, and many of you have made the point that the old way of training residents, in hospital, will not meet their practice needs.

But, consortium funding is going to have the same impact on the New York hospitals as reducing the number of IMGs, because if you are going to train them out of hospital you are not going to have the hospital soldiers to do the work, in hospital.

Now, is that going to be a problem? Have you thought it through? Do you have a consortium proposal? Would it help if we were able to give reimbursements for the training of advanced practice nurses and physicians' assistants, and people like that?

So that we look at what is the in-hospital component of all medical training that we should be funding versus in the context of the kind of consortiums that we really are going to need, and in not too many years are going to be typical of all medical education funding.

What is it going to do to your hospital labor when we go in that direction? And, do any of you have consortium proposals that you

would like to pilot for us, so we would know that it was a good idea to put pilot dollars out there?

Dr. FOREMAN. Let me tackle just a little piece of that. There is some confusion, I think, in using the term consortium, in which several different ideas are being commingled. That the consortia that are being proposed, or have formed in New York, are basically clusters of teaching hospitals and their affiliated school, coming together, to try to parse a rational system of training by specialty among the various institutions.

Consortia are likely to be ambulatory care facilities under hospital sponsorship, and as such are funded under the Medicare Act.

The ambulatory care sites that are not funded under Medicare are those that are not part of a hospital system, but there are very substantial numbers of ambulatory care sites and activities which are part of the hospital system, and in which training takes place, for which Medicare provides full funding.

A number of organizations, including our own, has advocated that funding be extended to ambulatory care sites that participate in the graduate medical education process, even if they are not a part of hospitals, simply because, right now, they are excluded from participation on the basis of being unable to recover their cost.

But, I do not think there is any quarrel, certainly among our institutions, that they should be given the opportunity, if they are being engaged in the training process, to recover the costs associated with that.

Now with respect to the consortia themselves, they are likely to be essentially position-allocation mechanisms rather than an activity that changes the way graduate medical education is conducted.

So that instead of five institutions, each having an ophthalmology program, perhaps two would have them, and somebody else would have something else.

It is not likely that they will get involved in the other aspects of changing graduate medical education funding.

Mrs. JOHNSON. Dr. Wickless.

Dr. WICKLESS. A couple comments, and first, about managed care, and just to point out a piece of information. I practice about 30 minutes from the University of Michigan, which is one of the larger academic medical centers in the United States, and have a lot of interaction with them because of patient referrals.

There is an article published by one of the physicians up there in the New England Journal, that talked about the decreased staffing needs in academic medical center based on a managed care model.

If you look at those numbers, and equate those numbers, and the amount of money that would go through a system based on a tax, you realize that the amount of money that would be going through there, that would be fed back to the educational process, is going to diminish.

I do not have any other studies in reference to managed care, and GME sources.

Number two, we have two initiatives in our profession. The first one is in Michigan. It is COGMET, Consortium for Osteopathic graduate medical education and Training. And, it has evolved into

a statewide campus system which is co-sponsored with our institution, College of Osteopathic Medicine at Michigan State University.

There has been a similar initiative recently implemented in the last 2 years in Ohio, CORE, The Centers of Osteopathic Regional Education Program Our profession is predominantly based in smaller hospitals scattered throughout regions, and because of this ability we are able to put all these hospitals and link them together with the benefit of a medical school, Osteopathic Medical School in these regions, or State, as it is here, that put together this consortium to get all these needs together that we want to.

This allows people that are in smaller hospitals to link with our telecommunications that we are developing, you know, back to a central area where they can get the academic, didactic things they need to continue the residency program, in the process, while they are out in the rural or smaller areas.

Mrs. JOHNSON. Thank you.

Mr. Brideau.

Mr. BRIDEAU. Thank you, Mrs. Johnson.

If I might, in the area of managed care and the response to the HMOs, essentially we have done an analysis of our costs as opposed to other hospitals in Rochester, and we are clearly the most expensive.

When you take out the teaching costs from all of the hospitals in Rochester, we become the third most expensive hospital.

When we talk to HMOs, they are not interested in paying us the prices that we have because we are a teaching hospital. They want to pay us that average cost, essentially, of the community and are saying, effectively, that they are not going to pay for graduate medical education.

My concern about providing AAPCC payments that include the GME component is that the HMO has that payment in hand, and basically is saying to us, we will pay you like a community hospital but we will not pay you for your teaching costs.

Mrs. JOHNSON. Right. The question I was asking was, how much of the difference between your being number one and number three are we already reimbursing through DME and IME, and other streams of funding?

And how much——

Mr. BRIDEAU. It is going directly to us.

Mrs. JOHNSON. And, directly to you. So, we do need more—I see my time has expired, so I will pursue my other questions later.

But, we need to know from you what you think in the long run is going to be the impact of the consolidation of hospitals, the restructuring of programs as we probably change the level of reimbursement for advanced levels of certification, so that we begin to look at what is going to be the total number of residency slots, in hospital, and how is that going to compare to the number of graduates of American medical schools.

There has been a tremendous increase in the number of foreign medical graduates into our system, and should we be negotiating with foreign governments to have contracts that provide some foreign dollars to support that training, and along with it contracts for people to return to their country to better utilize that training for the purposes for which presumably their Kindergarten through

college system investment in them by their National Government prepared them for.

So, there are some big sticky wickets here to think about, and while we are keenly aware of the problem of the inner city hospitals and their dependence on foreign medical graduates, I do not think that can shield us from the seriousness of the challenges we face, nor does it make those problems insolvable when you look at the number of reductions in residency slots elsewhere in the system, and the need to train people like advanced practice nurses.

Thank you.

Chairman THOMAS. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

I indeed want to welcome the witnesses today particularly Dr. Foreman who had such a distinguished career in Baltimore at Sinai Hospital. It is nice to have you here before our Subcommittee.

I agree with the point that most of you have made about the AAPCC dollars. Those funds should be directly used for graduate medical education.

But, I also agree with the point the Chairman has made. if we just provide the necessary funding, without dealing with accountability how the funds are going to be used, in order to deal with the problems that have been acknowledged by all of you, that that would be wrong. we would miss perhaps the only opportunity that we have in establishing national health policy to deal with the work force issues.

We have had difficulty in this Congress dealing with the work force issues because some believe that the market forces will work; others are somewhat suspect about that.

I just want to echo the comments that Mrs. Johnson made and the Chairman made about coming forward with recommendations that are workable in dealing with the underlying problems of work force allocation.

It is not just the number of medical students that we are training in graduate education. It is not only the geographical disparities that exist. But, it is the type of specialists that we are training in this country.

Because of the large numbers—140 percent of the medical students—we produce too many physicians trained in certain fields, not enough in other fields.

Certain communities have enough; other communities do not. Some fields have too many trained, and in many other fields we do not have enough trained.

Yesterday, I had the chance to visit the geriatric center at Hopkins, and was somewhat surprised to learn that there are only 200 fellowships in the country in geriatric medicine.

We all know that our society is changing, getting a lot older, the frail elderly is a growing number. It would seem to me that that is one area that is not very glamorous, may not pay a lot of money as far as a field of medicine to go into, but as we look at work force issues, that is an area that we need to concentrate on to make sure that we are going to have adequate personnel trained.

So, I just want to underscore the point, that from a person who strongly believes that the Federal Government must have a dedi-

cated funding source for graduate medical education, that the tradeoff must be to deal with these work force issues.

I want to underscore one additional point that has not been made, and that is, the major teaching public hospitals are really coming under attack today.

It is very, very difficult, when you look at the type of patients that you treat. You have got two and a half times the number of Medicaid patients that the typical hospital has—36 percent of your revenues versus 14 percent of their revenues.

You have three times more uncompensated care than the typical hospital in this Nation. And you have, it looks like, one-half the number of private paid, that a typical hospital would have.

So, your revenue flow from traditional sources is going to be more difficult. Therefore, it becomes even more important to establish a flow to deal with training costs, so that we can maintain the excellence in training in this country.

So you have our attention. There is a real desire for us to do something in this area. But I would just urge you, as a group, to take very seriously this opportunity and be a little bit bolder in coming forward with recommendations that will deal with the multiple problems we have in the work force.

We know it is not a simple solution. But, I really do think that our major teaching facilities are in jeopardy if they miss this opportunity, where you have our attention, to try to deal with the problems.

I would certainly welcome any comments any of you might have on that and give you a chance to respond.

Yes, sir?

Mr. BRIDEAU. If I may, Mr. Cardin, just comment on the shortage of geriatricians. There is no question about that, there is a significant shortage. I would point out, though, a report this morning on National Public Radio indicated that half the geriatricians in this country are foreign medical graduates.

This is not a simple issue, getting residents to go into specialties that we need.

Mr. CARDIN. Because I might point out that many times these residencies are the only ones open, so the foreign students end up in these residencies too.

Mr. BRIDEAU. So, they do go into them. We welcome the opportunity to provide you with some additional proposals, and will certainly do that. But getting back to the basics, though, one of the concerns that we have is we are concerned about the Medicare reductions that are being proposed in the Balanced Budget Act, and the impact that they will have, especially on teaching hospitals, because in addition to being hit on the regular across-the-board cuts, such as the marketbasket adjustment, and those sorts of things, if we, in addition to that, get hit for direct medical education, in disproportionate share, because we do treat a disproportionate share of the poor, that is a double hit to these kinds of hospitals.

So, to begin solutions to the problem, you first need to stabilize the base of where we are, to a degree. We are deeply concerned about the viability of some of these institutions with those kinds of reductions.

Mr. CARDIN. I Appreciate that.

Mr. Chairman, I yield back the balance of my time to any of the other Members who may wish to use it.

Chairman THOMAS. I was just going to say that that is just a little bit unfair, when you look at the program that we had from the House side, putting $17.5 billion into that general fund. There was not a desire to reduce the funding. There was a desire to shift the basis of the funding.

To argue that somehow, graduate medical schools and teaching hospitals suffered an unfair reduction vis-a-vis everything else, is simply not the case, and I would like to visit with you.

The idea of moving to the general fund to finance it, notwithstanding our desire for initiatives in the marketplace to deal with it, underscores how much all of us here, whether Republican or Democrat, believe that these institutions have a significant role to play.

But, we are not going to continue the current system, and either you folks who are doing it help us figure out a new way, or we will do it for you. I prefer having you folks help us, beyond telling us that the built-in costs you were supposed to get out of the AAPCC ain't coming your way right now, and that is your solution.

I know that is an unfair representation of what you said, but it ain't that far off.

The gentleman from New York. We had an interesting discussion, introduction of a gentleman from your area, and he keeps referring to the Finger Lakes area repeatedly, and you now have a chance to question him.

Mr. HOUGHTON. The garden spot of the——

Chairman THOMAS. Garden spot; right.

Mr. HOUGHTON. Thank you.

Well, Mr. Chairman, you have got other panels, and I will not take long. I have three questions, but they can be answered rather rapidly.

One is in terms of—I would like to focus this on Mr. Brideau, because he and I have been associated up there over the years.

Really spell out for me, again, how the changes in the payment factors are going to disproportionately affect your hospital.

Second, I would like to know the impact of telemedicine, and spreading the costs.

And third, maybe you could answer this, or maybe the others could. What have you done as far as reducing your basic costs?

We heard a man from Beth Israel talk about some pretty staggering cost reductions he had made over the past few years. We talk about reimbursement and we talk about revenues, but I do not know whether we have talked sufficiently about the basic cost base.

Mr. BRIDEAU. Let me take the last one first, if I could, Mr. Houghton, and then work back up.

In terms of cost reduction, just to deal with the reduction in revenue from governmental and non-Governmental sources in the last several years, we have had cost reduction programs at our hospital each year.

Last year, for example, we eliminated $15 million from our costs. We eliminated something on the order of 200 jobs at Strong

Memorial, and those are people who just are not working there anymore.

On top of that, this year we are putting in place an additional $14.6 million of cost reduction. This is just to stay even with the hit we have been taking on the Medicaid side, largely, and from business. The message we are getting from business is loud and clear. They want to see their premiums come down as well.

This is at a hospital that is already one of the more cost-effective teaching hospitals in the country.

Budgeted for next year will be similar cost reductions. So, people are losing their jobs, we have no way around that. Our nursing hours of care per patient day have declined. We are looking for ways to do things more efficiently.

So, we are not arguing for maintaining the current system. We know that is not possible. We are not arguing for business as usual.

But, we are arguing to not be hit, disproportionately. To go to that portion of the question, if our Medicare payments are about $130 million, in total, in the hospital. About $30 million of that is graduate medical education payments.

So, if we take a reduction on, for example, the marketbasket factor, that reduction affects the whole $130 million of revenue. But, if we also take reductions on graduate medical education payments, either through direct reductions in DME, or through reductions in the IME factor, that is a reduction, again, on that $30 million. So, it is a double hit from that standpoint.

We are also a disproportionate share hospital, so anything that happens on the disproportionate share side affects us as well.

So, we recognize that we need to be a part of a solution here, both in terms of the Medicare Trust Fund, and the balanced budget. What we are simply arguing for is a fair portion of that solution, and sort of an equitable portion of that solution.

In the area of telemedicine, we are actively involved in establishing a telemedicine network throughout the Finger Lakes region to keep us in touch with rural hospitals, because in our view, what makes most sense for patients is not for them to travel from 60 miles away, or 80 miles away, to come to Strong to receive their care.

But, wherever we can safely and effectively provide that care in their home communities, we think they ought to stay in their home communities.

The electronic infrastructure is not quite what it needs to be to fully support that, and we are working with the telephone companies and other companies, to put that in place. We think that holds significant promise, and certainly any grants in the development of that field would be very helpful for communication and for treatment of patients in those communities.

Chairman THOMAS. The gentleman from Washington wanted to inquire.

Mr. MCDERMOTT. I just had one last question, Mr. Chairman. I appreciate this.

You mentioned your relationships to HMOs. I wonder if there has been any approach to any of your hospitals by a managed care operation that wants to take over the hospital, just take over a uni-

versity hospital as a part of their operation, and as a part of inserting themselves into the teaching and training of physicians.

Mr. GOLDFARB. Mr. Chair, Mr. McDermott, not in our case. The health plans in our area are competing, frankly, viciously with one another, and I would suggest they would not want to take on the additional cost and burden of care in an academic medical center, and then have to compete against other health plans on an even playingfield.

That may be happening in other parts of the country, but, I have not yet seen it in ours. We have health plans that own clinics and want to work with us in rotating our residents. Some health plans are part of systems, they own clinics, and therefore, they want to expose our "best and brightest" to their outpatient programs and to rotate the residents there.

Mr. MCDERMOTT. So they come to you, asking that you rotate your people into their programs?

Mr. GOLDFARB. Mr. McDermott, exactly, and unfortunately, I am unable to say, well, if you will do that you need to send more of your inpatients to us. No. They want to negotiate that against other tertiary facilities in the area.

Mr. BRIDEAU. We have not had that experience in New York. The experience we have is that of HMOs essentially wanting to deal with us, and wanting to do a number of things collaboratively with us, but at a price that is competitive with community hospitals.

Mr. MCDERMOTT. But, if you are the only tertiary care center in the area, how are you competitive?

Mr. BRIDEAU. We are the principal tertiary referral center, but there are other hospitals, in the Rochester, Buffalo, and Syracuse areas that they can send patients to for those kinds of services.

We also provide secondary and primary care as well. What I want to do is get a clarification, if I can, to some of the data that we have been asked to provide around the impact of this, and dealing with the HMOs, because the easy rule of thumb, it seems to me, is that if 10, 15, or 20 percent of the business of Medicare is in HMOs, in a managed care environment, that is 10, 15, or 20 percent of the GME money that we are not getting.

Because the price they are willing to pay us is the price of a community hospital. They are not willing to pay for education.

So, if you have got a 20 percent penetration of managed care in the area for Medicare, you have lost 20 percent of your GME money. It is a one for one relationship.

Dr. FOREMAN. It is important to recognize that even hospitals that provide highly specialized care only do so for about 20 percent of their business. The other 80 percent is routine care and can be provided by a number of other providers in the community. Unfortunately, the costs are laid across the entire care spectrum, so that even if you could command the actual cost of your premium services from HMOs in the community, you still have a premium laid on your routine services ascribable to charity care and teaching, which no one will pay for, and which is now causing HMOs to march away from teaching hospitals and do business with their lower cost competitors.

There are some things, though, short of protective payments, that we think offer some promise for large teaching hospitals.

We have begun to bundle services and negotiate capitated payments from HMOs, and provide physician services, hospital services, specialty services, and ancillary services for a comprehensive fee, essentially stepping into the shoes of the HMOs and taking full risk capitation.

There have been some proposals before Congress to create provider-sponsored networks under Federal law, and that would go a long way, I think, to facilitating institutions like ours, and in upstate New York, to gathering an organization of other institutional providers, physicians, and ancillary services under a single roof, and then managing the care within a single premium dollar, in a way that protects both the public and the private benefits that are necessary.

Mr. MCDERMOTT. Has there been any medical school in New York, that you know of, that has been approached by a major HMO organization offering to actually pay tuition for medical students, and then train them so that they could join their program?

Dr. FOREMAN. No, sir. The last thing in the world HMOs want to do is pay for training. They would like somebody else to pay for training and then benefit from the products that are trained.

Mr. MCDERMOTT. Thank you.

Chairman THOMAS. Well, that is one of the areas we should be a bit more inventive in terms of examining. If they want certain kinds of physicians, there might be a way in which we can affiliate slots, or some other structure, and if they do not want to fill them, they do not get filled.

You know, there are a number of ways, I think, that we can be a bit more inventive. We, after all, are trying to figure out a better way of funding than the average area per capita cost, to begin with, and while we are doing that, in creating that general trust fund we were required, because we were not creative enough, to simply use the current distribution structure for those dollars that otherwise would have been sent out as DME, IME, and we left DSH out at the final end.

But, we did set up a commission to try to study a new way to distribute the money, and my hope is that as we begin moving toward solutions, that we could adjust the method of payment with some risk selection factor that needs to be worked on, and change that distribution structure.

Because we have got a number of teaching hospitals that, historically, by location, are basically inner city. We have a patient profile that, in part, comes with that location. And that is, in part, different from who gets trained and why. So, we have a lot of areas that we could be working on, to try to be a bit more creative.

I hope that some of you, although your testimony is primarily focused by virtue of the organizations and institutions that you represent, realize you are our primary source of understanding of the changing nature of the health care delivery system.

I would hope that you would respond to us from a personal point of view in as innovative and creative way as possible. We have had suggestions of simply pulling emergency care away from the traditional structure and run it under a societally funded operation like fire stations, to a certain extent, or other options that would allow

us to begin figuring out ways in which we can get a societal response for a societal benefit.

All of us here believe that the teaching of our future physicians is a societal benefit, and we have got to figure out a way to broaden that base, but to do so, in a way in which we do not create additional problems that the current system is obviously giving us.

I want to thank all of you for your testimony. Thank you.

If we could ask the second panel to come forward.

I want to thank this panel, consisting of Dr. Jacott, who is a member of the board of trustees, American Medical Association; Dr. Patrick Harr, who is president-elect of the American Academy of Family Physicians; Dr. Leslie Cutler, who is chancellor and provost of health affairs, University of Connecticut, Health Center, Farmington, Connecticut; Dr. Anthony Marlon, who is the chief executive officer and director of Sierra Health Services in Las Vegas. I have a hunch my colleague from Nevada may want to do some additional introductions. And Dr. Reeves, who is a senior vice president of the Health Care Operations, Sierra Health Services, Las Vegas.

Do you want to do some elaboration at this time?

Mr. ENSIGN. Yes, thank you, Mr. Chairman.

I would like to recognize both gentlemen and say how much I appreciate Dr. Marlon and Dr. Reeves for being here.

They represent Sierra Health Services, which is truly one of the more innovative health care companies in the country, not only from the State of Nevada, but truly, across the country.

They recently qualified for the SHMO, Social Health Maintenance Organization, II pilot project, one of three in the country, and so many other things, and I am just proud that they come from the State of Nevada. We have a lot of great things from our State, and this is just one of the great companies that we have in Nevada, and I thank them both for being here.

Chairman THOMAS. Thank you.

I would indicate that if you have written testimony, we will make it a part of the record, without objection, and you can proceed to inform us in any way you see fit, with the admonition that we are looking for bold and exciting new ideas.

We have heard all the old ones, but if you want to fill your time by telling us all the old ones again, we are more than willing to listen.

Dr. Jacott.

STATEMENT OF WILLIAM E. JACOTT, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. JACOTT. Thank you very much, Mr. Chairman, and Members of the Subcommittee.

My name is William Jacott. I am a family physician and I am head of the Family Practice Department at the University of Minnesota, and a member of the AMA board of trustees. We appreciate this opportunity.

As you have been discussing in your first panel, the Federal Government is the only payer to reimburse the costs of GME.

In the past, the private sector has contributed indirectly, but in the current competitive environment, the plans, the systems, the

groups are becoming less willing to pay the higher charges associated with the teaching hospitals.

In addition, the private sector is less willing to allow their physicians to be involved in voluntary teaching. Therefore, the growth of managed care has placed increased pressures on medical schools and teaching hospitals as more individuals enter into those plans, systems, and networks.

As you pointed out, Federal GME dollars are also lost through the AAPCC, but that is not the whole story.

The latest Trustees' Report on the Medicare Part A Trust Fund makes it clear that Medicare cannot, and should not continue to bear the sole burden of paying for our Nation's graduate medical education.

Medicare can reduce its burden, but only if the private sector begins to pay its fair share. It is important to note, that resident physicians provide a large amount of care to poor and underserved.

Some hospitals are heavily dependent on the medical services of resident physicians, and thus, any changes need to take those situations into account.

As you recall, Mr. Chairman, last year, the AMA presented Congress with a proposal to restructure Medicare, and a portion of that proposal involved GME. The AMA recommend that there be a 2 year transition period for changing the existing GME funding formulas to end the steady increase in costs.

During this period, Congress should limit full GME funding to the years leading to initial board certification, which is usually about 3 to 5 years, plus the full length of training programs in geriatrics and preventive medicine.

Second, we believe Congress should delegate authority to some kind of public/private consortium to make recommendations on work force and on funding of GME.

This group should obviously consider specialty mix, geographic distribution, and total numbers of physicians.

Third, we must restructure the financing of GME into an all-payer pool, which recognizes that patients covered by all forms of insurance benefit from trained physicians.

In addition, GME funds should be distributed to the entity that incurs the cost of training, and as you have discussed previously, payment currently to the hospital. That is the only way it is paid now, and actually, much of our training programs are in the ambulatory setting.

Fourth, the task force would develop a new indirect medical education adjustment funding mechanism. This would require careful study, because you know that is a very complex issue, and it cannot allow hospitals to bear a disproportionate share of any of those funding reductions.

Any changes to the IMEA must have an adequate transition period to allow hospitals to adjust for that.

Now just a couple of comments, in closing, about the IOM and the Pew work force reports. We commend the Institute of Medicine for a very thoughtful report.

We agree that in many areas in the country, there are too many physicians, and certainly, too many specialists. Certainly in my area, in the Twin Cities, we are seeing this significantly.

The marketplace is making some change, as has been pointed out, but Federal funding should be adjusted according to national needs.

So, we urge the Congress to authorize the development of that consortium, and the consortium needs to look at entry levels in both medical school and in residencies.

We could continue to believe that residency positions should be filled based on competence and merit, and not on discrimination.

We support the position of the IOM, that it is not prudent to open any new medical schools, not to increase current enrollments. We disagree with the Pew report, however, that we should be closing medical schools.

Each of our schools has a unique mission and role in meeting a variety of needs in their region, and our decisions today will clearly impact the work force in 8 to 10 years, because that is the pipeline.

So, in conclusion, we look forward to continue working with the Members of Congress in achieving the fundamental reforms needed to assure a quality national physician work force for our patients. Thank you.

[The prepared statement follows:]

Statement

of the

American Medical Association

to the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

RE: GRADUATE MEDICAL EDUCATION

Presented by William E. Jacott, MD

June 11, 1996

Mr. Chairman and Members of the Subcommittee:

My name is William E. Jacott, MD. I am a family physician, Head of the Department of Family Practice at the University of Minnesota School of Medicine, and a member of the Board of Trustees of the American Medical Association (AMA). On behalf of the AMA's 300,000 physician and medical student members -- and the millions of patients we serve -- I am pleased to have this opportunity to testify regarding Medicare's financing of graduate medical education (GME).

BACKGROUND

As you know, the federal government is, in general, the only payer to explicitly reimburse the costs of graduate medical education. Medicare contributes to the funding of graduate medical education through two payment streams. The direct medical education payment (DME) covers the salaries and fringe benefits of resident physicians, supervisory time for physicians who participate in training resident physicians and allowable overhead related to teaching. The Medicare indirect medical education adjustment (IMEA) originally was introduced to compensate hospitals for the increased costs associated with the presence of an educational program that could not be attributed to resident and attending physician salaries, the greater complexity of care provided in teaching hospitals due to the generally higher severity of illness of the patient population, and the uncompensated care that is provided that could no longer be supported through some cost shifting to Medicare patients.

It has been estimated that Medicare pays about 30% of direct graduate medical education costs through the DME. In the past, the private sector has contributed through paying the higher charges associated with medical care provided through teaching hospitals. In the current competitive environment, however, the private sector is becoming less willing to pay higher charges to support the training of future physicians at both the undergraduate and graduate medical education levels.

The growth of managed care has placed increased pressures on medical schools and teaching hospitals in several ways. First, the revenues that are used for educational program support are being negatively impacted by the increasingly competitive environment. Second, the patient base in teaching hospitals is decreasing, as more individuals enter into managed care plans, which restrict enrollee access to certain physicians and hospitals. This decrease or loss of a patient base compromises a critical element in the training of physicians.

In addition, federal GME dollars are lost through increased enrollment in Medicare managed care plans. While the average adjusted per capita cost (AAPCC) formula used by Medicare for risk based managed care programs includes medical education within the per capita payment, there is no requirement that the managed care organizations participate in medical education as a consequence of receiving the funding.

The latest report from the Trustees of the Medicare Part A Trust Fund makes all too clear the fact that Medicare cannot -- and should not -- continue to bear the burden of paying for our nation's graduate medical education. The participation of both the public and private sectors in financing medical education must be examined, and a mechanism developed to ensure an equitable contribution from all parties to preserve this national resource. Medicare can reduce its burden in financing GME, but only if the private sector begins to pay its fair share to support graduate medical education -- education from which the private sector continues to benefit.

However, the necessary restructuring of graduate medical education financing should not result in unplanned, negative consequences to teaching hospitals, which provide a high level of specialized care and care to the uninsured and underinsured, or to medical schools, which carry out both educational and research missions. It is important to remember that resident physicians also provide a large amount of care, often to poor and underserved populations. There are hospitals in some areas of the country that are heavily dependent on the medical services of resident physicians. Therefore, any changes in funding for graduate medical education should evaluate the effects on institutions with teaching programs, taking into account specialized regional needs and circumstances.

AMA PROPOSAL

Last year, the AMA presented Congress with a bold Transforming Medicare proposal to reform Medicare based on a competitive market driven system. The AMA's proposal provided for a fundamental shift away from government control toward personal responsibility, individual choice and an invigorated Medicare marketplace. While we were pleased that many of our proposals were included in the Medicare Preservation Act (which was incorporated into the Balanced Budget Act of 1995), we continue to support the comprehensive changes to the graduate medical education system found in our Transforming Medicare proposal.

Transitional Period

First, the AMA recommends a two year transition period for changing the existing funding formulas for direct medical education payments and indirect medical education adjustment to halt the current steady increase in costs. In this period, Congress should introduce differential weighting for a preset number of training positions into the existing funding formula for direct medical education payments and limit full funding to the years leading to initial certification by the 24 specialty boards recognized by the American Board of Medical Specialties plus the full length of training programs in geriatrics and preventive medicine.

The AMA recommends this transition period because we understand it will take time to develop and implement an all payer system for graduate medical education. While this is being done, the current funding formulas for graduate medical education under Medicare should be modified so that programs are not financially rewarded for increasing the number of residency positions.

Public/Private Task Force On Physician Workforce/Medical Education Financing

Second, the AMA believes Congress should delegate authority to a public/private physician workforce planning initiative to make recommendations about the need for physicians and the funding of graduate medical education. The AMA, the Association of American Medical Colleges and American Osteopathic Association would convene a task force of representatives from the medical professions from the various institutions/programs that are engaged in graduate medical education, the federal government, in addition to representatives from the states and private payers.

This task force would be charged to study physician workforce needs and to make recommendations about the future funding of graduate medical education, in the context of workforce needs as impacted by managed care and the use of non-physician providers. In developing its recommendations, this body would consider such things as specialty mix, geographic distribution and appropriate training for the emerging health system. There should be appropriate protection for the Task force from antitrust exposure arising from planning activities. The task force would submit a comprehensive report to Congress outlining its recommendations.

Creating An All Payer Funding Mechanism For GME

Third, the AMA strongly believes we must restructure the financing of graduate medical education into an all payer system. An all payer system recognizes that patients covered by all forms of insurance benefit from trained physicians and so all payers should contribute to the costs of that training. The relative percent contribution of the federal government to the all payer pool should not exceed the current proportion of total graduate medical education costs paid by the government. Eventually the total costs to the government can be decreased once the private sector begins to pay its fair share. In addition, GME funds should be distributed to the entity that incurs the costs of training, whether that entity is a medical school, hospital, nursing home or ambulatory clinic in order to encourage training outside of the teaching hospital.

Changing The Current Funding Formulas For GME Under Medicare

Fourth, the task force would analyze the current indirect medical education adjustment and consider the development of an appropriate funding mechanism to reimburse for the increased complexity of care/severity of illness in teaching hospitals. The current direct medical education payment and indirect medical education adjustment under Medicare are structured without limits on the number of residency positions that will be funded. This is a stimulus to increase the number of physicians in training. In addition, the IMEA discriminates against non-hospital based teaching settings by only allowing payment for hospital-based residents.

In addition, the indirect medical education adjustment has been used to compensate teaching hospitals for additional costs of patient care due to the presence of an educational program, but mainly for costs associated with the higher complexity of care and provision of uncompensated care in these institutions. The IMEA originally was designed to take the place of a complexity of care adjustment to diagnosis related groups in the Medicare prospective payment system. The IMEA should be analyzed and a new mechanism to allocate costs based on complexity of care should be developed. This requires careful study, to ensure that certain categories of hospitals are not bearing a disproportionate share of any funding reductions. Furthermore, any changes to the IMEA must be made over an adequate transition period to allow teaching hospitals to adjust for potential payment differentials.

Decreasing The Number Of Funded Residency Positions

The Council on Graduate Medical Education (COGME) has reported to Congress and to the Secretary of Health and Human Services (DHSS) over the past several years that the numbers of physicians being produced in the United States is exceeding what is required in both total numbers and by specialties. COGME has recommended that Federal funding policy be directed toward adjusting the total number of physicians being trained downward and the distribution toward generalist be increased.

The Institute of Medicine (IOM) and the PEW Health Professions Commission each recently issued reports which, in the main, reinforce and support these positions previously put forth by COGME and others. The AMA fully appreciates the problems set forth by these reports in terms of the supply of physicians increasingly exceeding the requirements for the national

good, and that the distribution among the different specialties is not optimal. Further, the AMA concurs with the general principles set forth in these reports that federal funding of GME should be adjusted to bring the physician supply into better alignment with national needs.

Because the AMA recognizes that not all groups can or will agree on tactical details for remedial action, the AMA strongly urges the Congress to authorize a new public/private workforce planning initiative to pursue the details of physician workforce strategy, as described earlier. In the interim, gradual reductions in Medicare outlays for GME can be initiated to both relieve Medicare expenditures as well as to begin a reduction in physician output. If there are to be any reductions, it should be made clear that positions should be filled based on demonstrated competence and merit, not based on irrelevant or arbitrary factors or discrimination.

The AMA supports the positions of COGME and IOM that it is not prudent to open further new medical schools (both allopathic and osteopathic) nor to increase current enrollments. The AMA disagrees with the PEW recommendation that some medical schools should be closed. Medical schools are a national resource beyond the simple training of physicians. Each school has a unique mission and role in meeting the variety of diverse needs across the country. Furthermore, if we misjudge the number of physicians needed for the future, it would take years and very large investments to restore medical schools that may be closed. We strongly urge that any adjustment in physician supply leave the current number of medical schools, but instead make changes through medical schools reducing class size.

While many details of these reports need reconciliation through a national workforce planning program, there are a number of other suggestions in these reports with which we support. For example, the IOM report recommends that data be collected on the relative difficulty physicians are encountering as they complete their residency in finding suitable practice positions. With support from the Robert Wood Johnson Foundation, the AMA has already started this ongoing study and published the first years findings in March 1996. Information on opportunities by different specialties will be included later this year in an on-line program to be available to all medical students as they select their residency.

CONCLUSION

The AMA is aware of and sensitive to the multiple problems facing the Medicare program today. We have offered recommendations on how to decrease the Medicare outlays in general in our proposal of Transforming Medicare. In addition we have proposed a reasoned plan for addressing the issues of Graduate Medical Education. In particular we recommend:

1. that the Federal government authorize a new public/private physician workforce initiative to make detailed recommendations about the need for physicians and the funding of graduate medical education;

2. that the financing of GME be re-structured into an all-payer system;

3. that the current indirect medical education adjustment be analyzed to assess how to develop an appropriate funding mechanism to reimburse teaching hospitals for the burden of increased complexity of care/severity of illness and disproportionate share; and

4 that the number of GME positions be gradually reduced over a period of several years to address the needs put forth from the new public/private physician workforce initiative consistent with the need to improve Medicare fiscal solvency.

We look forward to continue working with members of Congress in achieving the fundamental reforms needed to assure a quality, national physician workforce for our patients.

Chairman THOMAS. Thank you.
Dr. Harr.

STATEMENT OF PATRICK B. HARR, M.D., PRESIDENT-ELECT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. HARR. Thank you, Mr. Chair, Members of the Subcommittee.

My name is Pat Harr. I am a country family physician from rural Missouri, here today representing the 83,000 members of the American Academy of Family Physicians. Thank you for the opportunity to discuss Medicare GME reform and, in particular, the recent work force reports, the Pew Health Professions Commission in the Institute of Medicine.

Both the IOM and Pew Commission Reports make clear that now is the time to substantially reform GME policy. Both reports provide a clear definition of primary care and substantiate the need for more primary care physicians. Moreover, the IOM Report shows that, primary care is defined not just by how physicians are trained but what they do.

I am also here today to describe how Medicare GME policy can be changed in order to move the health care system where it needs to go and, that is, to achieve a system with a firm foundation in primary care. Whatever proposal Congress may eventually choose to adopt, the cost explosion in the Medicare Program will not be brought under control until the availability of primary care services is improved.

Medicare GME policies are largely responsible for the overspecialization of the physician work force. What powerful incentives are at work in the health care market are illustrated by the high demand for primary care physicians and challenges faced by subspecialists in finding the employment of their choice. The dollars for training come primarily from Medicare, which richly rewards institutions for training providers of inpatient and procedural services. This misalignment of Federal incentives must be addressed.

We acknowledge that redirecting Medicare GME dollars toward ambulatory and primary care training may cause some dislocations in the hospitals currently receiving these GME funds. However, the fact that training institutions will have to undergo change must not dissuade Congress from reforming Medicare GME. By removing the conflicting incentives of Medicare GME and managed care, these institutions can bring their service and training missions into alignment.

In making the following recommendations, we emphasize the importance of acting now. Because the current physician oversupply is so large and the training pipeline so long, any changes enacted now will not have a perceptible impact on the physician supply for some decades to come.

To address the physician surplus, a limit should be placed on the number of funded first-year allopathic and osteopathic residency positions equal to 110 percent of the number of U.S. medical school graduates and phased in over a period not to exceed 5 years. In addition, a national consortium should develop recommendations on the number of funded residency positions, taking into consideration societal need for these services, the number of graduates from U.S.

medical schools and the patient care needs of institutions that have a high proportion of residents who are IMGs.

In order to increase the number of physicians practicing primary care, Congress should establish an initial target of training at least 50 percent of new physicians in true primary care programs whose graduates enter primary practice. In determining eligibility for GME funding, quality should be the primary criteria. Other criteria should include the public's need for health care services, the demonstrated geographic location and career choice of program graduates, and whether or not the program truly produces generalist physicians. In addition, special consideration must be given to the needs of inner city and rural areas and to increasing the number of minority physicians.

The national consortium would determine the national average per resident amount as well as factors responsible for legitimate variations in GME payment costs. Eligible institutions for receipt of GME payments would be those sponsoring residency programs, which would include the teaching hospitals, medical schools, HMOs, group practices, federally qualified health centers, approved training consortia and other entities, such as the ambulatory-based programs.

The consortium should determine the indirect costs of GME, in ambulatory and inpatient training facilities, with both inpatient and ambulatory training sites eligible for payment. The distribution of GME funds should be accomplished through the individual programs. Alternatively, the allocation of funding could be accomplished through the approved regional or state training cooperatives. The consortium should undertake studies to assess the adequacy of the physician supply, as well as other studies relating to the mix of physicians and distribution of health care services.

Finally, the Academy believes that the direct, indirect, and transitional costs of graduate medical education should be distributed across all payers, public and private alike.

I would like to thank you for this opportunity to speak with you about the graduate medical education program and I look forward to answering any questions.

[The prepared statement follows:]

STATEMENT OF
PATRICK B. HARR, M.D.
AMERICAN ACADEMY OF FAMILY PHYSICIANS

My name is Patrick B. Harr, M.D., and I am President-elect of the American Academy of Family Physicians. In addition, I am in private family practice in Maryville, Missouri. On behalf of the Academy's 83,000 members, I appreciate the opportunity to address issues related to Medicare's support of graduate medical education (GME) and, in particular, the recent workforce reports of the Pew Health Professions Commission and the Institute of Medicine.

The Pew and IOM Reports in Context

The Pew Health Professions Commission and the Institute of Medicine are to be commended for producing comprehensive, timely, well-documented reports with many thought-provoking recommendations. These reports, however, should be viewed in the context of a three-decade history of similar reports, all of which have come to similar conclusions about composition of the U.S. physician workforce. What is remarkable is not so much the reports' recommendations regarding the size and specialty mix of the U.S. health care workforce, but, rather that policy makers have for so long failed to act on similar recommendations.

Thirty years ago the Millis Commission warned that the physician workforce had become overly specialized. Many other reports over the ensuing years have arrived at similar conclusions. Yet, the situation is far worse today. Mr. Chairman, what the Pew and IOM reports show us is that the health care system has evolved; what defined the American health care system in the past is not what defines it now or in the future. Yet, the bulk of our health care resources are still directed at inpatient, subspecialty care and research, while health care itself has moved out of the hospital and now places much greater emphasis on primary and preventive care. If there is one take-away message from the Pew and IOM reports, it is that it is time to stop studying this issue and start implementing corrective action.

Given the history that lies behind these reports, it is also important to avoid becoming distracted by their many individual recommendations, although each of them is worthy of debate. What is important is the reports' clear vision of where the U.S. health care system is going. That vision is one in which our health care system has a firm foundation in primary care. The Academy believes that current federal GME policies are severely misaligned in regard to where the health care system needs to be, and the failure to realign those policies has forced the federal government and the country as a whole to pay an extremely high price in terms of health care cost, quality, and access.

U.S. health care system is, in may ways, failing to meet the health care needs of the country because it is so overly specialized. Cost, quality, and access have all suffered. That is the price of failing to reorient the incentives driving health care training institutions with the health care needs of the nation. Higher costs mean not only larger federal budget deficits, but also unaffordable health insurance and greater numbers of uninsured individuals, whose care is more expensive and of lower quality. As we all know, uninsured individuals are eventually able to get health care, but it is often delayed, results in poorer outcomes, and is more expensive than it would be with ready access to primary care. Furthermore, those of us fortunate enough to have health care insurance wind up paying for the costs of caring for the uninsured anyway. With employers becoming less likely to provide health care insurance, this is a problem that is getting worse, not better.

Defining Primary Care

One of the most significant contributions of the IOM report is its detailed definition of primary care. As the contribution of primary care to health care delivery has become more widely recognized, having a clear, accurate definition has become more important. Primary care is not a simple range of tasks but rather the broadest, most comprehensive mode of health care delivery, and it is that part of medical practice with the greatest amount of uncertainty. Not all health care providers are inclined by personality or training to cope with the inherent uncertainty of primary care practice.

As defined in the IOM report, "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Value of Primary Care

Both the Pew and IOM reports emphasize the contribution of primary care to health care cost, quality, and access, a contribution that is largely unrealized by a health care system oriented toward specialty care. Both reports also note that the future of the health care system lies in primary care.

The Academy recently commissioned a study by the Barents Group, LLC of KPMG Peat Marwick, LLP, which examined the value of primary care. *The Role of Primary Care Physicians in Controlling Health Care Costs: Evidence and Effects* is a comprehensive review of existing studies on the role of primary care physicians in controlling health care costs. Among the findings of the study are:

- Primary care physicians produce services in a more cost-effective manner than do sub-specialists, with comparable outcomes.
- A significantly larger proportion of all necessary and appropriate health services could be provided by primary care physicians than is currently the pattern in the United States, offering the potential to reduce health care costs without sacrificing services or affecting outcomes.
- Projected Medicare outlays could be reduced significantly if the mixture of primary care physicians to sub-specialists were altered.

Specifically, the study indicated that Medicare spending could be reduced by at least $48.9 billion and as much as $271.5 billion over the next six years if primary care physicians were 50 percent of the total physician workforce. The analysis revealed a direct correlation between the availability of primary care physicians and the reduction of health care costs.

This study and others like it illustrate a glaring reality of American medicine: it is overly specialized and overly costly, and the two factors are directly linked. No matter what proposals the Congress may choose to adopt, **the cost explosion in the Medicare program will not be brought under control until Congress improves the availability of primary care services.**

Primary Care and Managed Care

Both the Pew and IOM reports tie the rise in primary care to the expansion of managed care. While it is true that managed care is able to achieve quality improvements and contain costs by emphasizing primary care, the benefits of primary care are no less applicable and no less important in the fee-for-service sector. The KPMG study referenced above demonstrated substantial Medicare savings to Medicare in its traditional fee-for-service program.

Misalignment of Federal Incentives

Medicare GME policies are largely responsible for the over-specialization of the physician workforce. These policies promote training in expensive inpatient settings and emphasize the procedurally-oriented subspecialties rather than in family practice and other generalist specialties. Medicare GME payments go exclusively to hospitals, where subspecialist physicians are primarily trained, rather than to ambulatory care sites, such as clinics and offices, where generalist doctors receive much of their training. A May, 1994 General Accounting Office (GAO) report reiterated that "barriers to primary care training persist in Medicare's payment method."

Medicare GME expenditures are expected to reach $6.3 billion dollars this year. Medicare's GME support constitutes an open-ended entitlement for hospitals that are able to establish accredited residency programs of any size and in any specialty without regard to local or national health care needs. The lack of accountability along with Medicare's incentives toward inpatient and sub-specialty training constitute an irresponsible use of tax-payer dollars. Reforming Medicare GME in order to both control GME expenditures and account for their use requires that

the federal government (1) establish broad national goals in regard to the physician supply and (2) align Medicare GME spending to achieve those goals.

The only current federal programs specifically targeted at increasing the supply of primary care providers are authorized by Title VII of the Public Health Service Act. However important these programs might be, their influence on the physician workforce is minor compared to Medicare's GME support. The annual funding for these PHS programs is less than $150 million as opposed to $6.3 billion in Medicare GME support and $11 billion in NIH research and training funding.

Market Incentives

Powerful incentives are at work in the health care market. The job market for physicians is changing dramatically, with primary care physicians in high demand and gainful employment in a number of subspecialties no longer guaranteed in every location. Medical school graduates are clearly reading the market signals before choosing residency training. For example, both the number of family practice residency positions and percentage of those positions that are filled are at an all-time high. While this is an encouraging trend, it has strained severely our training programs. Because family practice training is based largely in ambulatory settings, and because the major source of financial support for GME, Medicare, is almost entirely directed at hospital-based training, our residency programs are finding it increasingly difficult if not impossible to make ends meet. For example, there are currently over 1100 faculty vacancies in family practice residency programs, primarily because these programs are unable to offer competitive salaries.

Notwithstanding the above paragraph, it is essential for the members of this Committee to understand why market forces have limited impact on training institutions. The driving forces in the health care market are the purchasers of care, be they individual patients, health plans, or employers. These entities purchase health care services, either at the individual level, or at the level of a health plan. None of these entities purchase health professions training. Indeed, it makes little sense for a health plan to pay for training, because the benefit of an individual health plan's investment in training is not restricted to that plan. In economic terms, health professions training is a public good. Health care providers, with the exception of those with obligated scholarships, can go wherever they wish upon completion of training. Even if the bulk of health plans were to provide training support (there are a few that do) leaving training decisions to health plans would, by no means, ensure that national health workforce needs would be met.

To the extent that they also provide health care services, training institutions will respond to the market's demand for health care services. However, the dollars for training come from other sources, primarily from Medicare, which richly rewards institutions for training providers of inpatient care and procedural services. What these institutions face is a growing conflict between the incentives signaled in Medicare's GME support (inpatient and procedural services) and the signals of the health care market place (ambulatory and primary care services). Traditional, inpatient-oriented training institutions that may wish to respond to the market's new incentives do so at the peril of losing Medicare GME dollars, in some instances, substantial dollars.

Impact on Teaching Hospitals

It is well known that Medicare GME dollars are used by a number of training institutions to subsidize the provision of health care services to indigent patient populations. That is, Medicare GME is supporting the provision of health care services rather than its intended educational purposes. Furthermore, these training programs tend to train physicians in specialties that are already over-supplied. Redirecting Medicare GME dollars toward institutions that provide ambulatory and primary care training may cause some dislocations in the hospitals currently receiving GME funds. While Congress may wish to establish a separate fund to soften the impact of these dislocations, the fact that training institutions will have to undergo change must not delay Congress from undertaking the task of reforming Medicare GME. It no less important for large inner-city teaching hospitals to develop their own primary care base than it is for any other health care institutions. By reorienting their training programs toward primary care, these institutions

could also qualify for ambulatory and primary care training dollars. Furthermore, by removing the conflicting incentives of Medicare GME and the increasingly managed care market, these institutions can more easily bring into alignment their service and training missions.

Recommendations

The Academy offers the following recommendations for reforming Medicare's GME support. As noted earlier, controlling Medicare GME expenditures and responsibly accounting for their use requires that Congress establish broad national goals for the physician workforce and align Medicare GME spending to achieve those goals.

A number of concerns have been raised in regard to the federal government's taking a more active role in directing the expenditure of Medicare GME funds. The most frequently raised concern is that the federal bureaucracy will be unresponsive to changing health care needs and that distortions in the supply of physicians will persist in one form or another. We note that the current physician oversupply is so large and the training pipeline so long, that any changes put into place now will not have a perceptible impact on the physician supply for years to come. Similarly, there will be ample opportunities for mid-course corrections.

Another concern that has been raised is that targeting the expenditure of Medicare GME funds to meet national workforce needs will impinge on the academic freedom of training institutions. We believe this concern to be misplaced. Requiring accountability for the expenditure of public dollars is wholly different from determining the structure and content of training programs.

Finally, Medicare GME reforms have been criticized for potentially constraining the specialty choices of medical school graduates. In fact, it is the current Medicare GME support that constrains choice. As noted above, changes in the market are influencing graduates' choices of residency training. Because of the inpatient and subspecialty bias in Medicare GME funding, training institutions are hampered in their ability to respond to those changes.

Aggregate number of eligible residency positions

In order to address the aggregate physician surplus, an initial limit should be placed on the number of eligible first-year allopathic and osteopathic residency positions equal to 110 percent of the number of U.S. allopathic and osteopathic medical school graduates. This limit should be phased in over a period not to exceed five years. A national consortium (see below) should develop recommendations on the number of eligible residency positions taking into consideration societal need for physician services, the number of students graduating from U.S. allopathic and osteopathic medical schools, and the patient care needs of institutions that have a high proportion of residents who are international medical graduates (IMGs). As part of its ongoing duties, the national consortium should re-evaluate its recommendation relative to the aggregate number of eligible residency positions.

Primary care - non-primary care distribution

Because of the extreme over-specialization of the physician workforce, Congress should set a goal of increasing dramatically the number of physicians practicing in the primary care specialties of family medicine, general internal medicine, and general pediatrics. To achieve this goal, Congress should establish an initial target of training at least fifty percent of new physicians in programs whose graduates enter primary care practice. However, the national consortium described below should be permitted the flexibility to recommend an implementation plan that differs from the initial target percentage provided that its recommendation is based on scientific and analytical data and that the recommendation remains fully consistent with the goal of increasing dramatically the number of physicians practicing in primary care. Furthermore, Congress should specify that under no circumstances should the number of training positions in the primary care programs be reduced below current levels.

Allocation criteria

In general, quality should be a primary criterion in determining eligibility for graduate medical education funding. Only residency programs that are accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association Council on Postdoctoral Training should be considered for eligibility. Methods for assessing quality should be developed by the ACGME and its Residency Review Committees and the AOA Council. In approving eligible residency programs, other criteria that should be considered include the public's need for health care services, the demonstrated geographic location and career choices of program graduates, and the relevance of curricula to future generalist practice. The Secretary would be required to give special consideration to the needs of inner-city and rural areas and to increasing the proportion of physicians in under-represented minorities.

Direct medical education payments (DME)

The national consortium would determine the national average per-resident amount as well as factors responsible for legitimate variation in DME costs. Eligibility for DME payments would be based on the recommendations of the national consortium consistent with the specified allocation criteria. Entities eligible for receipt of DME payments would be those institutions sponsoring residency programs, which could include teaching hospitals, medical schools, health maintenance organizations, group practices, federally qualified health centers, approved training consortia, or other entities, including ambulatory-based programs.

Compensation for the direct costs of graduate medical education should be based on a national average per-resident amount. Per-resident amounts should be weighted to recognize legitimate variation in direct costs due to variables such as the use of ambulatory training facilities and regional differences in wages and wage-related costs. Entities receiving DME payments would have to submit documentation demonstrating that DME funds are expended only for direct costs of graduate medical education.

Indirect medical education payments (IME)

The national consortium should determine the indirect costs of graduate medical education in ambulatory and inpatient training facilities. Indirect costs include legitimate differences in patient care costs between teaching and non-teaching facilities. Both inpatient and ambulatory institutions serving as training sites for eligible residency programs could receive payments for the indirect costs of graduate medical education.

Transition payments

The national consortium should determine the transitional costs associated with unmet patient care needs in teaching hospitals that undergo a reduction in the number of accredited and filled residency positions. Transitional funds should be derived from an account separate from that used to pay for graduate medical education costs and should compensate for the costs associated with unmet patient care needs in teaching hospitals that are preparing or anticipating a reduction in the number of accredited and filled residency positions. Teaching hospitals initiating reductions in the number of accredited positions should have immediate access to transitional payments. Any phased reduction of transitional funding should be accompanied by longer-term solutions to unmet patient care needs such as an expansion of the National Health Service Corps.

Methods of allocation

The designation of eligible residency positions and the distribution of GME training funds should be accomplished through approved individual programs. Alternatively, allocation of positions may be accomplished through approved regional or state training consortia. In either case, the method of allocation should be consistent with national goals related to the aggregate number of training positions and the primary care - non-primary care mix of specialties.

Research

The national consortium should be required to undertake or commission studies to (1) assess the adequacy of the aggregate physician supply in relation to the public's need for health care services; (2) determine the appropriate mix of physicians in the primary care and non-primary care specialties; (3) assess the geographic distribution of health care services; (4) assess the status of minority representation in the various specialties; (5) determine the direct costs of graduate medical education including salaries, fringe benefits, and associated teaching costs; (6) determine the indirect costs of medical education in inpatient and ambulatory teaching facilities; and (7) determine direct transitional costs associated with unmet patient care needs in teaching hospitals that undergo a reduction in the number of accredited residency positions.

Implementation timetable

Full implementation of Medicare GME reform should be achieved in the shortest span of time that provides an opportunity for teaching hospitals to adjust to changes in their resident complement, for medical schools to adjust their curricula, and for entering medical students to be fully informed of the opportunities for graduate medical education. Five years from enactment is a reasonable target for full implementation.

Primary care practice incentives

Achieving and maintaining a balanced specialty mix will require measures beyond the reform of graduate medical education. It will be necessary to adequately fund the development and implementation of medical school curricula that increase students' exposure to ambulatory primary care training. Those factors that support primary care practice must also be addressed. These factors include increased stipends for physicians in primary care residency programs, adequate and fair reimbursement for primary care services; incentives for practice in underserved communities such as bonus payments, loan forgiveness, special income tax exemptions, and an expansion of the National Health Service Corps; the availability of funds for the capitalization of inner-city and rural primary care systems; and the development of referral and consultation networks.

National Consortium

Medicare's current support of GME is not only misaligned, but it is also rigid. It is probably not possible to design a system that is completely incentive neutral (i.e., one that is fully able to adjust to market signals regarding the desired mix of specialties without resulting in financial gain or loss to training institutions). For this reason, the Academy supports the creation of a public-private workforce consortium. Such a consortium should be broadly representative and, to the extent possible, insulated from the political process. **The consortium would be responsible for:**

- **projecting the aggregate need for the medical care workforce in the health care delivery system;**
- **making recommendations relative to the number of residency positions on a national basis, including the number of international medical graduates (IMGs), and maintaining the appropriate ratio of generalists to specialists;**
- **making recommendations regarding the allocation of residency positions by specialty and subspecialty according to population needs;**
- **recommending appropriate incentives to reinforce the selection of primary care by medical school graduates;**
- **conducting on-going research that will ensure the availability of appropriate data on which to base workforce decisions; and**
- **evaluating and monitoring the efficacy of all recommendations and their implementation, ensuring that the process allows for flexibility, particularly during a transition period, and reevaluating recommendations as appropriate.**

The consortium would make annual recommendations regarding the aggregate number of

physicians and the distribution of physicians in the primary care and non-primary care specialties. If the Secretary of the Department of Health and Human Services accepts the recommendations of the consortium, then he or she may proceed to publish in the *Federal Register* an interim final rule with comment period. If the Secretary decides to alter the recommendations of the national consortium, then he or she must publish in the *Federal Register* a proposed rule that includes an explanation of the specific areas where the Secretary disagrees with the recommendations of the national consortium and allows for a 60-day comment period.

The national consortium would also monitor and review the decisions of the Secretary of DHHS related to the specific number and specialty mix of approved residency positions in order to assess conformance with national goals. The national consortium could recommend modification of eligibility decisions in order to address the supply of specific specialties that remain in under- or over-supply.

The national consortium should be an autonomous and broadly representative body. It should be composed of knowledgeable individuals who have gained national stature for their expertise in health economics, graduate medical education, medical practice, and other related fields. A majority of its members should come from the medical profession, including practicing physicians in the primary care specialties, physicians who are faculty members of primary care residency programs, and physicians-in-training. The national consortium should be of sufficient size to ensure appropriate diversity in its membership, and it should include representation from the Departments of Veterans Affairs and Defense. The provisions currently applicable to the Prospective Payment Assessment Commission and Physician Payment Review Commission would apply to the national consortium in regard to staffing and administration, compensation of members, access to information, use of funds, periodic GAO audits, and requests for appropriations. Any government officials seated on the national consortium would serve in a non-voting capacity.

All-payer support

While the specific issue of today's hearing is Medicare's graduate medical education support, it must be recognized that Medicare's disproportionate share of the nation's GME burden produces distortions in the GME system related to the specific mission of the Medicare program. Medicare is structured to meet the needs of its elderly and disabled beneficiaries, while health professions training institutions must address the health care needs of the nation as a whole. Therefore, we believe that the direct, indirect, and transitional costs of graduate medical education should ultimately be distributed across all payers, public and private. After projecting the annual expenditures for graduate medical education, an annual GME surcharge should be applied to all health insurance premiums so that all payers contribute a proportionate amount toward GME costs.

Until an all-payer system of GME support can be established, it is essential that Medicare GME support not be decreased precipitously. Doing so will have a disproportionate impact on the most financially vulnerable training programs, which are those in the primary care specialties most needed.

Conclusion

As this committee continues its important work in reforming Medicare GME support, please do not hesitate to call upon the American Academy of Family Physicians. Family physicians are eager to work with you on this challenging undertaking.

Thank you for this opportunity to speak with you about graduate medical education. At this time, I would be happy to answer your questions.

Chairman THOMAS. Thank you very much and I will turn over the introductions of Dr. Cutler to the gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you. It is a pleasure to welcome Dr. Cutler here today. I have worked with him on many of these kinds of issues over the last 2 years. I am pleased he could be with us today and be a part of this point of the discussion.

Thank you for being here, Dr. Cutler.

STATEMENT OF LESLIE S. CUTLER, D.D.S., Ph.D., CHANCELLOR AND PROVOST, HEALTH AFFAIRS, UNIVERSITY OF CONNECTICUT HEALTH CENTER, FARMINGTON, CONNECTICUT

Dr. CUTLER. Thank you. First, let me say thank you to the Chairman and to Mrs. Johnson for their leadership in GME and this whole area, which is critically important to academic health centers.

I am Leslie Cutler. I am chancellor and provost for health affairs at the University of Connecticut Health Center. The Health Center has a medical school, a dental school, other health professions and graduate schools and its own teaching hospital and an integrated network of seven teaching hospitals to facilitate medical education. These hospitals have been organized as the Capital Area Health Consortium from several years.

We have heard from many of the other speakers about the changes in the health care workforce and the way the delivery of health care is moving out of hospitals and into ambulatory settings. A recent report from the Kaiser Health Plan of California indicates that at the end of the eighties and in the early nineties, the average Kaiser patient was in the hospital for care once every 7 years. By the year 2004, they are predicting the average Kaiser patient will only need to be hospitalized once every 16 years.

This does not mean that there will be less care, but the care delivered will be delivered in outpatient arenas rather than in the hospital.

The first chart shows two things: First, it shows you the obvious complexity of the payment system for graduate medical education. Second, the chart makes some important points. Medicare and Medicaid are the only payers of graduate medical education in the country. That is, we pay for graduate medical education with payments from the sick, poor, and the infirm, old. Virtually all the funds that are provided by these governmental sources flow directly to teaching hospitals and then, only on the fee-for-service patients.

Also the amount of the direct and indirect medical education payments received by the hospitals are directly linked to the number of residents in training. As other speakers have said, that provides an incentive to increase the number of residents.

There are other charts that could be put up, but they only reiterate what others have already said. They summarize some of the major changes in the delivery of health care, and correlate these changes and revisions in the education of the residents. They highlight needed revisions in the way GME is funded to achieve the desired outcomes. But, the most important factor is the shift to primary care medicine, and we all realize that primary care medicine

is not delivered in the hospitals. But, the GME funds flow only to hospitals. Similarly, even within medical specialty practice, more and more of the care is being delivered in outpatient sites. Therefore, funds that now flow only to hospitals must also be distributed to support training in ambulatory settings.

In addition, the trend toward managed care has created a dramatic change for academic medical centers. Current education paradigms do not focus as intently as they might on insuring the new generations of health care practitioners are educated to practice medicine in a manner compatible with the best principles of managed care. The cost of reegineering this entire medical education model must be covered from funds outside the traditional reimbursement scheme.

In the future, graduate medical education will involve many players beyond the traditional teaching hospital. Therefore, additional recipients of both direct and indirect medical education payments must be considered. The medical education consortium can be defined as an association of teaching hospitals, academic medical centers, ambulatory clinics, physician practices and other organizations including HMOs and insurers involved in medical care and medical education. Such a consortium can provide a structure to ensure the continuity of education and to develop centralized support for the direction and coordination of its members.

I would like to note that, our Capital Area Health Consortium has for several years served the paymaster and personnel functions for many of our integrated residency programs. Our consortium has served as a vehicle for planning and organizing many of our joint graduate medical education programs and, as we expand this consortium, we are bringing a continuum of care experience that involves family practice and other residents as well as medical students in a variety of curriculum alterations in our school of medicine. Many of these changes and the movement to ambulatory sites are not covered for graduate education by current graduate education payments.

Funding for consortium could come via shared responsibility funds from Medicare. However, given the value of medical education to all participants in the health care system, as well as the importance for ensuring the adequate funding of the special missions of academic health centers and teaching hospitals, it is clear that some new form of payment to finance the special costs incurred in these teaching institutions is appropriate. Such a payment system might include funding from all payers, health plan and insurance premium assessments, provider assessments, general revenue, and specific assessments on activities that raise health risks. Such payments could not only provide needed funds, but also help ease the financial burden carried solely by the Medicare systems graduate medical education funds currently included in capitation payments made through insurers offering Medicare or Medicaid managed care programs, should be withheld and returned to a pool specifically designated for graduate medical education. Payments for graduate medical education should be available to consortia. Whenever possible, a school of medicine should play a role in leading the consortium since education rather

than the provision of service should be the focus of graduate medical education programs.

Transitional replacement fundings needs to be made available to those teaching hospitals that hospitals that lost funding. It is interesting that the Medicare Preservation Act had several positive components that facilitated this mission: the trust fund that included funding from other sources than Medicare, consortia authority, decreased training for specialists and a moratorium on new residents, all of which will facilitate graduate medical education.

I would like to thank the Chairman and Ms. Johnson for the opportunity to talk to the Subcommittee and I am here to answer questions.

[The prepared statement and attachments follow:]

STATEMENT OF
LESLIE S. CUTLER, D.D.S., PH.D.
UNIVERSITY OF CONNECTICUT HEALTH CENTER

Mr. Chairman and members of the Committee, I am Leslie S. Cutler, Chancellor and Provost for Health Affairs at the University of Connecticut Health Center. I welcome the opportunity to comment at this hearing on Medicare's financing of Graduate Medical Education (GME). The University of Connecticut Health Center is an academic medical center with a medical school, other health professions and graduate schools, its own teaching hospital, and an intimately integrated network of seven community teaching hospitals which facilitate both undergraduate and graduate medical education. These teaching hospitals have been organized in the "Capitol Area Health Consortium" for several years.

It is not necessary to underscore to this group the dramatic changes that are occurring in both the delivery and financing of health care across our nation. The reports by the Pew Health Professions Commission and the Institute of Medicine on the size and composition of the country's health care workforce have emphasized the need for enhancing our primary care capabilities while reducing the number of medical specialists and subspecialists. At the same time, advances in science, medical technology and the expansion of managed care have facilitated the movement of substantial amounts of medical care from the hospital to ambulatory settings. In addition, these factors have helped reduce the length of time individuals must spend in the hospital should they require inpatient care. Indeed, a recent report from the Kaiser health system in California indicated that in 1990 the average Kaiser member (there are about 4.5 million in California) required hospitalization for medical care once every seven years. With the improved utilization of primary care physicians, the introduction of prevention and wellness programs, and the ability to deliver increased amounts of care in ambulatory settings, Kaiser predicts that shortly after the turn of the century their average member will only need hospital-based care once every 16 years. This does not mean that there will be less medical care delivered but rather that the bulk of the care provided will occur in outpatient sites. It also suggests that, in the future, when someone does enter a hospital they will be more acutely ill and require highly specialized and very intense levels of care.

The recent report on the solvency of the Medicare Trust Fund points out the challenges the country faces in financing health care. The way in which the nation chooses to solve the dilemmas in financing Medicare, in particular, and health care, in general, will have a substantial impact on our ability to educate the workforce that will provide the care we, as a nation, both need and demand. This is the case because the choices we make will have significant implications for the way that undergraduate and graduate medical education are funded.

This chart shows the way Medicare currently funds graduate medical education. Aside from the obvious complexity, I would like to make three key points regarding the funding of GME: 1) currently, there are only two sources of funds to support graduate medical education: the Medicare program, and in most states, Medicaid programs. While everyone benefits from, and demands, the presence of a high quality medical workforce, only governmental payments related to the sick elderly and the infirm poor support the education and development of that workforce, 2) virtually all of the funds provided by these governmental sources flow directly to teaching hospitals which have traditionally done a superb job of educating graduate physicians as well as providing clinical research, highly specialized care for the sickest of patients, technical advances, and the lion's share of care for those less fortunate in our society, and 3) the amount of the direct medical education payment received by the hospitals is linked to the numbers of residents in service while the indirect medical education payment is tied to the number of residents per bed in the hospital. Both of these payment formulas tie graduate medical education to the inpatient setting and are structured to provide incentives to increase the number of residents in training. At the same time, while there is some reimbursement for training in hospital based ambulatory care settings, there is virtually no payment for training in outpatient settings provided by organizations other than hospitals.

The next chart shows four major trends in the delivery of health care. First, there is a reduction in the need for the number of medical specialists and subspecialists coupled with an increased need for primary care practitioners. Second, there is a trend to decrease the amount of care which requires hospitalization and there is a concomitant increase in the amount and types of care which can be delivered in ambulatory settings. Third, there is a reduction in the length of time patients spend in the hospital, for even the most serious medical problems. This decrease in the time spent in the hospital is correlated with our increased ability to deal with patients in lower cost transitional/subacute care and homecare settings. The fourth trend is the continuing

constriction of the reimbursement for health care services. There is a movement away from the traditional fee-for-service type payment and movement towards managed care and capitation, both in Medicare and Medicaid as well as in the private sector.

The final chart summarizes the changes we must make in the way we educate the medical workforce that logically follow the evolving trends in the health care marketplace. These changes are correlated with needed revisions in the way we fund graduate medical education in order to appropriately achieve the desired outcomes. First, primary care medicine is not delivered in the hospital. The increased emphasis on primary care over specialty medicine leads to a need for increased training in ambulatory settings and a reduction of training in hospital venues. Therefore, funds that now flow only to hospitals must also be distributed in a way that supports training in ambulatory sites. Similarly, even within medical specialty practice, more and more of the care will be delivered in ambulatory sites and surgicenters rather than in the hospital. Thus, a portion of the funds targeted for specialty training must be available for training and education in outpatient centers. Correlated with the reduction in inpatient length of stay is the need for increased education and training in transitional/subacute care sites. Finally, the trend towards medical practice, which is of high quality but cost-effective within the managed care context, requires a revamping of both the undergraduate and graduate medical educational experience. Current educational paradigms do not focus as intently as they might on the mechanisms for insuring that the new generations of health care providers are educated to practice medicine in a manner compatible with the best principles of managed care. The cost of this reengineering of the medical education model must be covered by funds outside the traditional reimbursement schemes.

The requisite changes in both undergraduate and graduate medical education will involve many players beyond the traditional teaching hospital. Therefore, a new, or additional, focus as a recipient of both direct and indirect medical education payments must be considered. The Medical Education Consortium (MEC) provides such a structure. A MEC could be defined as an association of teaching hospitals, academic health centers with their medical and other health professions schools, ambulatory clinics, physician practices (individual or group), and other organizations involved or with interest in medical education. Such consortia could provide enhanced mechanisms to assure the continuity of medical education and to develop centralized support, direction, and coordination for its members so that they function collectively to meet the challenges and changing needs of the community as well as nation's health care system. I would like to note that our "Capitol Area Health Consortium" has, for several years, served a paymaster and personnel function for our many integrated residency programs. The "Consortium" has also served as a vehicle for planning and organizing many of our residency programs. The positive, cooperative interaction, within our consortium, to facilitate area wide planning and coordination of graduate medical education and other health care delivery issues demonstrates the value of such consortia. These consortia need to include a broader array of members and the funding of GME needs to support education at all of these sites.

The quality of the educational programs within the consortia should be under the leadership of the Accreditation Council for Graduate Medical Education and the consortia's academic health center/medical school (if one were available). Residencies, which were primarily service-oriented, would need to be a redesigned to primarily address the educational needs of the trainees. Funding for such consortia could come from a "shared responsibility" fund from Medicare. However, given the value of medical education to all participants in the health care system as well as the importance of insuring adequate and stable funding for the special missions and activities of academic health centers and teaching hospitals, it would seem that some new form of payment to finance the special costs incurred by these teaching institutions is appropriate. Such a payment system might include funding from all payers, health plan and insurance premium assessments, provider assessments, general revenue, and specific assessments on activities that raise health risks. Such supplements could not only provide needed funds but also help ease the financial burden currently carried by the Medicare system.

Graduate medical education funds currently included in capitation payments to insurers offering Medicare or Medicaid managed care programs should be withheld and returned to a pool specifically designated for graduate medical education. Payments for graduate medical education should be made to consortia or, if not available, to organizations or entities that incur the costs of the educational programs. For graduate medical education consortia in which multiple

organizations incur education expenses, the consortia should demonstrate general agreement among the participants on the distribution of the funds. Whenever possible, an academic health center/school of medicine should be included in a consortium and should play a leading role in the consortium since education, rather than the provision of service, should be the focus of a graduate medical education program.

Transitional and replacement funding should be made available to buffer those teaching hospitals that lose funding as existing inpatient residency training positions and programs move to outpatient venues and as education becomes more central to some residency programs. Sudden changes in the number and specialty mix of residents and their sites of training could disrupt the service activities of some teaching hospitals and could have broad effects on both the institutions and the communities they serve. Consideration for provision of a funding source to help such institutions through a transition in workforce composition should be seriously evaluated.

Let me briefly mention the importance and value of schools of medicine in providing the educational leadership that develops both undergraduate and graduate physicians. Focus on graduate medical education alone ignores the costs and needs of the institutions that educate those who will become "graduate medical trainees" we are discussing today. Please be aware that there is essentially no federal, and only limited state, support for undergraduate medical education. Keep in mind that the development of the pool of medical graduates that is the focus of this session, is funded largely through tuition and the provision of resources generated by the practice of medicine in ambulatory and hospital venues by the schools' faculty. A national fund should be established to assure adequate and stable funding for the special missions and activities of medical schools. Such a fund will be critical for most medical schools to remain fiscally viable and to fulfill their primary missions of education and research. These missions are increasingly under pressure as the marketplace eliminates the margins derived from the schools' clinical enterprise which serve to subsidize the academic mission. Since all of us ultimately benefit from the development of a high quality health care delivery workforce, this fund should come from assessments to all payers, health plan and insurance premiums, general revenues and other mechanisms such as specific taxes on activities that raise individual or group health risks.

I would like to thank the chairman and the committee for their efforts in this extraordinary task of designing a system to support graduate medical education. The academic medical community appreciates your efforts and stands ready to work with you on ways to strengthen the Medicare program and to insure that the nation's health care system continues to provide the best care in the world.

Payment for Graduate Medical Education

Current Direct GME Payment Methodology

Step 1: Calculate hospital-specific per resident amount using FY1984 or 1985 costs and base year number of residents

Step 2: Update base-year per resident amount for inflation

Step 3: Multiply the updated per resident amount by the number of residents in the payment (current) year

Step 4: Determine Medicare's share based on proportion of program's inpatient days

Computing a Hospital's Direct GME Payment

Payment Year Characteristics

• Residents in primary care specialties	=	55 FTEs
• Residents in non-primary care specialties in the initial residency period	=	135 FTEs
• Residents beyond period of initial board eligibility	=	60 FTEs
• Total Number of Residents		250 FTEs
• Medicare's Share of Inpatient Days		30%

Step 1:

• Based on 1984 or 1985 costs and base year number of residents

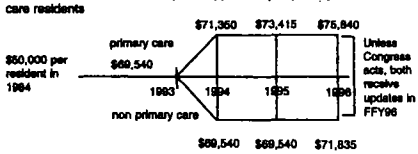
(Historical Audited Costs/Number of FTE Residents)

($10,000,000/200 FTEs) = $50,000 per resident amount

Step 2:

Update using percentage change in CPI-U

For FFY 94 and 95, inflation update applies only to primary care residents



Step 3:

• Two calculations: Primary Care (PC) and Non-Primary Care (NPC) Residents

A. (PC Per Resident Amount* Number of FTE PC Residents)
($75,840* 55 PC Residents) = $4,171,200

B. (NPC Per Resident Amount* Number of FTE NPC Residents)
($71,835* 135 NPC residents) + $71,835* (60* .5)) =$11,852,775)

C. Determine PC and NPC Aggregate Amount
$4,171,200 + $11,852,775 = $16,023,975

Step 4:

Medicare Inpatient Days = 30,000
Total Inpatient Days = 100,000
Medicare's Share = 30,000/100,000 = 30%

Aggregate * DGME Amt	Medicare's Share	= Direct GME payment
$16,023,975 *	30%	= $4,807,193

Current IME Payment Methodology

Step 1: Determine your hospital's resident-to-bed ratio (IRB).

Step 2: Insert your hospital's IRB into formula.

Step 3: Calcuate the IME payment.

Indirect Medical Education (IME) Adjustment

• Percentage add-on payment to basic DRG payment.

• Compensates teaching hospitals for higher inpatient operating costs due to:

- severity/DRG weaknesses
- operating costs associated with education programs

• Based on statistical analysis using intern and resident-to-bed ratios (IRB)

• Current level is 7.7% for every 10% increment in IRB

• 1,081 hospitals receive $4.3 billion in FFY96

Step 1:

Calculate IRB by dividing interns and residents FTE count by number of PPS beds.

eg: IRB = 150 FTE ÷ 500 beds = .30

Step 2:

Insert result from step 1 into IME formula.

IME % add on = $[1.89\ (1+IRB)^{.405}-1]\ 100$

$21.19\% = [1.89\ (1+.30)^{.405}-1]\ 100$

Step 3:

Apply percentage from step 2 to DRG payments.

Assume payment for DRG 106 = $23,228

IME payment = ($23,228 x 21.19%) = $4,922

Trends In Health Care Delivery

- ↓ Specialists
- ↓ Inpatient Care
- ↓ Inpatient Stay
- ↓ Payment & ↓ Fee-For-Service

- ↑ Primary Care
- ↑ Ambulatory Care
- ↑ Transitional & Home Care
- ↑ Managed Care (Private sector & Medicare & Medicaid)

Changes Needed in the Funding of GME

- Decrease specialist training in total and increase primary care and specialist training in ambulatory sites
- Make funds available for training in ambulatory sites. Fund ambulatory training sites in addition to hospitals
- Ambulatory sites include clinics, surgicenters, physician offices, group practices
- Support Medical Education Consortia (MEC) - hospitals, AHCs, clinics, physician offices, surgicenters, etc.
- Education trust fund is required

Chairman THOMAS. Thank you very much.

[The introductory statement of Hon. John Ensign follows:]

I am pleased to welcome Dr. Anthony Marlon, Chief Executive Officer and Director of Sierra Health Services, as a distinguished witness before the Ways and Means Health Subcommittee. He is accompanied today by Dr. Jerry Reeves, Senior vice President, Health Care Operations at Sierra. Dr. Marlon and Sierra represent some of the most creative and innovative thinking in the health care market today.

I would also like to mention the other half of this creative partnership, the University of Nevada School of Medicine (UMC) lead by Dean Robert Daugherty, who could not be here today.

In 1994, UMC and Sierra undertook the process of creating a teaching HMO. Based on the model of the Harvard Community Health Plan, UMC and Sierra developed a program wherein internal medicine residents were integrated into the patient care activities of the plan.

In the summer of 1995, the program was expanded into the outpatient setting. Residents were assigned to one of the HMOs ambulatory sites, saw patients under the supervision of an HMO-employed physician and/or a faculty member assigned to the HMO and, when necessary, follow those patients into the hospital on the HMO's service.

The UMC/Sierra partnership addresses a major shortcoming of current graduate medical education, namely, that the teaching hospital may not always be the best setting for much of graduate medical education. Experts indicate that, on average, American physicians spend over two-thirds of their professional time with patients in an ambulatory setting, much of this on primary care activities.

I believe that the UMC/Sierra model is one that could function as a demonstration project to gather information for other similar models functioning nationwide. This model would be an effective way to collect more information on how public funding could be used to allow ambulatory care settings to be reimbursed for the cost of training apprentice physicians

As we work to continue the task of saving the Medicare system, we must ensure that graduate medical education funding is concentrated in those areas or training programs that are the most cost-effective and accurately address the educational needs of tomorrow's physician.

I am proud to introduce Dr. Marlon who, along with Dean Daugherty of the medical school, have implemented a common sense plan for teaching future physicians in a manner that is advantageous to the student, the school, the health care market, and that which is ultimately best for the patient and the Medicare system.

Chairman THOMAS. Dr. Marlon.

STATEMENT OF ANTHONY M. MARLON, M.D., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, SIERRA HEALTH SERVICES, INC., LAS VEGAS, NEVADA; ACCOMPANIED BY JERRY REEVES, SENIOR VICE PRESIDENT, HEALTH CARE OPERATIONS, SIERRA HEALTH SERVICES, INC., LAS VEGAS, NEVADA

Dr. MARLON. Good afternoon, Mr. Chairman and I would like to thank John Ensign for his kind words. I certainly appreciate the opportunity to speak with you today regarding Medicare financing of graduate medical education.

I am a cardiologist and I am chief executive officer and chairman of the board of Sierra Health Services. With me is Dr. Jerry Reeves, who is a pediatric hematologist oncologist. Dr. Reeves is also Senior Vice President of Health Care Operations at Sierra and is an Associate Dean at the University of Nevada School of Medicine.

In the interest of brevity, I will present only a summary of our testimony but request that our entire statement be accepted into the record.

Sierra Health Services is a publicly traded company that finances, arranges and delivers quality health care to more than a half million people in eight states. We have approximately 2500

employees and we are based in Las Vegas, Nevada. Our wholly owned subsidiaries include the Health Plan of Nevada, the state's largest health maintenance organization and Southwest Medical Associates, the state's largest multispecialty medical group.

The purpose of our comments today is to affirm our commitment to the education of physicians and medical students to successfully meet the needs of delivering medical in the 21st century through a public-private partnership. Medical care in the United States today is shifting, as we have heard, toward ambulatory and office-based care. Even the Residency Review Committee which set the accreditation criteria for residency training programs, have begun to require more outpatient training.

These requirements follow a report from the Council on graduate medical education to Congress which contains suggestions on how to correct the mismatch between the physician work force and the health care system demands. Unfortunately, the funding streams supporting medical education have not shifted to reflect these changing patterns.

We believe future funding should be available to support medical education partnerships between medical schools and HMOs that provide ambulatory primary care training that emphasizes early intervention, preventive services and team-based coordinated care. We are experiencing a paradigm shift in health care from fee-for-service to coordinated care, from institutional care to office and clinic-based care.

The goal is to provide quality, coordinated health care services to patients in order to obtain optimum outcomes, whether it be in the home, the community health center, the doctor's office or the hospital. Integrated care teams supported by information systems provide this coordinated care. These teams need leaders and this is our challenge. How do we educate these leaders and how do we pay for it?

In addressing these changes in our environment, I would like to describe to you the relationship between our publicly traded company and our state-funded medical school.

We at Sierra have had more than a decade long tradition of providing teaching services and clinic practice opportunities for the University of Nevada School of Medicine. Initially, most of this teaching took place in a hospital setting. In 1994, the school of medicine and Sierra expanded a program to integrate internal medicine residents into the full spectrum of patient care activities provided by the health plan of Nevada.

Currently, Sierra and the school of medicine are engaged in a pilot program in which revenues from private patients are used to help fund the education of residents. Continuity of care is emphasized throughout the 3-year training program. A coordinated care curriculum is added to the traditional academic, internal medicine education curriculum. Residency requirements for expanded outpatient care are satisfied and an alternative source is developed for some of the funding.

The integrated training in ambulatory coordinated care and internal medicine is now expanding in Nevada to include family practice residents, medical students and physician assistant trainees. Nevertheless, the primary challenge to long term success will al-

ways be a portion of unreimbursed cost of medical education. While costs may be less for primary care, they will indeed be more for certain non-primary care specialties and for medical students. It appears easier to us to integrate primary care resident training into the health plans than to integrate the non-primary, often hospital-based specialties.

In conclusion, I would like to reiterate that, I believe publicly traded companies like Sierra have an obligation and a responsibility to assist in the training of future physicians. I believe it does happen across this country.

I believe also that Federal funds should continue, but should no longer be allocated only to hospitals. Federal funds should be available for graduate medical education where it is taking place, whether it be in HMOs, in teaching hospitals or in teaching community health centers.

Finally, we are prepared to offer the Sierra and University of Nevada School of Medicine model as a site to study and define the direct and indirect costs of medical education in a public-private partnership in an HMO setting.

That concludes my testimony, Mr. Chairman and I appreciate the opportunity.

[The prepared statement follows:]

STATEMENT OF
ANTHONY M. MARLON, M.D.
SIERRA HEALTH SERVICES, INC.

Good afternoon Mr. Chairman and Members of the Subcommittee. I appreciate the opportunity to speak with you today regarding Medicare financing of Graduate Medical Education. My name is Anthony Marlon. I am a cardiologist and CEO and Chairman of the Board of Sierra Health Services. Accompanying me is Dr. Jerry Reeves, who is a pediatric hematologist/oncologist. Dr. Reeves is Senior Vice President of Health Care Operations at Sierra, and is also an Associate Dean at the University of Nevada School of Medicine.

Sierra Health Services is a publicly-traded company that finances, arranges, and delivers quality health care to more than 500,000 people in eight states which has entered into a public-private partnership with the University of Nevada School of Medicine to prepare medical graduates for the changing health care delivery system. We have approximately 2500 employees, and we are based in Las Vegas, Nevada. Our wholly owned subsidiaries include the state's largest health maintenance organization and the state's largest multi-specialty medical group practice. Health Plan of Nevada, a federally-qualified HMO, currently has approximately 117,000 non-Medicare enrollees (representing more than 49% of the state's non-Medicare HMO enrollment) and 27,000 Medicare risk HMO members (representing more than 50% of the state's Medicare population enrolled in HMOs). Southwest Medical Associates, the medical group, has 140 medical providers in 12 locations. These providers, who practice in more than 20 specialties, provide services in our clinics, ambulatory surgery center, and 24-hour urgent care facility as well as in affiliated tertiary care hospitals and subacute care facilities.

The purpose of our comments today is to affirm our commitment to the education of physicians and medical students to successfully meet the needs of delivering medical care in the 21st century through a public-private partnership.

Medical care in the United States today is shifting towards ambulatory, office-based care. The old approach focused on delivering often wasteful high- tech, specialized, invasive hospital-based care. The new approach emphasizes early access to evaluation and treatment by primary care provider health teams in less restrictive environments. The combination of these early interventions along with ongoing preventive health care services often result in improved health care outcomes and higher patient satisfaction.

A number of major social and political forces have converged simultaneously to influence -- and change dramatically -- the structure of medical education. Foremost among these forces is the more than 130 million Americans enrolled in health plans.

Second, increasing enrollment in health plans demands an increased number of primary care physicians and allied health providers and a decrease in the number of specialists. Some anticipate that the current ratio of 20% generalists to 80% specialists will need to be reversed by the year 2020. If current trends continue, the Council on Graduate Medical Education predicts in the year 2000, a surplus of 125,000 specialists and a modest shortage of 20,000 generalist physicians in an increasingly health care network-based system.

Third, in response to these changes, the Residency Review Committees, which set the accreditation criteria for residency training programs, have begun to require that up to 50% of the training time of residents be spent in an outpatient setting. These recommendations follow a report from the Council on Graduate Medical Education to Congress that contains suggestions to correct the mismatch between the physician work force and health care system demands.

Unfortunately, the funding streams supporting medical education have not shifted to reflect these changing patterns. Today, postgraduate medical education funding remains focused on hospital-based training. We need to redeploy funding of medical training programs for medical students and residents to ambulatory sites where they are most needed. We believe future funding should be available to support medical education partnerships between medical schools and health care organizations that provide ambulatory primary care training that emphasize early intervention, preventive services, and team-based coordinated care.

We are experiencing a paradigm shift in health care from fee-for-service to coordinated

care, from institutional care to office and clinic-based care. The goal is to provide quality, coordinated health care services to patients in order to attain optimum outcomes, whether it is in the home, the community health center, the doctor's office, or the hospital. Integrated care teams supported by information systems provide this coordinated care. These teams need leaders. That is our challenge. How do we educate these leaders? How do we pay for it?

In addressing these changes in our environment, I would like to describe to you the relationship between our publicly-traded company and our state medical school. We, at Sierra, have more than a decade-long tradition of providing teaching services and clinical practice opportunities for the University of Nevada School of Medicine. Initially, most of this teaching took place in the hospital setting. In 1994, the School of Medicine and Sierra expanded a program to integrate internal medicine residents into the full spectrum of patient care activities provided by the Health Plan of Nevada. Residents received education and medical services opportunities on our HMO service in the private tertiary hospital where we admitted most of our patients. The costs of training these residents continued to be covered by the hospitals.

Currently, Sierra and the School of Medicine are engaged in a pilot program in which revenues from private patients are used to help fund the education of residents. In 1995, the program expanded into the outpatient setting. Residents were assigned to one of our ambulatory clinic sites. These residents continued to follow their HMO patients throughout the year under the supervision of Southwest Medical Associates employed physicians with clinical faculty appointments at the School of Medicine. Full-time faculty members of the School of Medicine assist with supervision and teaching of residents.

Two affiliated teaching hospitals, the affiliated subacute hospital, and our outpatient clinic provide continuity of care training experiences which is emphasized throughout the three year training program. Residency requirements for expanded outpatient care are satisfied and an alternative source is developed for some of the funding. At any given time, residents care for hospitalized HMO patients, evaluate and treat outpatient clinic patients, and serve subacute care unit patients. A coordinated care curriculum is added to the traditional academic internal medicine education curriculum, preparing graduates to succeed in health plans after graduation. It includes:

- fostering health promotion and disease prevention services;
- communicating effectively with patients and panels of patients;
- effective detection, diagnosis, and management of common symptoms and physical signs;
- management of common acute and chronic medical conditions;
- understanding and practicing the principles of effective quality improvement;
- coordination of all aspects of care, including referral to other specialists, and the appropriate use of technology;
- detection, understanding, and management of health risk problems;
- demonstration of leadership and team building skills, including appropriate resource utilization;
- the use of clinical and management information systems to analyze and improve practice and outcomes patterns;
- understanding and engaging in decision making with patients, families, and other providers; and
- applying knowledge of coordinated care systems in evaluating and applying advances in the medical literature.

The integrated training in ambulatory coordinated care in internal medicine is now expanding to include family practice residents, medical students, and physician assistant trainees.

Although we have experienced some of the anticipated pressures between the School of Medicine academic culture and health plan culture, we are finding that by building on our base of mutual trust and respect, mutual benefits, and commitment from the top, we are overcoming

the potential clash of organizational cultures. However, unreimbursed medical education costs remain an issue.

The federal government has long recognized the cost of medical education and teaching of physicians. In our competitive marketplace, it is unreasonable to assume that health care organizations can succeed for the long term if their real costs exceed those of their competitors. Failure to address this cost disadvantage can threaten the viability of such relationships on a going forward basis.

For example, in our primary care clinic staffed by salaried physicians, we calculate the direct salary cost of precepting two medical students for a 20-week rotation to total $30,000. The salary cost for an internist to oversee two part-time medical students and three part-time residents weekly for a year totals more than $110,000 in our tightly managed outpatient clinic setting. These do not include overhead costs for support personnel, facilities, equipment, and information systems. Some of these costs can be supported by patient-generated revenues.

Nevertheless, the primary challenge to long term success will always be the unreimbursed cost of medical education. While costs may be somewhat less for primary care, they will indeed be more for non-primary care specialties and medical students. It appears easier to integrate primary care residency training into health plans than to integrate non-primary, often hospital-based, specialties.

In conclusion, I would like to reiterate that I believe that publicly traded companies, like Sierra, have an obligation and responsibility to assist in the training of future physicians. I believe also that federal funds should continue, but should no longer be allocated only to hospitals. Federal funds which are available for graduate medical education should fund education where it is taking place -- in teaching HMOs, in teaching hospitals, or in teaching community health centers.

Finally, we are prepared to offer the Sierra and University model in Nevada as a site to study and define the direct and indirect costs of medical education in a public-private partnership in an HMO setting.

That concludes my testimony, Mr. Chairman. We would be happy to answer any questions which you or any other Members may have.

Chairman THOMAS. Thank you very much.

Dr. Reeves, do you have any testimony?

Dr. REEVES. My comments are his.

Chairman THOMAS. Good. The gentlewoman from Connecticut, do you wish to inquire?

Mrs. JOHNSON. Thank you, Mr. Chairman.

Dr. Cutler and Dr. Marlon, do you feel that you have sufficient authority in the law to develop consortium relationships that will enable you to reimburse the diverse kinds of training sites that are necessary to train physicians for the future?

Dr. CUTLER. Under the current law?

Mrs. JOHNSON. Right.

Dr. CUTLER. No. We would like that authority. From our perspective, we would like to see the facilitation of the kinds of programs that were just talked about.

Mr. MCDERMOTT. Would the gentlelady yield for one specific comment?

Mrs. JOHNSON. Yes.

Dr. CUTLER. From our perspective, we would like to see the funding come to a consortia or to a public-private partnership that would allow us to place residents in partnership with a private entity. We would have to work that out. I do not have the specifics of how that would work at this time, but that would allow us to do training out of the hospital; that would allow us to train our residents, to practice medicine in a way that is conducive to the way medicine will be practiced in 2000.

It is an obligation of academic health centers to train medical students not for today, but for tomorrow. That is where it is going to be. That is where the action is.

Dr. MARLON. I agree wholeheartedly. Under the current law, the money flows to the hospital. As we, in fact, do more of our teaching in whatever the setting is, it is necessary to train these professionals for the future. We in Nevada have determined—have found a funding source from private dollars, from private patient activities to fund some of this. Currently, we cut a check to the university to fund or to pay for what services are performed in the HMO setting.

The revenue currently from Federal funds all still goes to the hospital. There is no way to reimburse Jerry and his subsidiary company for those indirect costs that we are currently bearing and that, for example, may be increased as we move this forward to try to assist more medical students in this kind of an environment or try to expand this to certain specialty training.

Mrs. JOHNSON. But, do you have no right to reimburse non-hospital entities for training costs under current law?

Dr. MARLON. No, under current law, the money goes to the hospitals.

Mrs. JOHNSON. Right, but could the hospital not reimburse a practice for the indirect costs of medical education?

Dr. MARLON. Now, you are entering into a market situation where the hospital then talks to the chief executive officer of a publicly traded company and says, I am going to pay you for the residents that work at your shop.

Mrs. JOHNSON. Well, one possible iteration of a consortium is, the consortium would be the administrative unit of a group of providers that got together to provide the scope of the training that would qualify the residents. It is not necessary to have the hospital the entity that the money flows through. It could conceivably be an entity that was certified by the medical school. Somebody has to certify that this group is capable of providing the training that the residents require, but it need not be necessarily a hospital.

It seems to me, in 10 years, some other group might want to contract with the hospital for this amount of training in this area and this amount in this area and this hospital for subspecialty training in this area and outpatient and geriatric and nursing home and whatever else.

Is there a theory in the law now for someone other than a hospital to be the recipient of the total dollars and allocate them to whomever they have contracted with?

Dr. CUTLER. It is extremely complicated to do anything like that. The idea of a consortium makes that possible because the funding would go to the consortium rather than individual institutions. The consortium would decide where the residents would train and where the dollars flowed. The dollars logically should flow where the costs are borne in terms of that. If a managed care company, whether publicly traded or not, was part of that entity, it would work.

Mrs. JOHNSON. Now, you have succeeded in doing this with a group of hospitals. Do you have the authority to include non-hospitals in your consortium and to reimburse them for cost of training including indirect?

Dr. CUTLER. Not indirect costs, only the direct costs and it is very difficult. It is very complicated and one needs to do all kinds——

Mrs. JOHNSON. The problem is, you cannot train somebody in a practice setting. You are going to slow down the pace at which they see patients, unless you can help them offset the loss of income.

Dr. CUTLER. Absolutely.

Mrs. JOHNSON. Yes, OK.

So, you really do need more authority?

Dr. CUTLER. Yes.

Mrs. JOHNSON. We do need to envision more flexibility as to whom the consortium should be?

Dr. MARLON. You need that change in law.

Our program involves not only the ambulatory care site, not only the in-hospital, but we have subacute and geriatric care that, in fact, is incorporated into the whole gambit. A lot of those things are not covered.

Mrs. JOHNSON. Would a simpler, quicker way to do this be to give every medical graduate a voucher and then he would just use his voucher wherever he would go? Like you get a scholarship, you can use the scholarship at whatever institutions you choose to go to, I mean, some scholarships, not all.

Dr. CUTLER. I am not sure that is the way to drive medical education. When you are talking about undergraduate education where you want to be an English professor, it is like giving everybody a scholarship. You get to choose where the money should flow. It is through a consortium headed by a medical education organization

that would then ensure quality and the right mix of people and the right mix of training, I think.

Dr. MARLON. The policymakers need to decide how many internal medicine residents you want, how many general surgery, how many cardiology residents.

Mrs. JOHNSON. We cannot decide that. We have never been good at work force planning. We have a hard time even hiring the right people to do the jobs in Federal Government. So, forget that. [Laughter.]

Chairman THOMAS. We do see the wisdom in letting the people choose their representatives, however. [Laughter.]

Mrs. JOHNSON. Look at how rapidly the change in demand in the market is already affecting resident choice. It takes us 5 years to make any appreciable change in law. By the time we made any change in the allocation of slots, it is simply not practical.

Thank you, Mr. Chairman.

Chairman THOMAS. Yes, I am going to go to the gentleman from Washington.

This is one of my real concerns, because I sit here listening and the solution primarily is to scrunch down and to define who gets what, which creates a reward for some people and a denial of others. All of us, I think, agree we need medical education and training, but it is back to by whom, for whom, where.

To a certain extent, if you will take the model of that undergraduate where you have an accrediting institution, but more and more, these accrediting institutions have different profiles. It is very difficult to determine. If you had a voucher in which we freed up the ability to put together a consortium as to what they did and how they did it, you could also then have a little bit of a market determination of who is doing it right. Rather than us picking the model that is going to do it for tomorrow, let tomorrow's doctors pick which models they think work.

Of course, you do not think they have the ability to do that as much as they should. I understand that, because we would limit it in part by accreditation and examination. Short of that kind of fairly revolutionary thinking in terms of who gets what, when and how in medical education, we are not going to solve the problem.

The gentleman from Washington.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

The most interesting person at this table has not said anything yet, so I am going to ask him. Dr. Reeves, tell me—it seems to me that you live in about three different worlds. You are working for Sierra. You are a medical school dean and you are also related to one of the attendant companies to Sierra. Can you explain your relationship, how you operate in those various capacities?

Dr. REEVES. Yes, sir, I appreciate the opportunity to testify and thank you very much.

Mr. MCDERMOTT. I am asking this, because Dr. Cutler says you cannot integrate managed care into a State medical school. Yet, some way or the other, they got their arms around you.

Dr. REEVES. I will give the answer by example of what we are doing in our particular partnership. The University of Nevada School of Medicine and Sierra have come together to provide integrated training in primary care. We have done it by setting up

what you would call a consortium in the earlier discussion, that is, a governance group that says, we are going to agree to do this together.

There are cultural clashes that relate to the culture of care coordination, the private company and the academic world. However, we have found that, by commitment from the top, namely Dr. Marlon's commitment as chief executive officer of Sierra Health Services, Dr. Doherty's commitment as dean of the medical school, my commitment from the health care delivery, my responsibilities within Sierra are all of the health care delivery entities as opposed to the insurance side.

By bringing that group together and mapping our strategy for how to integrate our activities, we have found that we can meet the educational goals. We can prepare graduating residents to work better in my medical group practice, Southwest Medical Associates we mentioned and can do it more effectively from the minute they start, rather than the significant training costs that we had to incur to bring them up to speed to practice successfully in our managed care environment based on their abilities graduating from the existing models of medical education.

I am going to now wear three hats. I am going to talk about the hat that I wear as president of the medical group practice.

I am now getting graduates who enter our program as practicing physicians who I do not have to spend 6 months of training at learning how to practice efficient care and coordinate it in a team-based approach with placing a patient in the least restrictive environment. That was a real cost we were bearing. I also decreased my real cost in what——

Mr. MCDERMOTT. Give the Subcommittee some understanding of what it is you had to train out of the previous medical graduates.

Dr. REEVES. When residents graduate from medical schools and from residency programs, they tend to have had hospital-based, ICU training where you order everything in the book just in case the professor may ask. You really are not trained in a mode of, if you did not do this, so what. It takes a while to change that modus operandi to this different approach and it is a day in, day out thing that is very, very frequent in the outpatient setting and becomes less important and, therefore, is less incentivized in the hospital setting.

So, there is real cost to that, that we were bearing from their ordering a lot of unnecessary things that had no impact on achieving our goals of the patient satisfying health improvement. We would go through an elaborate training curriculum for these new graduates who come into our faculty to get up to speed to accomplish these kinds of patterns of practice through feedback. It takes administrative overhead to generate the reports, to drive those kinds of behaviors.

The other major cost that we have minimized is the recruiting costs, because these residents who have trained with us in this setting tend to want to stay in that setting. They feel comfortable there. It is the right way to practice, in their view. It is something that they want. So, that has been the offsetting benefit to us. Plus, we believe it has enhanced the quality of the practice that our providers are delivering.

Now, from the medical school point of view, they have gotten another source of funding for residents. We pay the medical school, the medical group.

Now, I am going to take my hat as the associate dean of the medical school, receiving a payment from myself as president of the medical group.

We pay, from Sierra Health Services' funds through the Southwest Medical Associates, which is the multispecialty medical group practice with 12 sites in Las Vegas. We pay the medical school per patient seen for patients that the residents see in our outpatient clinic setting. These patients are empaneled to that resident plus his supervising attending physician, who is a Southwest Medical Associates physician. That patient continues to see that doctor who is a resident in internal medicine for the 3 years that that internal medicine resident is there.

That patient perceives that resident as being his or her doctor, backed up by the attending physician who is the supervising teaching physician.

We, Southwest Medical Associates, pay the medical school so many dollars per patient seen for the care given by that resident, which is an adjustment factor. The fact that that panel of that particular physician can be a larger panel if that physician is supervising two residents and the three of them are seeing patients in the clinic rather than just that one physician seeing patients in the clinic.

So, even in a prepaid, managed care environment, where 90 percent of our revenues come from prepaid patient care, managed care revenues, there is a way to cover our direct costs for much of what the residents do. There are still inefficiencies and that is why we are testifying today. You cannot totally recover from that. It relates to the teaching mission. It relates to some of the patterns it takes until they get fully efficient. It relates to the administrative overhead for coordinating these programs. There are some real education costs, but some of those, as far as the medical school is concerned, are helping them with an additional stream of revenues for the training programs in primary care.

Mr. MCDERMOTT. Since you get a continuous flow of physicians who you have acculturated going right into your Sierra Services, why don't you, Dr. Reeves, dean of the medical school, charge Sierra's Dr. Reeves more for the training that the medical students have gotten? You have essentially trained them. Sierra does not have to go out around through the community and try and guess what doctor is any good. They know who is good. So, why don't you charge Sierra more? Sierra is ultimately going to reap the benefit. It is a privately funded stock company.

Dr. REEVES. Well, I am not sure I understand the flow. Maybe Dr. Marlon can answer that.

Dr. MARLON. The question is, we already have paid for it. There is no possible way that within this public-private partnership, we can identify certain direct costs. We have some revenues flowing from the company back to the medical school, but the commitment, Jerry's commitment, my commitment, the staff commitment can never be repaid in its entirety. That is a tradeoff.

We get well-qualified, trained physicians in return for a commitment that we make to the training process and the time that we spend that is, in fact, never compensated for.

Mr. MCDERMOTT. Is there any other——

Chairman THOMAS. The gentleman's time is expiring.

Mr. MCDERMOTT. Thank you. One last question.

Is there any other medical school that you know of that has the kind of relationship you have developed with a managed care operation? I ask the question of the doctor from New York, from Montefiore. Is there any other hospital or any other medical school and HMO that you know of that has this kind of relationship?

Dr. REEVES. After a fashion. Our particular combination is a private HMO with a state medical school, which is much more generalizable in this nation than would be the not-for-profit institution, like Harvard Community Health Plan or Henry Ford Hospital System, that is predominantly hospital-based or predominantly medical school-based and they have added an HMO into their system. That is not as generalizable as ours.

To my knowledge, there are not other combinations of our particular combination that have experience yet. There are several who we have been contacted by to talk with them, to assist them with setting these up. As far as actual operational experience yet, I am not aware of them yet.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Dr. Jacott wanted to respond.

Dr. JACOTT. Yes. We have an arrangement at Minnesota that is not quite like yours, but within our department of family practice, we have our own HMO. That was developed as a Medicaid managed care product, based on a waiver that you granted to our state. That HMO provides revenues for our department, for the training in our—we have seven clinics where we train family physicians. It provides revenue, but it also teaches our family physicians managed care techniques.

Mr. MCDERMOTT. Mr. Chairman, I would make a distinction—maybe you do not—between a for-profit HMO's relationship to a medical school and what are essentially not-for-profit HMOs associated with a medical school that developed internally. This was not developed internally. This was an external graft by an HMO on to a medical school.

So, for some financial reason, you decided to split off this HMO and set it up. Is that fair to say?

Dr. JACOTT. Well, yes, that is correct. That is why I say it is not exactly like theirs, but it is a variation of using managed care to support medical education.

Chairman THOMAS. Your model is far more common. This one is, I think, relatively unique.

Mr. MCDERMOTT. This is more common.

Chairman THOMAS. That is a more common approach in terms of a structure.

Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Yes, thank you, Mr. Chairman. You can see why I am proud of this company and many other innovative things to come out of the great State of Nevada.

Anyway, tell the gentleman that he ought to caution these folks when the gentleman from Washington indicated he thought they should pay more, because take a look at taxation on dividends under our current personal corporate income tax structure if you do not think you can get hit twice. [Laughter.]

I have a couple of questions. First of all, how do you determine how many residents you are going to have in this area, Dr. Marlon? How do you determine how many residents with the university you would determine to go into what fields?

Dr. MARLON. What we tried to do when we started this was, integrate, fully integrate the department of medicine. The ultimate strategic vision was that the department of medicine at the HMO and the department of medicine at the medical school should be fully integrated and be essentially one department. Under those responsibilities or division of labor, the HMO is responsible for marketing and patient generation and the economic side of it. The medical school was responsible for the teaching mission. Then it was our job to make sure this thing paid for itself.

We did that in a way that is commensurate, in terms of numbers, with the number of residents that the medical school currently had under its auspices in internal medicine, what we thought we could handle legitimately inside of our system dealing with the capacity. We are responsible to generate the patient flow, not only the Medicaid patient flow, but Medicare and commercial patient flow into this kind of a system.

So, it was a market-driven decision in terms of the number. We currently have about—let me turn this over to Jerry—but, it is about 18.

Dr. REEVES. Right. We right now have 18 residents. On any given day, there are nine residents that are working in our outpatient unit at Southwest Medical Associates, one who is at the subacute care facility and eight who are at the hospital.

Mr. ENSIGN. The point of my question is, we talked earlier about—and Dr. Cutler responded also about—determining or having policymakers determine the number of residents in internal medicine and in surgery. My point was to ask the question and you answered it just the way I thought you would answer it. The market determined that.

I sometimes get back to veterinary medicine, because it is a really good model in a lot of ways of how the market determines. How many surgeons are there going to be? How many ophthalmologists there are going to be. The market determines that. Certainly, everything is accredited and everything has to be licensed, but still it is determined by the number of people who are going to be able to provide jobs out there.

It would seem to me that, more and more of what you are experiencing here is partially being driven by the market. Certainly, nothing that Congress did drove you to do what you did there. It would seem to me that, we seem to do more at the congressional level to make it easier for the market forces to determine which residencies, how many ophthalmologists, specialties or subspecialties or family practice people we are going to have out there. Instead of putting barriers up, we should make it easier for the mar-

ket to determine that. Instead of us just doing it, let that happen out there.

Dr. MARLON. I absolutely agree. You have heard testimony today, multiple times, about the fact that the marketplace, in terms of the jobs available are, in fact, determining what residencies are sought after, what residences are, in fact, being filled. There is no question that we will continue.

Mr. ENSIGN. The followup to that is, if we had a voucher-type system that we have talked about today, how would the logistics of—instead of having a consortium you just have a voucher and it goes to the resident and the resident determines where they go. Is that implementable in a situation like yours?

Dr. MARLON. We would be able to accommodate it, but I have to caution you about a simple voucher system, because there has to be an organizational framework, whether it is a consortium, whether it is a medical school, whether it is a hospital. I do not know enough about that and I would defer to Dr. Cutler.

It should be a variety of different opportunities. It should not only be hospitals. It should be consortiums. It should be medical schools. It should be whatever seems to get the job done within the framework of either the support being generated or people being able to, in fact, measure up to certain standards.

Mr. ENSIGN. I do not know, Mr. Chairman. From the different testimony, I have not really heard anybody come up with how this thing is going to work. Who is going to determine what specialties? Whether that is a consortium, I still do not see how that is going to work.

Dr. CUTLER. You are correct. The marketplace should drive. I would suspect that the Department of Medicine at the University of Nevada has residents at other places other than Sierra. So, the value of the consortium would be to get all the players in the room and say, what is the total number of residents the marketplace needs, could support, should be trained. What are the best venues?

It may, in fact, turn out that the marketplace can absorb 50 residents, 18 of which would be at Sierra and there might be another organization that would get zero. Bringing them together in a consortium provides the organizational framework upon which you can then ask those questions.

Mr. ENSIGN. The problem that I have—and I do not know, Mr. Chairman, what your feelings are on this. The problem that I have with a consortium-type thing is that becomes a bureaucracy in itself and the difficulty in a consortium is keeping up with those market forces. When you get in a bureaucratic environment, you end up protecting certain of your favorite—maybe you happen to like this particular subspecialty over there and that is the one your constituency—that you end up determining that you are going to protect a certain number of those.

It seems to me that, whether it is the Federal Government determining it or a private consortium or whoever it is, it is still a bureaucracy set up that stops market forces from happening.

Thank you, Mr. Chairman.

Chairman THOMAS. It is a bit of conundrum for us, because you are asking for market forces to work, but then you want to set up a structure which picks the number of folk that are going to be able

to go in there because of the market forces. You have then violated that scientific phenomenon of actually affecting what is going to occur to the market forces. So, it is like sticking a thermometer in the water to measure the temperature of the water and the water is changed by the thermometer going into it.

Notwithstanding that, we have to look at the relationship of supply and demand. I guess, the most difficult thing I have with it is, why is this area so unique that we have to create this significant limiting and screening structure based upon our reading of the market. Especially in Nevada, it seems to me, the phrase, "you pay your money and take your chances" would be the most appropriate one for dealing in this area as well.

So, you miss the number you are supposed to have. Some folk have a job, some do not. Some people decide that they are going to go into something else. Somebody goes beyond that, like a lot of the English majors, to get an M.A. so they can actually be employable.

I am just trying to understand why you use market forces and then you do not live up to the statement of market forces, because what you want is a structure that determines how many are going to go into it, based upon our reading of the market forces at that time for a job that is going to be available 8 or 10 years down the road.

Dr. CUTLER. It is a great question, but your measuring the water temperature is the answer. There is inherent, in every experiment in life a certain amount of bureaucracy or measurement costs, if you will. If you want to know the temperature of the water, you must put in the thermometer. Once you have done that you, indeed, have changed. You want to do it in a way that minimizes the costs or, the change in the water temperature, in the most cost-effective way.

The way you do that is, to reduce the cost, increase the margin, and increase the quality of your product. So, if you eliminate order, that is called chaos, and that is not good.

Dr. MARLON. I think the other thing is, if you want pure market forces——

Chairman THOMAS. When you say that chaos is not good and you are looking at it from an individual point of view, the whole concept of markets is the collective and not the individual.

Dr. MARLON. We are talking about the amount of money that the Federal Government spends on graduate medical education and on residency training. By definition, you have distorted the market. If you want a free market to work and I believe it possibly could, stop all payment for graduate medical education and then watch the market work. The minute you are going to throw any kind of Federal money at it, you should make some kind of rule. Now, if you do not want to make rules, stop the flow of money.

Chairman THOMAS. All right. [Laughter.]

If you do not want to take a risk, do not go to Nevada. [Laughter.]

The gentleman from Maryland wished to inquire.

Mr. CARDIN. Yes. You have made a very strong point. I am for the Federal Government providing funds, but I also believe that we must influence the outcome here a little bit. We are doing that

today. Unfortunately, the incentives that we provide, are the wrong incentives.

Market forces can work. That is an interesting concept, but it seems to me that, every trained, high-cost specialist that we produce is going to make a comfortable living in medicine today. So, we can say the market forces will work, but we know that there is no risk in going into a high-cost specialty area. There is a risk going into family practice. There is a risk going into primary care. There is a risk going into the areas that are not as well financed as far as the return to the person that goes into that area.

Yesterday, I had a chance to talk to a medical student who is going into geriatrics. She is looked upon with some degree of curiosity by her classmates. They do not know why she is interested in that field of medicine.

The stigma that we have in today's society in medical schools, among medical students and medical faculty all play a part to the distortion we have in the type of people we train in the medical field. So, I really do think we need to develop a mechanism to deal with the division of who we train in medicine and how we train. We have to deal with it. Whether it is the AMA's suggestion that we delegate this authority or whether it is some form of national standards that are developed, I do not think that the market forces will provide for the training of specialists and doctors the way they need to be without some involvement from the Federal Government.

After all, Medicare should be paying part of that cost. But, we over pay today. Instead, there should be an all-payer source of funding and most people agree to that. So, we should be able to find a way to train new graduate medical students. We also need to make sure that we have the appropriate mix of the people trained.

I appreciate that you have training programs that work. That is important. It is very important. We can try to encourage more residency or training programs in less costly settings in primary care, but if we do not do anything about the number of residency slots in this country, we are going to have a terribly inefficient health care system and we are not going to have any money to pay.

So, forces by themselves will not work. Withdrawing Federal support, to me, is not the right answer. I appreciate Dr. Marlon's suggestion there and I assume that it will be taken up by one of my colleagues soon in an amendment on the floor to withdraw all funding. Your name is going to be used as one of the reasons to support it. [Laughter.]

Mr. CARDIN. This testimony has been very useful and I really do hope that we will throw out the old models and let us take a look at some innovative approaches to encourage more residency training or more training-type programs that you have in Nevada that are wonderful. Let us have more training spots like that, but let us also encourage the brightest in our medical school classes here in the United States to use primary care as their first choice in residency. Let us have our deans of medical schools encourage more people to go into primary health care and not have a stigma from his/her classmates for the person in the class who wants to do something in primary care.

Thank you, Mr. Chairman.

Chairman THOMAS. Tell my friend that we do not have a lot of time to pursue these. We have discussed them in a number of other areas, but I do not know that the new market forces might not provide some kind of a countervailing relationship to the historical model of the high-cost specialist in the old fee-for-service world on a referral basis being able to absorb as many as they can because they could refer to each other. The new forces out there, I think, do change the equation on your ability to play the old game. It is a new game and the winners in the old game are not going to be the same winners.

So, to a certain extent, finding a job is going to take precedence over the old fee-for-service referral structure of the specialist.

Mr. CARDIN. I appreciate that, Mr. Chairman. I just wonder whether——

Chairman THOMAS. It is a slight compensation from the model that I do not think we can control. I do not know that that is not the case anymore.

Mr. CARDIN. I would be curious whether we see that in our communities. Are people who are finishing their training in residencies in high-cost specialties having a tough time finding a job? Are they making ends meet?

Dr. MARLON. They are finding that, it is a much more difficult row to hoe.

Mr. CARDIN. I appreciate that, because I have not heard that too much about people not being able to be employed with a comfortable living after finishing a residency. I take it, the cardiologists are not being hired today?

Dr. REEVES. Mr. Chairman, I can give you specific examples.

In a recent series of articles in our local paper, there were interviews with private practice physicians, the main emphasis being on how much do you estimate your pay has changed in the past 2 years as managed care has grown. The consensus was a 25 percent decrease.

Mr. CARDIN. I would like to see objective information. Doctors tend to exaggerate the circumstances that are out there. All the statistics I have seen are that, the average physician's in this country salary using current hours, adjusted for inflation, has grown.

Chairman THOMAS. I do not want to spend a lot of time on argument. I was just offering the possibility that the equation may require some rethinking.

Mr. CARDIN. If we could get some information on that——

Chairman THOMAS. An absolute requirement.

Mr. CARDIN [continuing].—that would be objective, not subjective information, but objective information.

Dr. MARLON. There is recent data to support that the number of anesthesiology residents and the number of radiology residents have gone down dramatically because jobs are not available out there to support them once they finish.

Dr. CUTLER. The residencies are not filling.

Dr. MARLON. The residencies are not filling.

Dr. CUTLER. Indeed, the shift this year to many more residents making—many more medical graduates going into primary care residencies has left a dearth of applicants for things like anesthesi-

ology, radiology, anatomic and clinical pathology. The residents in family medicine are going up.

Chairman THOMAS. Well, this might reflect then some market forces in the matching aspect of slots.

Mr. CARDIN. I appreciate the information.

Chairman THOMAS. It is just an emerging trend.

I am not dismissing the panel. The gentleman from Louisiana wanted to ask a question.

Mr. MCCRERY. I would be interested to know if any of you have a comment on our general proposal to limit the overall number of residencies. Would any of you like to comment on that?

Dr. HARR. I will take a stab at it.

Mr. MCCRERY. Sure.

Dr. HARR. If you look at the market forces and what is being required of a physician to take care of a panel of patients, and you extrapolate that into the future, the need for the current number of subspecialist physicians is definitely going to decrease, and the need for generalist physicians is going to increase. There needs to be a shift in who is taking care of the patient. In other words, the shift will be to more ambulatory-based medicine where the general internist, general pediatrician, and the family physician will be the primary physician taking care of those patients.

So, those numbers will need to increase over the current numbers. Primary care physicians constitute about one-third of the marketplace now and the reports call for half the marketplace to be physicians in those areas. Not everybody who has chosen a traditional specialty is going to want to make that transition and there are not going to be all that many jobs.

If you are an orthopedic surgeon on the west coast, you may not be able to do orthopedics on the west coast. You might find a place in Wyoming or North Dakota where you can do orthopedics or you might end up being an English teacher if you cannot find a job. The total number of physicians required in the new marketplace is different, because you have a larger number of patients that you are empaneled to take care of.

If you look at what is happening to the marketplace with the number of physicians that graduate from our medical schools and you add the 6,000 who come from afar, I do not say decrease their opportunity. Just let everybody compete. Let it be known that there are enough funded slots to accomodate 110 percent of U.S. medical graduates and you compete one on one for those slots. If a hospital or a training program wanted to have more slots and fund them on its own, let it do so. The funded slots ought to be awarded with the idea that, down the road, there ought to be x number of physicians providing care in this country.

The institutions that provide that care, if they do not follow the rules, if they do not provide the right type of physician to meet the needs of the marketplace, then they may go the way of the dinosaur and the Edsel.

Mr. MCCRERY. Dr. Cutler, do you agree?

Dr. CUTLER. Very much so. In fact, we are downsizing our residencies and most academic health centers are taking their residencies down by 5 and 10 percent a year and that matches up with the movement to ambulatory care.

Two things need to be considered. One, drop in inpatient need. But, we need more innovative kinds of ideas for training residents so we get more opportunities in the ambulatory sites. How far we take the residency numbers down and ensuring we get the right mix needs to be thought through very carefully, but that is a marketplace thought, not just a random shot in the dark.

Chairman THOMAS. The gentleman from Washington, Mr. McDermott, for one last question.

Mr. MCDERMOTT. I just want to clear up one little anomaly. When we were talking about international medical graduates, the figures that we were shown showed a very high proportion in Nevada. Explain that to me.

Dr. MARLON. Up until about 4 or 5 years ago, Nevada was an area that was underdoctored. Our ratio of physicians to 100,000 population was relatively low and up until about 5 or 6 years ago, it was a wide-open fee-for-service system. As you know that defies the laws of economics and you make as much money as you can generate in a town that grows as dramatically as Las Vegas would grow.

With the advent of managed care over the last 4 or 5 years you have seen that begin to decrease somewhat. We still have a high percentage of international medical graduates but now the number of people being licensed on an annual basis reflects the national numbers and is no longer larger in Nevada than it is any place else.

Mr. MCDERMOTT. It was something in the high seventies or 75 percent of your residencies were occupied by foreign medical graduates, is that correct?

Dr. REEVES. That is correct if you went back 3 or 4 years ago but the total number of residency spots is very low. So, one or two paces——

Mr. MCDERMOTT. Yes, I understand that.

Dr. REEVES. —from that would make a huge skew in the numbers. But you are correct.

Mr. MCDERMOTT. Is that done by recruiting? You offered them residencies, or the combination of Sierra and the medical school?

Dr. MARLON. No. That predates our involvement. Right now the residency program at the University of Nevada School of Medicine is virtually 100 percent graduates from the United States. A few years ago, these are hospital-sponsored residency programs that would not fill during the match program and would go out and fill their spots in order to fill those necessary spots, that they perceived as necessary, to provide care to indigents or Medicaid or what have you.

Mr. MCDERMOTT. Thank you very much.

Chairman THOMAS. Yes. I don't want anyone to misinterpret what I'm saying but to a certain extent with the very low population of Nevada and the location, looking for residents was kind of like the inner-city. Nevada had similar problems in terms of trying to find folks.

As the population has grown, there are a number of amenities and atmosphere which make it far more congenial to family living in the larger sense in Nevada and it will continue to change, looking more like Phoenix in terms of a population center all the time.

I want to thank you very much, if there are no more questions. Do you have one question?

Mrs. JOHNSON. I just have one question.

Chairman THOMAS. All right, one side, 5 minutes.

Mrs. JOHNSON. Yes. I just have one comment. Very briefly, a number of people who have testified have mentioned the trust fund that we have set up, in our Medicare Preservation Act, to begin funding medical education. That is the best all-payer system.

It is far better than having all-payer in terms of insurance providers and other parties, because you never get them all. All-payer is all taxpayer in our trust fund.

On the other hand, it creates allocation problems. If we get all the money into a trust fund how do we give it to you? If we are not going to give it to you per patient, if we are not going to give it to you per resident or per number of beds? In the bill, we just arbitrarily give it to you and then sort of the percentage of the Medicaid money you got last time. We can't do that indefinitely.

So, that whole issue of how do we flow the money out of the trust fund is one you have got to be thinking about.

Thanks.

Chairman THOMAS. We look forward to some ideas and perhaps some of the discussion of the consortium would help us.

The Subcommittee will stand in recess until we get back for the next panel.

[Recess.]

Mrs. JOHNSON [Presiding]. The Subcommittee will reconvene. My apologies for the delay. There were two votes and so the Members were delayed longer than expected.

For our last panel we have Mary Mundinger, dean, Columbia University School of Nursing and Lynn Caton, president of the American Academy of Physician Assistants.

Dr. Mundinger?

STATEMENT OF MARY O. MUNDINGER, RN, DrPH, DEAN, COLUMBIA UNIVERSITY SCHOOL OF NURSING, NEW YORK, NEW YORK, AND MEMBER, BOARD ON HEALTH CARE SERVICES, INSTITUTE OF MEDICINE

Dr. MUNDINGER. I am delighted to be here and pleased to have this opportunity to comment on the Medicare reform proposals to make some observations about how advanced practice nursing may pose a solution to some of these daunting problems and to make a plea for replacement funding for our Nation's inner-city hospitals and academic health centers as we go forward.

I would like to start by offering some observations about the nursing work force. There are 2.2 million nurses who are registered to practice in this country. About two-thirds of those nurses are trained at the associate degree or diploma level, preprofessional level. And another, perhaps, 600,000 nurses are trained at the baccalaureate level. A very small cohort, perhaps 100,000 at this time, are advanced practice nurses.

Chairman THOMAS. Excuse me, was that 3,000?

Dr. MUNDINGER. About 100,000 that are advanced practice nurses. The group that forms the major work force in nursing, the associate degree cohort, are really trained for hospital care and

those hospital jobs are eroding and they are changing. And as the system changes, we need nurses with far more community health experience and management experience. Those are the baccalaureate nurses.

Advanced practice nurses are those with graduate training in a clinical specialty. It is primarily in primary care that they are trained. They can diagnose and treat and manage basic illnesses. In most States they have some level of prescriptive authority and in about half the States they can have their own practices without physician supervision or collaboration.

Although there is a great deal of overlap between what advanced practice nurses can do in basic medical care, the idea is not to supplant physicians with advanced practice nurses, it is to extend the medical care that physicians give and nurses bring with that a value-added component of skills in prevention, health education, promotion, community-based care that really is a value-added piece to our traditional, very high-level medical care.

Medicare funding for nursing education is the largest single funding source. In fiscal year 1995, $245 million in Medicare funds was given to hospitals for pre-professional education. This means that the hospitals, which are training perhaps 10 percent of the nursing work force, are getting three times the federal subsidy of all other nursing schools.

We would make a plea that in redirecting those Medicare funds to advanced practice, the contribution of Medicare to the level of nursing that Medicare patients need is far more appropriate.

I would also like to observe that nurses form one of the major components of primary care in this country. If we count them in the numerator with all primary care physicians and in the denominator of specialists and primary care providers, we are much closer to the 50/50 ratio between specialists and primary care givers that is widely acknowledged as being ideal in this country.

While there is strong consensus in the Pew and IOM reports for downsizing residents, the potential damage to hospitals and patients depending on the care of IMGs, in particular, is enormous. These residents tend to practice where under-served patients are seen in inner-city public hospitals and they are much more likely to take primary care residencies.

Notwithstanding these findings, the final route of IMGs, in their career decisions, isindistinguishable from U.S. medical grads. Thirty-four percent of IMGs are currently in primary care; 34 percent of USMGs are currently in primary care. And, they are similarly distributed in geographically under-served areas.

We believe that advanced practice nurses are a potentially valuable IMG replacement. Having completed their graduate clinical training, the out-patient care competency at least is useful as a first year entering resident. They also bring with them the basic nursing skills from their undergraduate education. They have prevention, health education, and the use of community resources. They grow in competency each year and do not exit the system in 3 to 5 years establishing costly practices, but remain providing continuous high-quality care.

Let me conclude by saying that the role of academic health centers in these improvements is central. This is not only the site

of medical training, it is where medical leadership for the next generation begins. Academic health centers are not only the centers of excellence, they are the entities that make excellence in health care possible. Academic health center hospitals and clinics bear a disproportionate burden caring for vulnerable patients. It will take stable financing to secure these continuing contributions to the nation's health.

Thank you very much.

[The prepared statement follows:]

Medicare GME Financing
and
Recommendations of the
Pew Commission, IOM study, and Balanced Budget Act FY 95

statement by
Mary O. Mundinger, RN, DrPH
Dean and Centennial Professor in Health Policy
Columbia University School of Nursing
Member IOM Board on Health Care Services

Good afternoon Mr. Chairman and members of the subcommittee. I am dean of the Columbia University School of Nursing, and a member of the Institute of Medicine and its Board on Health Care Services. In 1984-85 I served as a Robert Wood Johnson Health Policy Fellow on the US Senate Committee on Labor and Human Resources.

I am pleased to have this opportunity to comment on Medicare Graduate Medical Education reform proposals, and to commend you, Mr. Chairman, for your leadership in developing the Balanced Budget Act provisions for Medicare financing improvements. The establishment of a new trust fund to support health professions education is a promising initiative, one that could secure a broader and more equitable base for health professions training.

Recommendations in the Pew Health Professions Commission Report and the IOM Report on the US Physician Supply center on the emerging physician surplus, the role IMG's play in this surplus, and the cost, financing and reorganization of the health care system. The turbulence imposed by these changes could harm academic health center hospitals where so many underserved patients receive care, and could disrupt the only access to care many vulnerable individuals now have. New York City hospitals bear a disproportionate burden of this care. The changes being considered in the health care system must protect access and quality care during this time of transition.

The site of care is shifting away from hospitals, outcomes research is informing us of better cost benefit care decisions for individuals and for populations, and under managed care, prevention and health promotion count and are paid for. These changes suggest that regulating numbers and specialty selection of physicians will be an inadequate solution to cost and access problems. New professional configurations and new cross discipline teams, including nurses, will be critically needed, and can provide solutions to these daunting problems.

NURSING EDUCATION AND THE HEALTH CARE MARKETPLACE

The US healthcare workforce currently includes over 2.2 million registered nurses. Approximately two-thirds of these RN's and two thirds of current nursing students are educated at the pre-professional level, in hospital diploma schools or two year associate degree (AD) programs in community colleges. These programs prepare nurses to provide basic nursing care to hospitalized patients, with the parameters of their practice in a structured supervised environment. Until recently two thirds of nurses worked in hospitals, but with hospital downsizing, only about 54% of nursing positions are in hospitals, and there is a rapidly growing surplus of diploma and AD nurses. To add to the disparity, the practice of hospital nurses is increasing in complexity, including care of more acutely ill and technology dependent patients, management decisions to safely deploy paraprofessional assistants, and using skills in community based care, prevention, compliance, and health education - all components of baccalaureate nursing education.

Nurses with advanced training, called Advanced Practice Nurses, (APN's), are those who have completed a graduate degree program in a nursing specialty. Most states require a certification exam, and most APN's also take a national certifying exam in their specialty. APN's include nurse practitioners who practice in primary care, clinical nurse specialists, such as a critical care specialist, who practice in hospitals with the sickest most complex patients, nurse anesthetists, and nurse midwives.

In the past decade APN's have gained more independent authority in every state. Nurse Practitioners in 20 states have full independent authority without requirements for physician supervision or collaboration, have pharmaceutical prescribing authority in 48 states (at varying levels of drug categories), direct access to reimbursement from Medicaid in every state for some nurse practitioner specialties, and direct access to private insurance reimbursement when clients request this of their insurer. Nurse Practitioners are statutorily excluded from direct Medicare reimbursement except for rural areas and managed care plans.
Evaluation of nurse practitioner quality and competence have been the focus of over 100 published studies. In all areas of these studies nurse practitioners measure up to physician primary care practice and can manage 80-90% of the patient problems that primary care physicians can manage.

Under the fee for service system for health care that focused on disease detection and management, physicians were seen as the "gold standard", and nurse practitioner's were measured by that standard. Now, with the focus of the nation's health care on a more balanced set of skills, including prevention, health education, patient compliance and empowerment, it is clear that nurse practitioners are more than a less expensive substitute for physicians.

It has long been recognized that a physician brings extra value to a medical encounter with a patient, and that the nurse practitioner provides a medical subset of care. What has been less recognized is that the nurse practitioner also brings a unique value-added component to care. Increasingly, the value of the nursing component is necessary for quality, for comprehensiveness, for health outcomes, and for cost effectiveness. Managed care requires this broader set of health, as compared with medical, interventions.

MEDICARE FUNDING FOR NURSING EDUCATION

Medicare is the largest single funding source for nursing education. In FY 1995 $245 million in Medicare GME funds were given to hospitals for preprofessional nurse training programs. These funds go to hospitals as general revenues and are not specifically earmarked for education. More than 90% of Medicare funding for hospital nursing programs goes to private non-profit hospitals. Only 28% went to Council of Teaching Hospitals, which more often provide care to underserved patients and vulnerable high risk populations, and only 9% went to hospitals in rural areas.

Although hospital diploma programs decreased by half between 1981 and 1991, and currently enroll only 10% of all nursing students, they receive three times the amount of money that is available to all advanced nurse training programs.

Title VIII funds for graduate nurse training were $60 million in FY 95, and Medicare provided only $2.2 million for advanced practice (nurse anesthesia), for a total of $62.2 million federal subsidy, less than one percent of the $6.4 billion that Medicare spent on graduate medical education. It is estimated that the GME nursing subsidy for preprofessional hospital nursing programs could reach $420 million by the year 2000. While still minuscule in comparison with the projected $10 billion GME medical subsidy for that year, this nursing subsidy would provide crucial assistance for the training of advanced practice nurses needed desperately in the new health care system.

Without adding a dollar to existing Medicare nurse training funding, redirecting these funds to advanced practice programs from hospital training programs would begin to bring balance and rationality to Medicare support of nurse education. The Physician Payment Review Commission recommended this change in 1995, as did the Association of Academic Health Centers the same year. The Pew Commission report recommends reducing the number of nursing schools by 10-20% through closure of diploma and AD programs. This recommendation, and the following one, to increase federal subsidies for nurse practitioner education, are in the public's interest and should be enacted.

It is important to recognize that nurse practitioners are part of the nation's total resource of primary care practitioners. It would be wrong to titrate the medical workforce into primary and specialist providers without including nurse practitioners in the primary care numbers. When that

is done, the proportion of all primary care providers comes closer to the 50:50 ratio of specialist:primary care that is considered ideal.

INTERNATIONAL MEDICAL GRADUATES AND VULNERABLE POPULATIONS

The IOM report and the Pew Commission report recommend bringing first year medical resident numbers closer to the number of US medical graduates each year, giving preference to US medical graduates for residencies. The Balanced Budget Act of 1995 recommended limiting the number of residents funded by Medicare. These actions taken together could reduce resident numbers by nearly one third, making significant progress toward limiting the overproduction of physicians. In addition, the IOM report recommends replacement, not transition, funding to hospitals for International medical graduate (IMG) downsizing, and recommends that education policy be disentangled from service needs. All of these recommendations make quality and financial sense.

Concerns have been raised in this subcommittee and with others within the health care policy arena about the gaps in medical care that could occur by reducing IMG's this dramatically. IMG's are more likely to be in resident positions where underserved patients are seen, such as inner city public hospitals, are more likely to take primary care residencies, and to take practice positions in underserved and rural areas.

While strong consensus exists for downsizing residencies, and the virtual elimination of IMG's, the potential damage to hospitals and patients dependent on care from IMG's is enormous. The plight of acutely ill patients bereft of medical care could irreparably harm a health care system in our inner cities and academic health centers which is already fragile and in jeopardy. Any long term solutions must be tempered with interim investment to assure that adequate resources are in place. The IMG resource is centered in a few major areas, including many academic health center hospitals, and special attention must be given to them during this transition period.

Notwithstanding these findings, the final route of IMG career decisions are indistinguishable from US medical graduates. The same percentage of IMG's as USMG's (34%) are currently in primary care. A May 1996 CRS report suggests that IMG's initially take primary care residencies because they are most available, but eventually subspecialize to the same extent that USMG's do. IMG's and USMG's are similarly represented in geographically underserved areas.

Providing culturally sensitive care is one of the Pew Commission recommendations. With Medical school applications at an all time high, reducing medical class size or closing medical schools as a first remedy for the physician surplus could be damaging. Minority applicants are often less competitive, and yet they are a preferential resource to serve our nation increasingly represented by minorities with special cultural needs. IMG's are represented by nationalities not reflective of our major minority/international population, and would therefore be less attuned to culturally sensitive care than US applicants. The best first option to limit physician surplus would be to limit IMG positions.

Medical residents give care to hospital patients with low cost to hospitals, but the real cost to the public is high. Medicare pays approximately $70,000 a year to hospitals for each resident. But the public cost does not stop there; each resident exits the system and incurs, on average, $1 million a year in health care costs. This inordinate cost to the public cannot be legitimized where there is an oversupply of physicians. The IOM report recommends resident **replacement** funding for the service value of residents, a strategy that would have secure funding, and put in place a new structure, not simply an interim one.

Even if there were no reason to change the medical resident workforce, resident practice and responsibilities are changing dramatically. More outpatient and primary care sites demand their presence, taking time away from hospital productivity. Even in the hospital, patient length of stay has decreased so drastically that the learning time for residents is compacted and takes more time away from service contributions. Managed care also increases the necessity that the resident have knowledge of community resources, and skills in health education and compliance behaviors.

The changing of the guard each July, as a new cohort of freshly minted MD's enters the resident workforce, produces a downturn in productivity, one that the new fast paced hospital under managed care cannot sustain. Therefore, a resident replacement strategy for IMG's that places a permanent skilled provider in the position, is a quality and productivity enhancer for hospitals which will still need to find resources to enter and train new US residents.

Advanced Practice Nurses could be valuable IMG replacements working collaboratively with physicians in new team configurations. APN's, having completed a graduate degree program, already have the patient care skills that are at least as sophisticated as a beginning resident. In addition, APN's have the community and patient care/education skills that are inherent to their basic nurses training. Nurses are particularly astute in regard to cultural needs, and are therefore valuable caregivers with underserved populations. This constellation of competencies fits the managed care requirements of quick and seasoned response to patient needs, safe and early hospital discharge, and fewer costs associated with the learning process of residents. In addition, these APN replacements will not exit every three to five years to establish costly and competitive practices, but will remain in the positions, increasing in competence each year, and providing continuous quality that can sustain the cyclical process of US medical resident training. States and cities that now have the preponderance of IMG's have significant numbers of APN's and APN training programs, making the workforce transition more likely.

The Pew Health Professions Commission has recommended expansion of the National Health Service Corps (NHSC) as a means of securing care now given by IMG's to patients in rural and other underserved areas. HPSA designations also focus on filling these gaps. A recent CRS report states that these rural service deficits may worsen further under managed care as large urban networks make inner city primary care more attractive.

There are some problems in the Pew Commission recommendation to expand the NHSC; only professionals with high financial burden or lack of other job opportunities need take these positions, and they do so for limited time, not making the life time career decisions to serve in those communities. Incentives should be developed for career-long commitment that will attract quality providers. NHSC funding might better be invested in preferential reimbursement programs, or other continuous career enhancement incentives for professionals practicing in shortage areas.

MEDICARE FINANCING AND THE FUTURE ROLE OF ACADEMIC HEALTH CENTERS

The Medicare reforms developed in the Balanced Budget Act of 1995 should be resubmitted and enacted. The trust fund for health professions education is particularly important and would serve three crucial functions; it would broaden the base of funding appropriately, would shield funding from the vagaries of the budget process, and would make private sector subsidies explicit. Private contributions to health professions training, hidden in the cost base of hospitals, are probably equal to or slightly larger than the Medicare subsidy. With aggressive managed care hospital payment negotiations, that private subsidy could wither. Making the contribution explicit and required could protect health care for millions of patients. The Pew Commission also recommends this change in financing. Nurse education subsidies should be explicitly included in this trust fund; Medicare now includes nursing education funds and the new system should, also. The funding, however, should be redirected from hospital training programs to university based advanced practice programs.

A second payment reform is needed to move funds to the entity incurring costs of health professionals training; now funds flow to hospitals, and these sites are rapidly moving to private practices or other primary care sites for health professions training. The Pew Commission recommends that one quarter of medical student and medical residency training take place in primary care sites. It will take a redirection of resources to carry out this important recommendation.

The role of the academic health center (AHC) in these improvements is central. This is not only

the site of medical training, it is where medical leadership for the next generation begins. AHC's are not only centers of excellence, they are the entities that make excellence in health care possible. The cascade of new knowledge to reduce the burden of disease and disability cannot happen without dedicated research...patient care research including those with expensive and rare conditions.

The Pew Commission recommends more cross discipline training, more engagement of public health professionals with the clinical professions, and development of broader competencies within medicine and nursing. AHC's are where the majority of APN's are educated, and where most Schools of Public health reside. AHC'c are where these new teams will be forged and evaluated, with doctors and nurses and public health experts working together to design and establish more comprehensive, cost effective, high quality care. It will be these innovations that can sustain the excellence in American medicine that makes us the envy of the world. It will take stable financing to secure these continuing contributions to the nation's health.

Mrs. JOHNSON. Thank you very much, Dr. Mundinger, for your testimony.

Mr. Caton, welcome.

STATEMENT OF LYNN E. CATON, PA-C, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Mr. CATON. Thank you, it's very nice to be here. I appreciate this opportunity to represent the American Academy of Physician Assistants and 26,000 practicing PAs.

In addition to serving as president this last year, I am also a PA practicing family medicine in Vancouver, Washington and a volunteer faculty member for the Oregon Health Sciences University PA program. The PA profession is slightly younger than Medicare but in our 29-year history PAs are credited with providing quality care.

It is quite cost-effective care. PAs are heavily depended upon to provide physicians services to hundreds of thousands of patients annually. We were pleased when Dr. Detmer of the Institute of Medicine and Governor Lamm of the Pew Commission appeared before this Committee just a few weeks ago and discussed GME. And, they both acknowledged the value of physicians assistants and the need to ensure an adequate supply of PAs.

The PA profession has its roots in the active-duty medical corpsmen who served in Vietnam. Today, there are 78 accredited educational programs and PA must pass a rigorous certification and recertification examination, as well as complete 100 hours of continuing medical education every 2 years.

More than 85 percent of PAs have a minimum of a baccalaureate degree and of those 15 percent have either a master's or a doctorate degree. PA education is grounded in primary care, and the disciplines of family medicine and internal medicine remain the largest areas of PA practice.

Both the didactic and clinical rotation phases of PA training are focused on the physician/PA team approach to the delivery of health care which continues once the PA enters practice. Both physicians and patients respond quite favorably to this team approach, as evidenced by the increasing physician demand for, and patient acceptance of PAs.

As someone who has completed my formal education some years ago, Federal support of PA education is no longer a help or hinderance to my ability to diagnose and treat patients, be they Medicaid or Medicare, private pay or uninsured. However, as president of the Academy, addressing the educational needs of the PA profession, is of great importance. Because PAs did not exist at the time of Medicare, we are not included in graduate medical education funding. It is available to other health care providers such as physicians, nurses and other allied health professionals.

Nonetheless, PAs, today are heavily relied upon to provide physician services to both Medicare and Medicaid beneficiaries. Congress has long recognized the value of PAs to deliver health care. The Rural Health Clinics Act, for example, requires PAs or nurse practitioners to own, or staff at least 50 percent of the time, all federally-certified rural health clinics. The clinics are also eligible for Medicare reimbursement. This Act alone has resulted in greatly

improved health care access for Medicare beneficiaries in this country's rural and medically under-served communities.

In fact, more than one-third of PAs in the United States practice in communities of less than 50,000. In addition, Congress has recognized PAs as cover providers of physician services under Medicare in numerous practice settings, culminating in a recent provision for all out-patient settings that was included in the 1995 Balanced Budget Act. Unfortunately, that bill was vetoed by the President. The Academy is hopeful that comparable provisions will be incorporated into future legislation and we would like to take this opportunity to thank the chair for supporting this legislation.

Understanding the valuable role that PAs play in providing health care to patients, the Physician Payment Review Commission adopted a recommendation last year calling for inclusion of PAs in the GME funding stream currently available to nurses and allied health professionals. This funding, projected to be somewhere between $300 and $500 million by the year 2000, is limited to hospital-based training programs. The PPRC recommendation, in addition to including PAs as eligible GME providers, would also permit training of all eligible providers to occur in 4-year colleges and universities, since the majority of providers no longer train in hospitals.

And we have heard from several panel members, preceding this one, that this is becoming a very important trend. I must add here that PAs have been doing this for about 30 years and for some of that time, before managed care, we have been able to entice physicians to actually provide payment to teach our students. So, if the general trend for medical education goes away from hospitals to out-patient settings and medical students and residents are trained in these settings, it will have a major impact on PA training.

We believe the PPRC recommendation is a good one. We urge your consideration of it for several reasons. First, it is simple fairness. Both the Medicare and Medicaid Programs are heavily dependent upon PAs to provide medical care to beneficiaries, but PAs are the only primary care providers not currently eligible for GME. Perhaps most importantly, supporting PAs with GME funding is a sound investment in an important public policy objective. GME is intended to ensure an adequate supply of providers for Medicare beneficiaries. The number of PAs in clinical practice is quite high—85 percent full time and when we add in part-time practice it jumps to 93 percent. Obviously PAs are committed to practicing clinical medicine, making them a sound GME investment.

Also the Federal Government is a significant employer of PAs. Many Federal agencies, ranging from the Department of Federal Affairs, Justice, Defense, National Institutes of Health, Indian and Public Health Service rely on PAs to provide care to their respective patient population.

The other professions heavily relied upon by the Federal Government for delivery of health care, such as physicians and nurses, have long been in the GME funding stream.

Also, despite the impressive job that States and private educational institutions and students have done in supporting the PA programs, demand for PAs continues to exceed the supply. Current PA graduates continue to report six to seven jobs per graduate. The

only funding currently available to PA programs comes under title VII of the Public Health Service's Act and is targeted for programs that graduate students who enter practice in medically underserved areas or from disadvantaged backgrounds. Title VII plays an important role but its goals are very limited in what they can achieve.

Finally, we believe that the current structure of PA programs and their funding streams would be a good model for other health professions receiving GME. Given the existing State, local and private funding of PA programs the potential for PA programs to become dependent solely on GME funds is both low and preventable. But, GME funding would go a long way toward ensuring an adequate supply of PAs. Given the Federal Government's reliance on PAs to provide needed medical services to a diverse patient population, it seems only reasonable that PAs be eligible to receive GME funding.

In conclusion, we believe that including PAs in the GME funding stream currently available to nurses and allied health professionals would not only help to ensure an adequate supply of PAs, but also to send a message to the Medicare Program that Congress recognizes the valuable role that PAs play in ensuring access to quality, cost-effective medical care.

Thank you for your attention.

[The prepared statement follows:]

STATEMENT OF
LYNN E. CATON
AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Overview

Physician Assistants (PAs) have become an integral part of the nation's health care workforce. As PAs have achieved legislative and regulatory recognition as well as professional acceptance, they have greatly improved access to primary care services throughout the United States. Unlike many health care professions, PAs have never received educational funding through Medicare graduate medical education (GME), because the PA profession did not exist at the time Medicare and GME were created.

As Medicare celebrates its thirtieth anniversary, however, PAs are depended upon heavily to provide the very services the framers of Medicare sought to make available to this country's senior citizens. The Academy believes the clinical, scientific and academic evidence strongly indicates that the time has come to ensure that PAs are among the GME-eligible provider pool. As Congress addresses proposed changes to GME, we urge you to adopt the PPRC's recommendation that PAs be included in the GME funding stream.

As reported in the *Ninth Report to Congress, Health Personnel in the United States 1993*, a higher percentage of PAs practice in rural and medically underserved areas than any other primary care providers. PAs also provide health care services where there is a lack of general physicians, such as inner city and urban underserved areas, and are also in increasing demand in managed care and HMO settings. And of great significance to the GME debate is that PAs are well suited to deliver the care now provided by residents, particularly International Medical Graduates, which seems likely to be lost in the restructuring of residency program funding.

Including PAs in GME is also a sound investment. One of the clear public policy objectives of GME is to ensure an adequate supply of health care providers who enter clinical practice and actually deliver health care. Eighty-five percent of all PAs are in clinical practice, and when those practicing part-time are added in, the number jumps to 93 percent. Congress can be assured that funding PA education through GME will achieve the fundamental objective of an adequate provider pool.

Background

A creation of organized medicine, the first PAs began practicing in 1967. In the ensuing 29 years, the PA profession has grown steadily and solidly. The profession now consists of 25,700 clinically practicing PAs, educated in accredited PA programs and certified by the National Commission on Certification of Physician Assistants. In order to maintain their certified status, PAs are required to sit for a recertification exam every six years and complete 100 hours of continuing medical education every two years. According to the AAPA 1995 census data, 85.9 percent of PAs hold a minimum of a bachelor's degree, and of that, 15.5 percent hold either a masters or doctorate. PA education is grounded in primary care, and family/general practice remains the most common area of PA practice, followed by general internal medicine.

The US Department of Labor projects a 36 percent increase in the number of PA positions by the year 2005, and self-reported data from new PA graduates indicates approximately six job offers per graduate. The demand for PAs continues to grow in part because of satisfaction by the physicians who supervise PAs. Because physicians and PAs usually train in the same medical schools, receiving instruction from the same faculty and working as teams during clinical rotations, physicians have become increasingly supportive of the physician-PA team. The team approach to health care delivery is strongly rooted in PA education, and every PA in the United States practices with the supervision of a licensed doctor of medicine or osteopathy. Another significant aspect of PA demand is patient satisfaction. A recent survey of patients who receive care from a PA found that "nearly nine in ten of those surveyed said they're very or somewhat satisfied with the care they receive. That's nearly as great a vote of confidence as the 97 percent

of patients who said they're satisfied with the doctor's medical know-how." (*Medical Economics, August 21, 1995)*

Graduate Medical Education - Eligible Providers

As noted earlier, of all the providers that the federal government recognizes as vital to the delivery of primary care services, PAs are the only professionals not currently eligible to receive GME funding. The single largest component of GME is dedicated to physician residencies. However, significant funding, equivalent to approximately 15 percent of current expenditures on Direct Medical Education for physician residents, was also established for a wide range of other health professions. While some of these professions may require graduate study today, most do not, and few, if any, did at the time Medicare was enacted.

According to the Congressional Budget Office, GME funding for the training of medical residents is expected to exceed $6 billion for FY 95; payments are projected to grow to more than $7.5 billion in the year 2000. (*CBO Report, Medicare and Graduate Medical Education, September 1995)* In addition to entitlement funding available to physicians under GME, categorical grant funding is also available to primary care physicians (family physicians, general pediatrics and internal medicine) through Title VII of the Public Health Service Act. The FY 95 appropriation under Title VII for the education of these physicians was approximately $64 million.

In addition, "Medicare is the single largest federal source of support for nursing schools," according to Physician Payment Review Commission member Linda Aiken, PhD. Aiken further notes, "Medicare funding for nursing education has been a stable and reliable resource, increasing from year to year because it is an entitlement, and thus not subjected to the congressional appropriations process. According to recent unpublished projections from HCFA, hospitals will receive approximately $248 million in Medicare support for nursing education in 1994, rising to some $420 million by the year 2000." In addition to entitlement funding available to nursing under GME, Aiken notes that "Title VIII Public Health Service monies, which constitute most of the other federal support for nursing education, now total roughly $60 million a year." (*JAMA, May 17, 1995, Vol. 273, No. 19*)

Also, 13 other health care provider training programs are eligible for GME funding under the collective title of "paramedical or allied health" personnel. PAs are not included in that definition, which covers medical technology, medical records, x-ray technology, physical therapy, occupational therapy, pharmacy residencies, inhalation therapy, hospital administration, dietetic internships, and cytotechnology, as well as professional nursing, practical nursing, and nurse anesthesia. Despite the legislative mandate for funding professional nursing, Aiken argues that, "Medicare supports primarily *pre*professional education in nursing. Graduate education does not generally qualify for reimbursement." Aiken notes that diploma nursing programs, particularly those in Ohio, Pennsylvania, and New Jersey, account for one-half of the total Medicare payments, and that "65% of all new nurses in the United States are trained at less than the baccalaureate level." Thus, the argument appears to be that professional level education is commensurate with attainment of at least a baccalaureate degree. Aiken thus concludes that "graduate level clinical education and baccalaureate education would be targets consistent with the assessed needs of the nurse workforce of the future. One example cited for reaching these targets would be increased GME reimbursement for nurse practitioner programs, not all of which qualify for Medicare reimbursement now." (*JAMA, May 17, 1995, Vol. 273, No. 19*)

PAs would be a unique addition to the GME funding stream, in that the profession has worked diligently to meet the demand for PA graduates without the benefit of GME support. There is already significant financial support from states, localities, educational institutions and students for PA programs. Yet despite the reliance on PAs to provide medical care to Medicare beneficiaries, PA programs have never been eligible for GME funding. While there is no likelihood of PA programs becoming dependent upon GME, the Academy believes it is only fair for Medicare to help support the training and education of PAs.

PPRC Recommendations Regarding GME

Commissioner Aiken made a recommendation to the PPRC on April 27, 1995, calling for a change in current GME funding away from diploma nursing programs and towards baccalaureate and graduate advanced practice nursing programs. Members of the PPRC pointed out that the initial recommendation excluded physician assistants, and directed Commissioner Aiken to work with other members of the Commission to revise her recommendation to include PAs.

The intent of the Commissioners to include PAs in their final recommendation results from much discussion and study by the PPRC about the important role that nonphysician providers, defined by the PPRC to be advanced practice nurses and PAs, play in the delivery of health care. (*PPRC Annual Report to Congress, 1994, citing a RAND study commissioned by the PPRC*) One of the key components of the PPRC's recommendation regarding GME eligibility standards for PAs and advanced practice nurses pertained to education and training programs operated by four-year colleges and universities, as well as those programs based in hospitals.

The PA profession sincerely appreciates the PPRC's recommendation and support for including PAs in the GME funding stream, as well as its recognition of the role PAs play in health care delivery. As mentioned earlier, unlike physicians and nurses, PAs historically have had no educational entitlement funding. Categorical grant funding available under Title VII for physician, dentistry and PA programs is the only federal support available to PAs, but as the PPRC has noted, "Many of these programs lost substantial funding during the early 1980s and have not yet been restored to their previous funding levels." (*JAMA, September 1, 1993, Vol. 270, No. 9*) The peak allocation for PA program funding came in FY 94, at $6.5 million. After rescissions in FY 95, funding fell to approximately $6 million. By contrast, Title VIII funding available to advanced practice nursing is significantly higher. In FY 95, advanced nurse education received a $12,253,000 appropriation, along with an additional $16,943,000 for nurse practitioners/nurse midwives. Despite similar ratios in funding levels over the years between Title VII and Title VIII, the number of clinically practicing PAs and NPs were quite similar at the time those appropriations were authorized; specifically 23,000 PAs, and 24,100 NPs. (*PPRC Annual Report to Congress - 1994; Moses, Division of Nursing, Bureau of Health Professions; Aiken, study for the Department of Health and Human Services)*

The need to expand the pool of nonphysician providers (NPPs) comes from many different sources. First, "NPPs treat many patients who have traditionally faced barriers in obtaining health care." (*PPRC Annual Report to Congress, 1994)* Second, PAs are a viable alternative to replace the services of International Medical Graduate (IMG) residents that will likely be lost as a result of GME funding reductions. And third, unlike countries with higher ratios of generalist to specialist physicians, the United States is the one country that makes extensive use of PAs, and has in fact come to rely on PAs as important and integral providers of primary care. A brief discussion of these points follows.

Medically Underserved Populations

Time has proven that with reasonable supervision requirements and prescriptive authority, PAs are able to extend physician services to patients who are underserved or who have traditionally gone unserved altogether. This is evidenced by the number of PAs who have chosen to practice in rural areas. PAs have an extremely good record of practicing in our small towns and rural communities that are traditionally underserved. As of July 1995, 34 percent of PAs practice in communities of 50,000 or less. (*AAPA 1995 Census Data)*

IMG replacements

Many experts have recommended a reduction in the number of GME-funded physician residencies. A serious concern has been raised about who will deliver the services now provided by those residents. Upon researching this question, staff of the PPRC concluded that PAs are viable substitute providers for lost residents:

> "Teaching institutions could respond to the loss of residents by . . . using highly skilled nonphysician practitioners [such as PAs]. There is growing literature documenting the

> favorable experience teaching hospitals have had using nonphysician practitioners on the wards, in critical care, and in surgery. NPPs may actually be preferable to residents. Some faculty would rather work with NPPs; they have a lower turnover rate, greater familiarity with departmental procedures, and more clinical experience than junior residents."

Further, in response to concerns that NPPs are more expensive to hire than residents, PPRC staff also noted that "NPPs may cost institutions less than salary figures suggest if they are more efficient than residents or require less faculty supervision." *(JAMA, September 1, 1993, Vol. 270, No. 9)*

Of equal importance to the question of PA substitutability is that inpatient services provided by PAs are already covered under Medicare at 75 percent of the physician fee schedule. Although hospitals may not now commonly make use of the ability to bill for physician services provided by PAs under Part B, that is likely to change if PAs were employed in larger numbers, thus minimizing the per resident loss of both Direct and Indirect Medical Education payments for teaching hospitals.

Generalist versus Specialist ratio

As the health professional workforce debate has evolved over the past few years, there has been much discussion as to the appropriate and necessary physician generalist to specialist ratio. Some have argued for a 50-50 ratio, without necessarily agreeing on how to reach that goal. Others dispute the need for such a large percentage of primary care physicians, particularly given the availability of PAs in this country, which countries with higher percentages of generalist physicians do not have.

Michael Whitcomb, senior vice president for medical education at the Association of American Medical Colleges, argues that the current supply of generalist physicians in the United States is adequate, due in no small part to the reliance on PAs to delivery needed primary care. In a cross-national comparison of generalist physician workforce data, Whitcomb notes that, "Differences between the relative sizes of the US generalist physician workforce and that of Germany and Canada are partially due to the more extensive use in the United States of physician assistants (particularly in managed care organizations)." *(JAMA, September 6, 1995, Vol. 274, No. 9)*

As Dr. Whitcomb correctly points out, PAs have evolved as a critical component of the nation's primary care workforce. And practically speaking, PAs, the vast majority of whom come to PA training with extensive science and health care backgrounds, can be trained more quickly and less expensively than physicians. The cost of educating a PA is about one-fourth that of educating a physician, and the time needed for PA training is approximately two-thirds that of medical school. The categorical grant funding under Title VII also shows that federal support of PA training is highly cost effective. In 1995, approximately half of the country's 64 accredited PA programs received an average federal grant of $135,000. With a combined first and second year class size of approximately 70 students, the per pupil support equals $1,928. By any standard that is a sound investment, and a small fraction of the estimated $58,000 to $102,000 annual cost for physician resident stipends. *(CBO Report, September 1995)*

In response to this point, as well as the question of appropriate levels of GME funding for physician residents, Kenneth Shine, MD, of the Institute of Medicine of the National Academy of Sciences, notes that "the nation subsidizes the education of a high-cost physician rather than increasing the number of physician assistants who are supported and are more likely to be in great demand in the future." *(JAMA, April 5, 1995, Vol. 273, No. 13)*

Conclusions

If we have learned anything from the health care reform debate which recently raged with such fervor, it is how quickly the pendulum can swing and how significantly the terms of the debate can change. Two years ago we faced the question of how to expand health care access to all Americans, as well as how to ensure an adequate supply of providers. The challenge before the

Congress now is significantly altered. Specifically, it is how to ensure continued access, in the most cost effective way, including the increased use of PAs as providers of primary care.

The AAPA believes it makes eminent sense to rely on well-trained PAs to provide needed primary care services. PAs, based on their shared training with physicians, are fully cognizant of the additional knowledge, skill and experience that physicians have. Physicians created the PA profession, thus ensuring that the physicians' patients would receive needed primary care services, while allowing the physician to provide those services he or she trained for additional years to learn. The physician-PA team approach to the delivery of medical care is a reflection of health care market forces in action.

It is the position of the Academy that the best course Congress can take towards ensuring an adequate supply of primary care providers, which clearly includes PAs, is to ensure that GME funding is available to PAs.

Mrs. JOHNSON. Thank you very much.

Do either of your training programs for either advanced practice nurses or PAs involve a residency type rotation?

Dr. MUNDINGER. Yes. In advanced practice nursing most of those programs are 2 years and usually the last semester is in a very concentrated clinical residency.

Mr. CATON. PAs, half their training is in a clinical clerkship. We do have some post-PA program residencies in specialty areas but the first phase of the PA education is didactic, and the second phase is residency or clinical clerkships.

Mrs. JOHNSON. Is there anywhere in the country where your organizations are participating in any consortium type training model?

Mr. CATON. In a large number of areas, especially from where I'm from, Vancouver, Washington, we participate in the WAMI program. As one of the panelists noted earlier, we have a satellite training program in Nevada that participates in the Sierra program and those students came through the Medex Northwest program.

Dr. MUNDINGER. Nursing is not, that I know of, participating in any of these consortiums. It would be so appropriate, because this is not simply a cheaper substitute for medical care, it's a real value-added component that under managed care is very needed.

Mrs. JOHNSON. One of the things that was interesting was the team from Nevada's testimony about coordinated practice and team medicine. As one representing an old manufacturing district, I have seen the incredible difference that team manufacturing makes to both quality and productivity. While I know that is a completely different area, I can really testify to the fact that the level of integrated service delivery and the level of communication and the ideas and what comes out of that is so much bigger than what the individual changes in input that it is hard to imagine.

And, I do think that one of the reasons why we have to pursue consortium training models is because they are the setting within which some of the new developments are going to take place. They are the only way we are going to develop an understanding of how to hold managed care systems accountable for quality and how to assure that they actually do all the testing and all the diagnosis that's necessary in that delicate balance through which you define what is appropriate care. It is going to be hard to reach and yet, if we don't reach it, managed care will fail. If managed care fails, we miss an enormous opportunity to, frankly, improve the quality of health care and access to health care for just really one-third or half of the population.

So, it is very important that we think bigger and broader and more creatively than we have been thinking in the past. That is part of the reason I support you so much in the things you are trying to do.

Thank you for being here.

Dr. MUNDINGER. Thank you.

Mr. CATON. Thank you.

Mrs. JOHNSON. The hearing is adjourned.

[Whereupon, at 3:59 p.m., the Subcommittee was adjourned.]

[Submissions for the record follow:]

AMERICAN ACADEMY OF NURSE PRACTITIONERS
AMERICAN ASSOCIATION OF COLLEGES OF NURSING
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
AMERICAN COLLEGE OF NURSE PRACTITIONERS
and
NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN REPRODUCTIVE HEALTH

The American Academy of Nurse Practitioners (AANP) representing over 17,000 nurse practitioners nationally and encompassing all nurse practitioner specialties, the American Association of Colleges of Nursing (AACN), representing 480 baccalaureate and graduate nursing education institutions, the American Association of Nurse Anesthetists (AANA) representing 27,000 nurse anesthetists, the American College of Nurse Practitioners representing five national nurse practitioner organizations, fifteen state nurse organizations, and 1400 individual nurse practitioner members, and the National Association of Nurse Practitioners in Reproductive Health (NANPRH) representing 1500 nurse practitioners in reproductive health urge that Medicare funds now focused on entry level nursing education be redirected for clinical training of graduate nurses. This innovation would provide an on-going revenue source, not subject to the uncertainties of the annual appropriations process, to expand the production of advanced practice nurses, a vital resource for meeting future Medicare population needs.

The Committee's concern about physician workforce and the supply of residents, especially international medical graduates, is understandable in view of the extent of Medicare financial support and the types of physicians it produces. But the Committee should not overlook the relevance of other health care professionals such as advanced practice nurses, in meeting the needs of the health care system for workforce. As the Committee examines Medicare funding and services for the nation's elderly, Medicare's lesser-known side--the system's financial support of training for nurses, physicians, and other professionals--itself is in dire need of reform. For example, Medicare supports the costs of training resident physicians with direct and indirect Graduate Medical Education funds amounting to over $5 billion per year. At an estimated $250 million in 1994, Medicare is the largest single source of federal support to train America's largest health care profession--registered nurses. Yet, 70 percent of every Medicare dollar for nursing education goes to hospitals that operate diploma programs that produce less than 10 percent of the nation's RNs. These programs are geared toward the hospital in-patient population. Hospital downsizing, resulting in sicker patients discharged to home, means that the care once provided in a hospital setting with a myriad of sophisticated support systems must now be provided by more appropriately trained nurses working in home and community settings. By the year 2000, Medicare payments to hospitals for nursing education are projected to reach $420 million. In addition, hospitals receiving these payments are concentrated in Pennsylvania, New Jersey, and Ohio, and receive nearly half of the Medicare nursing education funds.

At the same time, growing specialization among physicians, the health system's increasing demand for front-line primary care, and the accelerating drive toward managed care, prevention, and cost-efficiency are spurring the nation's need for nurse practitioners, certified nurse-midwives, certified nurse anesthetists, and clinical nurse specialists with advanced practice skills. While there has been much discussion in the media and in Congress on how Medicare redesign may ultimately affect funding for physician residencies in the nation's teaching hospitals, nursing and other health care leaders are focusing on a concern equally as big--the need to produce sufficient supplies of advanced practice nurses for an increasingly outpatient world where more needs of current and future Medicare patients will lie. Reforming Medicare will require more effective targeting of Medicare dollars that support the training of health professionals who provide that care. Since its creation in 1965, Medicare has reimbursed hospitals for a portion of their clinical, classroom and other costs to train nurses, physicians and other health personnel with the aim of providing high-quality inpatient care for Medicare recipients. With recent and dramatic shifts in where and how health care is delivered, the time is long overdue to overhaul the other side of Medicare--its health professions education expenditures that increasingly have become irrelevant and misdirected.

At no additional cost to Medicare, money presently spent to educate diploma nurses with skills limited to basic hospital service could be used to educate Advanced Practice Nurses (APNs). APNs are expert clinicians trained to deliver primary care, manage chronic medical conditions, and address other needs of the Medicare population. They include nurse practitioners, nurse

midwives, nurse anesthetists, or clinical nurse specialists. APNs are educated in graduate nurse education (GNE) programs accredited by nationally and regionally recognized accrediting bodies.

Redirecting Medicare funds to the education of advanced registered nurses not only makes clear sense for a health system dominated increasingly by the competing concerns of quality and cost, but would support preparation of the nurses in greatest demand by today's Medicare patients. In 1965 at Medicare's inception, most categories of advanced practice nursing had not yet emerged. In the years since, Medicare policy has not kept pace with the growing prevalence and documented quality and cost-effectiveness of APNs. Annually, millions of Medicare dollars that could support the preparation of the APN instead have funded the continued production of diploma graduates, fueling an imbalance in the nation's nursing pool.

Reports from other national organizations forecast greater demand for the APN than ever before. In a 1994 report, the Pew Health Professions Commission urged doubling the number of nurse practitioner graduates by the year 2000 to offset the shortages of primary care physicians in major metropolitan centers, rural sites, and inner cities. Among their roles, the nation's approximately 35,000 nurse practitioners (NPs) conduct physical exams; diagnose and treat common acute illnesses and injuries; provide immunizations; manage high blood pressure, diabetes and other chronic problems; order and interpret lab tests; and counsel patients on adopting healthy lifestyles. Many NPs work in gerontological, pediatric, family health, women's health, and other specialties and some have independent practices. In 48 states, nurse practitioners can prescribe medications, while several states have given NPs authority to practice independently without physician supervision or collaboration.

More importantly, the NPs often provide services of the type most needed by Medicare patients: primary care at easily accessible, community based sites. These services are available at lower cost than would be possible in a hospital setting.

In a recently released report by the Institute of Medicine (IOM) on nurse staffing in hospitals and nursing homes, an IOM panel urged that increasing numbers of registered nurses with advanced practice skills be utilized in outpatient and inpatient settings to meet the demand for RNs with management, leadership, and supervisory abilities. As the panel noted, advanced registered nurses such as clinical nurse specialists not only provide high-quality and cost-effective care, especially for patients with complicated or serious clinical conditions such as Medicare patients, but are well-skilled for the sophisticated levels of practice required in today's hospitals. They work on multi-disciplinary teams and deliver a continuum of care across settings rather than focus on a "single event" of hospitalization. IOM also recommended that nursing home care be enhanced through increased presence of gerontological nurse specialists and nurse practitioners. While Medicare's role in nursing homes is limited, the patient population in these facilities is primarily Medicare eligible.

Similarly, in a recent study commissioned by the Association of Academic Health Centers entitled *The U.S. Health Workforce: Power, Politics, and Policy,* author Jerry Cromwell came to the strong conclusion that nurse anesthetists "will be in greater demand over the next ten years, and in significantly greater demand depending on how fast and how hard the public and private payors push." It is clear that the current educational system is simply not capable of producing an adequate supply for future Medicare beneficiaries.

The efforts of nursing organizations in the 104th Congress have been to focus on redirecting Medicare funding for hospitals operating diploma programs into APN education. The following Medicare changes would provide a greater benefit to the Medicare population.

1. Redirecting eligibility to add "jointly operated" programs and to phase out diploma programs.

Since the inception of Medicare, nursing education has shifted almost entirely to community colleges, senior colleges, and universities. At present, Medicare reimbursement for nursing education programs is limited by the "provider-operated rule," which directs most of the funding to hospitals that operate diploma programs that produce entry level nurses who are trained in hospital oriented care. Most APNs represent categories of providers not in existence when Medicare educational payment policies were designed, such as nurse practitioners, clinical

specialists, and others. Educational costs of these new providers are, with one exception (nurse anesthetists), not eligible for Medicare reimbursement now. Consequently, reimbursement eligibility requirements should be changed to include "jointly-operated" (provider-academic) programs that incur costs for APN education. To be eligible for reimbursement, Medicare providers would have to: 1) demonstrate that they incur clinical costs for the support of graduate nurse education programs, and 2) have a written contractual agreement with the program's academic partner institution. Cost items for determination of Medicare's share of reimbursement could include student stipends, costs of nursing clinical faculty, and supervision of APN students at the clinical site. (Now the students, school, and clinical sites bear these costs.) Determination of the specific cost of education would be based on a modest stipend, an appropriate ratio of training faculty to students, and faculty and supervisory salaries.

A major limitation in educating APNs, is the need for resources to cover costs of clinical faculty. Redirection would allow for additional clinical faculty to expand the number of APNs in training, thus helping to eliminate the waiting lists that many graduate nursing programs are experiencing. Indeed, Medicare reimbursement would give practice sites an incentive to take on additional students for clinical training, particularly because the numbers of specialty physician residencies likely are to be reduced. The lifting of restrictions on Medicare funding for nursing education would result in increasing the production of APNs, (both in terms of number and their program completion time) making cost-effective care more readily available to the Medicare population.

Unlike medical residency programs, most nursing programs pay their own clinical training faculty or make arrangements with preceptors at clinical sites to provide clinical training at patient care sites outside the schools' academic facilities. The cost of faculty at the clinical site and cost of preceptorships for advanced nursing students, however, are actually part of the cost of providing patient care because patients, including Medicare beneficiaries, receive the benefit of the care delivered by graduate students and their faculty. In almost all cases, APN students are RNs licensed to practice in a variety of patient settings, and most have practice experience as well.

2. Clarifying "provider" definition to include outpatient facilities serving Medicare patients.

Medicare defines "provider" as "hospitals, skilled nursing facilities, home health agencies, and other facilities." With health care delivery for Medicare populations evolving beyond the hospital to more accessible and lower cost, community based sites, ambulatory care facilities, as well as tertiary care sites, should be reimbursed for costs incurred for clinical training of APNs. Support for training in these settings where primary care is delivered is critical. The Medicare definition of "other facilities" should be clarified to include those facilities that provide health care to Medicare recipients, with or without links to acute care settings, including, but not limited to, nurse managed centers, ambulatory care facilities, community health clinics, health maintenance organizations, and public health departments. Reimbursing clinical sites for training APN students recognize the value of their services to Medicare patient care. As the number of specialty resident physicians is reduced, APNs could deliver many services formerly performed by resident physicians, as well as nursing care, and maintain quality of care. Acute care nurse practitioners are already working in a number of clinical sites.

Under this proposal, facilities that incur clinical costs for support of APN education would have access to Medicare funds, but only for the portion of the cost attributable to the Medicare patient population. Thus, for a site with 30% Medicare patients, about 30% of the training costs would be eligible for reimbursement. (This is the same formula used now.) Medicare funding would provide resources for added clinical faculty to expand the numbers of APNs in training, and promote quality service to the Medicare beneficiary. With an increasing proportion of older Americans, APNs are precisely the type of health professional the Medicare population will need for its primary care, management of chronic medical conditions affecting older people, and patient education to help this population avoid injury and expensive hospitalization of nursing home care.

The APN is a vital component in increasing access to quality health care services for Medicare patients in a rapidly changing health care environment. This is the time to shift Medicare funding toward the recognized need for advanced practice nurses. Other organizations support the redirection of Medicare dollars to APN education. In April 1995 the Physician Payment Review Commission (PPRC) recommended that advanced degree nursing programs operated by four-year

colleges and universities be eligible to receive Medicare funds that otherwise would be available only to hospital-operated programs. In July 1995 the Association of Academic Health Centers (AAHC) supported the allocation of funds for graduate nurse education by directing Medicare funds towards APN programs. Supporting APN education with Medicare dollars also has been urged by the Tri-Council for Nursing which, together with AACN, includes the American Nurses Association, American Organization of Nurse Executives, and National League for Nursing.

Redirection of the current Medicare monies for nursing education to APN education will increase the numbers of APNs and will ensure that Medicare patients will have the benefit of their skills in the future. Since the vast majority of undergraduate nursing education programs do not currently benefit from Medicare funds, the national supply of these personnel will not be adversely affected by the redirection of Medicare nursing educational dollars into advanced practice training. The redirection of these funds to APN education requires no new Medicare expenditures and could actually reduce expenditures. By recognizing only clinical costs of APN education and limiting eligibility to full-time APN students, costs would decrease substantially. Funding levels should not be reduced for those APN programs that currently benefit from Medicare support, such as nurse anesthetist programs. Redirection of funds would focus Medicare support on the preparation of the nurse in great demand by the Medicare beneficiary population, and help meet the needs of a health care delivery system that is changing for Medicare and other patients.

As the Committee considers Medicare reform and health care workforce issues, nursing groups ask that it examine the current structure of Medicare funding for nursing education and graduate medical education and the on-going changes in health care delivery. We urge your support for APN education at a time when these nurses are in great demand and capable of meeting the sophisticated needs of today's Medicare beneficiary.

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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the U.S. House of Representatives
on
Financing Graduate Medical Education

June 11, 1996

The American Hospital Association welcomes this opportunity to testify on Medicare payment to teaching hospitals. The Association's membership of 5,000 hospitals, health systems, networks, and other providers of care includes the full array of teaching hospitals: university-based academic medical centers, hospital-based independent academic medical centers, affiliated community teaching hospitals, VA medical centers, and military hospitals. These AHA members are the settir for the vast majority of residency programs conducted in our country.

SUMMARY

The deliberations of this subcommittee on payments to teaching hospitals are of special importance to AHA members, physicians-in-training, and the communities they serve. Medicare is the largest payer for hospital services. Its policies for medical education have an impact far beyond the monies spent. They set the social benchmark for other payers--private and public. Thus, hospitals urge the subcommittee to consider the following points as it re-examines policies for paying teaching hospitals. Medicare payment policies for teaching hospitals should:

- recognize the higher costs of teaching hospitals,
- provide clear public recognition of the social missions that teaching hospitals fulfill in our nation,
- help teaching hospitals continue their historical mission of caring for a large proportion of beneficiaries who lack personal physicians in private practice,
- provide continuing access to essential hospital care in underserved communities, and
- set important precedents for supporting medical education and uncompensated care in a payment environment moving toward capitated health care plans.

Given these multiple impacts, changes being considered by the subcommittee could either reinforce traditional commitments and demonstrate new initiatives, or potentially jeopardize both hospitals and the communities they serve. Therefore, the AHA would be pleased to work with the subcommittee as it continues its deliberations in the weeks ahead.

STATEMENT

Since its origin, Medicare has recognized and supported the additional costs teaching hospitals incur in sponsoring and conducting residency training programs for physicians. In the cost-based reimbursement era, Medicare recognized and paid its share of these costs. When Section 223 and TEFRA payment limits were adopted, Medicare recognized its share of the direct program costs of medical education and provided special exceptions and/or adjustments for the higher hospital costs accompanying medical education. Under Prospective Payment, Medicare has paid a prospectively determined amount per resident for the direct costs of graduate medical education programs (DGME payments) and an adjustment to the DRG rates based on the ratio of residents-in-training to the number of beds (IME payments). In this way, Medicare has set an important precedent for all payers, public and private. In short, Medicare's policies have been the national role model. The importance of this role model cannot be overstated.

Now, as market-based health reform occurs throughout the nation, it is vital that Medicare continue to set the social benchmark for all payers. No other payer will feel obligated to set a higher standard than Medicare. If Medicare reduces its historic commitment to support hospital costs for physicians-in-training, other payers will use the Medicare policy as justification for failing to support these costs. **The AHA strongly urges the subcommittee to continue Medicare's support for the educational costs of teaching hospitals.**

The AHA also wishes to remind the subcommittee of the relationship between the DRG update factor and IME payments to teaching hospitals. Because IME payments are calculated by multiplying the base DRG rate by a formula based on the ratio of residents to beds in a hospital, reductions in the update factor automatically decrease the payments that are made for IME. For example, if the update factor is reduced from 3 percent to 2 percent, IME payment increases will simultaneously be reduced from 3 percent to 2 percent. Thus, while Congress has retained the current formula for IME for several years, the DRG update reductions enacted by Congress have also reduced spending for IME payments. **The AHA strongly urges the subcommittee to acknowledge that IME payments are directly affected by reductions in the DRG update factor. Teaching hospitals will be impacted twice if the DRG update factor is reduced and the IME formula is reduced.**

In the past several years, there has been a number of reports and recommendations urging the federal government to limit the number of residents in training and to allocate positions by specialty to teaching hospitals. While this approach may have been consistent with the health planning legislation of the early 1970s, it is inappropriate to the market-driven changes occurring today. Hospitals are adapting to changes in their local communities. Any effort to superimpose a national resident allocation structure on local, market-based reforms will produce unintended and harmful results. Hospitals are already revising residency training programs to better match the needs of their markets. **The AHA believes there is no need to enact a system for allocating resident positions to local communities or to teaching hospitals.**

Last year, the Budget Reconciliation Conference Agreement included an important initiative to help ensure that hospitals continue to have the funds necessary to provide the residency training required before physicians can establish independent practice. Recognizing that payment systems are changing, Congress proposed new trust funds for medical education, which would be supported by Medicare payments as well as general revenues. While this approach is an important step, the use of general revenues could result in funding being affected by federal budgetary pressures rather than the needs of patients and graduate medical education programs.

A federal trust fund for graduate medical education supported by both public and private payers is essential as individual payers seek to establish the lowest prices for their enrollees. Unless such a fund is established and adequately supported, teaching hospitals will have to choose between being price-competitive by reducing their educational responsibilities, or retaining their responsibilities and being priced out of the market. **The AHA congratulates Congress for proposing graduate medical education trust funds in 1995 and encourages further refinements that emphasize the participation of private payers and self-insured entities in supporting the fund.**

Residency programs began in the inpatient units of teaching hospitals. Over the past two decades, an increasing amount of residency training has moved to ambulatory training sites, both hospital-based and free-standing. Medicare has recognized hospital-based training, both inpatient and outpatient. It has also recognized hospital-supported programs in non-hospital sites. Nevertheless, there is a need to expand support for residencies in ambulatory training sites, home and community service sites, and long-term care sites. **The AHA believes a trust fund for graduate medical education is an appropriate vehicle for supporting a broader array of training sites that are better suited to contemporary needs of residency programs.**

As Congress continues to work on a trust fund for graduate medical education, there is an opportunity for a more limited immediate step. Medicare beneficiaries are increasingly selecting private health plans for their coverage These plans are paid a fixed monthly payment based on the county of the beneficiary's residence. The payment, known as the Adjusted Average Per Capita Cost (AAPCC), includes both DGME and IME payments made under traditional Medicare. There is, however, no requirement that the health plan use the portion of the AAPCC that results from the DGME and IME payments to support medical education. As a result, the health plan benefits financially if it can avoid using hospitals that support medical education. **Therefore, the AHA supports removing the DGME and IME payment amounts included in the AAPCC and making those payments directly to the entities that incur the costs of graduate medical education programs.**

CONCLUSION

The Subcommittee on Health has periodically reviewed Medicare policy for supporting graduate medical education. The AHA has always welcomed these opportunities to share its views with the subcommittee and describe, whenever possible, the impact of proposed changes on hospitals, physicians in training, and local communities. We appreciate this opportunity to present a statement and we look forward to a continuing dialogue with the subcommittee.

STATEMENT OF THE AMERICAN LUNG ASSOCIATION
AND
THE AMERICAN THORACIC SOCIETY

The American Lung Association and members of its medical section, the American Thoracic Society, would like to thank the Ways and Means Health Subcommittee for the opportunity to comment on the U.S. physician workforce needs. The American Thoracic Society is a professional, scientific society of health care providers and scientists dedicated to the advancement of pulmonary medicine. As such, the American Thoracic Society has an interest in federal policies regarding professional training and physician supply.

We would also like to give special thanks to the Institute of Medicine's Committee on U.S. Physician Supply and the Pew Health Professions Commission for their work in defining the current challenges facing policy makers regarding U.S. physician workforce needs and developing a set of policy options to respond to the perceived trends. The work of both the IOM and the Pew Health Profession Commission was thorough and balanced. They should be commended for their work.

Although we are grateful for the effort of these commissions in collecting and reviewing existing data on physician supply trends, we view the work and recommendations of these committees as preliminary. Congress should exercise caution in reviewing the policy recommendations of the IOM and Pew Health Professions Commission report.

The American Lung Association and its medical section, the American Thoracic Society, have four specific comments we would like to relay to the Subcommittee:

1) Data suggesting a U.S. physician surplus will occur in all specialities should be viewed as preliminary.

2) Time should be allowed for market forces to respond to changes in physician supply.

3) Caution should be used in considering closing existing schools; intermediary steps should be used first.

4) Alternative funding sources for providers of care in under served areas should be developed and implemented before changes to foreign medical graduate residency payments are initiated.

1) Data suggesting a U.S. physician surplus will occur in all specialities should be viewed as preliminary.
Although recent studies have suggested a potential surplus of physicians in the U.S. in the future, such data should be viewed as preliminary. Recent studies, though using accepted and appropriate methodological techniques, do contain a number of major assumptions that may or may not be accurate estimations of future trends in the U.S. health care market. Should these assumptions prove to be incorrect, the projections of U.S. physician surplus could prove to be widely inaccurate.

Additionally, we are concerned that current studies make projections only on aggregate U.S. physician supply. Such studies are not sensitive enough to elucidate needed changes in the U.S. physician mix. We are particularly concerned that a quick response to perceived physician surplus may reduce the number of trainees in critical care medicine. Recent technologies and changes in U.S. demographics may require an increase in the number of subspecialty-trained critical care physicians.

2) Time should be allowed for market forces to respond to changes in physician supply.
Clearly the federal government, through the Medicare program, is a large stakeholder in supporting the cost of physician training in the U.S. While we recognize that the federal government has a compelling interest in ensuring appropriate supply of physicians in the U.S. we urge extreme caution in using payments through the Medicare program to change current physician supply trends. The American Lung Association and the American Thoracic Society strongly urge the Subcommittee to allow time to determine how market forces may lead to

changes in the U.S. physician supply. We are concerned that major changes in the Medicare program could result in unforseen and unintended consequences.

3) Caution should be used in considering closing existing schools; intermediary steps should be used first.
The Pew Health Profession Commission recommended that U.S. medical schools be closed to reduce enrollment by 20 to 25 percent. Although reducing the number of medical school graduates may be a necessary step, should projections regarding physician supply be accurate, we would urge extreme caution in recommending closing existing schools. The mission of medical schools extends beyond providing training to health care providers. Medical schools provide care in their communities and in many cases are the only point of access to care for low income populations. Further, medical schools play an important role in the local economy and in many cases are the primary employer. Medical schools also play a prominent role in conducting basic clinical research. Closing existing schools would have severe consequences to the health and economic infrastructure of local communities and could hurt the U.S. position as the leader in biomedical research.

We would suggest to the Subcommittee that there are a number of intermediate steps to pursue before considering closing existing training facilities. We recommend considering reducing class size and distributing information on physician employment prospects to undergraduates as mechanisms to reduce enrollment. These steps and others should be exhausted before considering closing existing medical schools.

4) Alternative funding sources for providers of care in under served areas be developed and implemented before changes to foreign medical graduate residency payments are initiated.
We support the recommendation that an alternative funding mechanism to support providers of care in under served and low-income communities be developed. We further recommend that such a funding mechanism should be fully developed before reductions in residency payments be initiated. Providers of care in under served areas should be held harmless in any transition to a new payment system for medical residency training programs.

In summary, the American Lung Association and its medical section, the American Thoracic Society, commend the IOM and the Pew Health Professions for their efforts to identify trends and policy options to meet future U.S. physician supply needs. We look forward to working with the Committee as it considers policy options for the future U.S. physician workforce needs.

June 21, 1996

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RE: Statement for the June 11, 1996 House Ways and Means, Subcommittee on Health Hearing on Graduate Medical Education (GME)

Statement on Medicare reform in relation to Graduate Medical Education (GME) and Teaching Hospitals from Louisiana State University Medical Center

Funding for GME from Medicare is vitally important and crucial for Academic Health Centers and Teaching Hospitals, whose role in turn is vital and irreplaceable in health education, research, and patient services for this nation. These institutions and their contributions to the Health Care workforce, new biomedical knowledge, and patient care delivery are recognized as the best in the world. The return on this investment to Medicare patients is substantial, as well as, proportional.

We agree that funding from Medicare for GME should be reexamined and reset in proportion to necessary changes in the total Medicare funds to achieve a balanced budget. A major concern is not only the amount and source of GME funds, but also the distribution to assure that the residents and the GME programs are the proper recipients. The accredited GME programs originating the recruitment and providing the education in the context of patient services should be designated to receive such funds, thus directed to the Medical Schools or if Medical Schools are not primary the Teaching Hospitals or a consortium fund for this purpose. This should ensure proper reimbursement of medical education costs by managed care contracts, and other federal and public funding, distributed properly to the accredited entity that incurs the cost and responsibility of training.

In Louisiana, LSU Medical Center operates two primary Academic Health Science Campuses in New Orleans and Shreveport. Our GME programs involve two separately accredited Medical schools and multiple affiliated teaching hospitals. We own and operate our University Hospital in Shreveport, but do not do so in New Orleans. Currently about 1000 residents and fellows are educated in this system, predominantly in public teaching hospitals spread geographically throughout the entire state. In respect to last years proposal on GME, we have and alert you to a technical problem; LSUMC is the accredited GME program but does own or operate the teaching hospitals except in Shreveport. If the hospital or other institution receives the funds, the problem is that we may not be reimbursed the full amount even though we incur the costs. This problem should be solved by payment directed to the GME program responsible, i.e. the LSU School of Medicine, to reimburse the cost.

Thus we depend predominantly and heavily on Federal Medicare funding and on Medicaid as well as Veterans Hospital funding to provide for the cost of training the future workforce, the majority of whom stay and practice in Louisiana. A very large amount of patient care is delivered to Medicare, Medicaid, and the uninsured and indigent patients through this system.

Therefore, we express our concern, as changes take place in the public and private sectors, that the funds from Medicare for GME continue in proportion, properly directed to pay the costs of workforce training and public service. Academic Health Centers in the United States, including LSUMC, are challenged by reductions in funding upon us and potential, in all of our missions for providing excellent education, research, and patient care. Funds for

education are being reduced by state, research grants are harder to obtain and sustain, and patient care reimbursed is less as managed care and negotiated contracts increasingly enter the market place. We cannot and should not lose our competence, capacity, or competitive edge for providing these vital and interrelated national services.

In this context, we favor the development of an all payor system from both public, Federal and State, and private entities. We favor targeting the subsidy for teaching hospitals to facilities with the highest uncompensated care costs due to uninsured patients and severity of illness factors. We favor combining the DME and at least some of the IME funds with other sources to provide for continuity and stability. We favor a transition period of 5 years to allow adjustments needed in a changing system.

In respect to anticipated changes in Medicare, legislation can and should go only so far. Some incremental and even substantiated adjustments can be written into law, with continual performance under the same federal system accomplished. However, certain proposals, if implemented, require more monitoring, careful decisions and allocations, and considerable and constant updates. There are also to be acknowledged significant trends currently underway, chosen by institutions and individuals, achieving desired outcomes. The prescription of law may be neither necessary or desirable as creeping incrementalism is working.

Some significant trends demonstrate that more American Medical School graduates are going into primary care, and these GME programs are enlarging. The overall cost of health care in the U.S. is rising more slowly. The increase in the number of total residents and the physician workforce is slowing in relation to countrywide needs.

As these trends and responses take place, proper study, reporting, discussion and policy become considerably more important - first do no harm. Thus a balance is desirable as to what should be set into legislation and what should be purposefully omitted. Innovation is desirable, likely to occur with good policy and fewer rules.

For the purpose of improved monitoring, more study and data reporting, and better decisions chronologically, we favor the creation of a new commission on GME of objective, knowing, and responsible persons. This could be accomplished under HHS.

Not withstanding the above, certain limits and incentives may well be appropriate at this time. We favor a limit set for the total number of GME positions countrywide. The minimum position is a moratorium on the current number, nationally and for states.

Incentives to institutions to encourage primary care recruitment, programmatically and individually are desirable. Full reimbursement for the first 5 years of residency programs, less for later years is one possibility. Pay back for finishing GME participants entering public service or under served geographic areas is another. We are in general agreement with the fundings of the studies by the Institute of Medicine, the PEW Commission, and the AAMC and AAHC that emphasize and concentrate efforts and resources on the opportunities for GME positions for U.S. Medical School senior graduates.

Finally, we favor the carve-out from the negotiated budget of a medical student education fund. A small percent (2%) of Medicare GME funds should be set aside to be distributed to U.S. Medical Schools. This is the pipeline to graduates and to GME, and these costs are represented in the workforce and service provided by these professional schools as part of the Academic Health Center.

For Louisiana State University Medical Center.

Mervin L. Trail, M.D., Chancellor

Perry G. Rigby, M.D., Director, HCS

WRITTEN TESTIMONY

NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS

The National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) is pleased to present written testimony to the committee on the issue of graduate medical education (GME). Specifically, we support reform of GME to include a transfer of current funds from diploma nursing programs in hospitals to a new fund for graduate nurse education (GNE), to include masters-level advanced practice nursing education in clinical settings.

NAPNAP represents over 5,100 pediatric nurse practitioners (PNPs) nationwide. We are a growing field of efficient, qualified primary care providers, with a special commitment to enhancing health care for infants, children and adolescents.

Nurse Practitioners Fill A Growing Need

As the committee knows, the need for primary care providers continues to exist and increase in the United States. The private and public sector shift toward managed care has increased the emphasis on primary care and placed a greater demand for and on primary care providers.

At the same time, geographic distribution of health professionals continues to create an access problem for underserved areas. The Health Resources and Services Administration reports that two-thirds of the nation's 3,000 counties have shortages of health professionals. These positions in underserved areas are traditionally hard to fill with U.S.-educated physicians.

Nurse practitioners (NPs) are uniquely qualified to help answer the demand for primary care providers. NPs serve many health care needs throughout the country, particularly in rural and underserved areas. They provide quality health care services at a level equal to or better than physicians, and are less costly to educate. NPs perform routine physical exams, immunizations, prevention education and screening, treat minor illnesses, and perform other health care services.

NP practice is broad in scope. NPs have full practice authority and are able to practice without direct physician supervision in 20 states. NPs have prescriptive authority in 48 states. Most private insurers reimburse NPs directly, as do most public programs, including CHAMPUS (health insurance for military families), FEHBP (Health insurance for Federal employees), and Medicaid for specialties like PNPs. Direct Medicare reimbursement recently passed Congress, but was included in the Medicare reform legislation that was vetoed. We hope that it will be enacted into law in the near future.

The Pew Commission, the Institute of Medicine (IOM), the Physician Payment Review Commission (PPRC) and others have recognized NPs for their role in providing efficient, quality primary care and their potential to help alleviate primary care shortages in underserved areas.

Medicare Medical Education Should Focus on What is Needed

Given the above situation, investment in the education of health care professionals like NPs is a prudent and worthwhile federal initiative. Funding nurse practitioner education programs is an investment in primary and preventive care for service in parts of the country where the need is the greatest. We believe this funding is a needed investment, with a sizable return.

Currently, although Medicare is the largest single source of Federal funding for nursing education, over 90% of its funding goes to entry-level, diploma nursing programs. Diploma nursing schools, which train registered nurses primarily for inpatient care such as that offered in hospitals, have decreased as a result of the changing demands of the marketplace. Only 10% of all registered nurses graduate from diploma programs. At the same time, the need and demand for advanced degree programs, which educate NPs in outpatient settings and prepare them for careers in primary care and service in underserved areas, are growing. Due to limited funding sources, however, these programs are struggling to pay for qualified clinical faculty and are forced to turn qualified applicants away.

Since the marketplace and changes in the health care delivery system have driven more care to outpatient settings, while shrinking the need for care in hospitals, NAPNAP believes it is time for Medicare to shift nursing education to meet the demands of outpatient and primary care needs. We recommend that Medicare redirect its funding for nursing education, without incurring additional costs, from the entry-level diploma programs to the advanced degree nursing programs. Such a shift would ensure that Medicare is preparing nurses who can efficiently provide quality care for future Medicare beneficiaries.

Conclusion

NAPNAP commends the committee for addressing the current Medicare GME program. As our health care delivery system continues to change and evolve, Medicare also needs to adapt and adjust in order to sustain high quality, efficient care for its beneficiaries. We believe that advanced degree nursing programs are well-suited to help meet the challenges of future care for Medicare beneficiaries, and we urge the committee to re-target nursing education funds as part of GME reform.

School of Medicine
UNIVERSITY OF MARYLAND
AT BALTIMORE

OFFICE OF THE DEAN

Statement of Donald E. Wilson, M.D., M.A.C.P.
Dean, University of Maryland School of Medicine

submitted to the

House Ways and Means Subcommittee on Health

June 11, 1996

Chairman Thomas, Members of the Subcommittee: Thank you for continuing your examination of Graduate Medical Education (GME) and the Physician Workforce in the United States. Few issues are as complicated as determining efficient and equitable models for the financing of Graduate Medical Education, and supporting appropriate mechanisms for shaping the size and specialty composition of a physician workforce adequate to serve the full range of our country's health care needs.

125 accredited U.S. medical schools - and the teaching hospitals, health systems and other clinical and research organizations with which they are affiliated in academic health centers - are an essential component of the nation's health care system. They provide all levels of patient care - from preventive to quartenary services; furnish a disproportionate share of health care services to the most disadvantaged members of society; ensure the availability of highly trained health care providers, including physicians, nurses and other health professionals, by serving as principal sites for clinical education; and provide the environment and expertise for the conduct of basic and clinical research leading to the introduction of new, lifesaving drugs, treatments, devices and procedures. The increasingly rapid transformation of the American health care system to a market-driven, price-competitive structure threatens the fiscal stability of the academic enterprise and its ability to maintain commitments to research and education, as well as patient care. Yet the current method of funding GME - having the Federal government assume much of the burden for financing broad social responsibilities, and funneling its contributions through the Medicare program to inpatient hospital settings - does little to encourage a rational and equitable distribution of such costs across the health care system and actually impedes innovation in clinical training.

Graduate medical education -- the clinical training of physicians after their graduation from medical school -- is an expensive proposition. While salaries paid to residents and interns are relatively low, other costs associated with training are not. Teaching programs must recruit and support experienced faculty to teach and supervise trainees. Teaching hospitals must incur the additional indirect costs of training residents and interns such as additional diagnostic tests and therapies and the time needed by young doctors to effectively treat their patients, as they master up-to-date techniques and state-of-the-art procedures. The costs of graduate medical education are increased still further by the intensity and expense of services provided in training facilities. That is because the most severely ill and difficult to treat patients are seen in the teaching hospitals and academic medical centers which have the specialized departments and research capabilities necessary for their care. On average, the clinical education of each resident or intern training at a hospital in Maryland, for instance, costs well over $100,000 per year.

Historically, academic health centers have relied on patient care revenues to cross-subsidize the costs of graduate medical education. But today most purchasers of health care, whether managed care organizations or traditional insurers, want to pay only for those services that they judge

necessary for the care of the patients for whom they are fiscally responsible. Where once patients could go to almost any hospital on the recommendation of their physician, today most must have their care pre-approved and are directed to "in-plan" facilities. In an environment in which cost has become a primary criterion for inclusion in managed care networks, patients can be directed to less expensive hospitals, those without graduate medical education costs. As a result, teaching physicians and hospitals are under considerable pressure to price their services to meet the lowest price in the local market. But there is a difference between the prevailing market price of health care services and the costs of care at academic health centers - the difference caused by the educational and research missions of academic medicine, as well as the provision of uncompensated care to the 41 million uninsured in this country. Obviously, these costs will not disappear simply because the competitive marketplace "refuses" to assume them. Someone has to pay for the education of the next generation of health care professionals.

In the absence of a marketplace in which all insurers or sponsors of patient care programs support a fair share of the academic mission of teaching hospitals and teaching physicians, Medicare's explicit payments for direct graduate medical education (DGME) and the indirect medical education (IME) adjustment have taken on crucial importance. But the payment mechanism - directing GME funding exclusively to hospitals - is increasingly out of step with today's clinical training, both graduate and undergraduate. Care that once was delivered in a hospital is now being provided in clinics, ambulatory surgery centers, community health centers, and other alternate sites, and medical educators have recognized that if physicians are to practice appropriately in the future, it is important for them to be trained in similar settings. Our students at the University of Maryland, for example, interact with patients in primary care and ambulatory settings throughout their four years of medical school.

The Association of American Medical Colleges (AAMC) believes that the funding for graduate medical education should support residents and programs in the ambulatory and inpatient training sites that are most appropriate for the educational needs of the residents (and their future patients.) Further, GME payments should be made to the entity that incurs the cost of training physicians. Payments could "follow" residents to teaching hospitals, ambulatory surgical centers, medical schools, multi-specialty group practices or other organizations, formally organized under the umbrella of a graduate medical education consortia responsible for assuring continuity and coordination of training and for distributing payments across various training sites.

Discussion of GME funding invariably leads to consideration of physician workforce issues. It is widely reported that the U.S. has an excess of doctors, especially specialists. But, despite this wealth of physicians, there is no doubt that geographic, financial, social and cultural barriers leave many in this country without adequate medical care. Some argue that the GME funding system should be used to shape the workforce, producing fewer physicians overall, concentrated more in primary care areas, less in specialties. Others believe that the employment market for physicians will adequately address issues of supply and distribution. Two points are worth making briefly. While there has been an explosion in the number of international medical graduates (IMGs) who come to the U.S. for residency training, for more than a decade American medical schools have graduated essentially the same number of new physicians each year. And our students are not ignorant of the economic realities of the new marketplace; for the last two years more than half of U.S. medical school seniors - (66% of 1996 University of Maryland School of Medicine graduates) - have chosen a residency in one of the generalist disciplines.

Funneling Federal support for graduate medical education only through Medicare does not implement health policy in a sensible way, since the elderly are not the only, or even the primary, beneficiaries of the clinical training of physicians. More importantly, the present system of gentlemanly cost-shifting and implicit cross-subsidization masks genuine social responsibilities which should be borne by all. Increasingly, it encourages insurers and other payers to make purchasing decisions based not on quality but on the opportunity to avoid education and other "unnecessary" costs. Market forces are indeed shaping the physician workforce and redirecting the energies of the American health care enterprise. Today it makes little sense to rely on a federal subsidy, to exempt the market from significant costs in the system. Nationally, funding for graduate medical education should occur through an all-payer system, ensuring that all -- patients, physicians, private and public insurers, managed care companies, and society as a whole -- who benefit from the fruits of the finest medical education system in the world contribute equitably to its costs, reducing the current disproportionate reliance on Medicare as a funding source and, ultimately, diminishing the role of the Federal government in establishing and shaping medical education policy.

Comments for the Record
by
William A. Peck, M.D.
Executive Vice Chancellor and Dean
Washington University School of Medicine
before the
Ways and Means Committee
Subcommittee on Health

June 4, 1996

Academic health centers (AHC) consist of a medical school or college of osteopathy, one or more affiliated teaching hospitals, and usually one or more other professional schools or programs. Medical school faculties, via affiliated teaching hospitals, provide care to community residents, provide undergraduate, graduate and continuing medical education, perform cutting-edge biomedical research and ensure assess to highly specialized patient care.

Washington University Medical Center is one of the world's premier centers of health care, research, education and community service. Its institutions are Washington University School of Medicine, Barnes-Jewish Hospital, Barnard Free Skin and Cancer Hospital, Central Institute of the Deaf and St. Louis Children's Hospital.

Academic health centers receive funding from many different sources. The primary sources of funding for Washington University School of Medicine are clinical revenue (private health insurance, Medicare and Medicaid) and research funds (primarily from federal sources).

There is a real concern that price competition in the health care market will undercut our ability to conduct cutting-edge research, teach the next generation of physicians and other health care providers and provide clinical care to all who come to our door.

Until now, medical schools have been able to use their clinical revenue to support education, research and care for the medically indigent. A recent study conducted by the Association of American Medical Colleges estimated that 28 cents of every faculty-practice-plan dollar supports medical school academic programs. This will change as managed care penetrates the market and purchasers continue to reap the benefits of, become less willing to pay for the costs of research and education associated with AHCs.

Furthermore, changes in federal government policies are hurting the hospitals with which medical schools are affiliated. Medicare contributes to the "mission-related activities" of teaching hospitals through payments for graduate medical education (including direct and indirect components - DME and IME), and disproportionate share (DSH) payments. When Medicare recipients choose to enroll in managed care plans, the adjusted average per capita cost calculation (AAPCC) paid to the insurance company includes these mission related payments. Once these payments are included in the AAPCC, the contractor has no requirement to pass them on to academic health centers. We believe these mission-related payments should be carved out of the AAPCC and paid to the institutions that Congress intended.

Finally, many people believe that Medicare pays more than its fair share of graduate medical education costs. Since all health care recipients are beneficiaries of the research, education and high-technology patient care that takes place at AHCs, we believe all payers should contribute to a fund for payment of these societal goods.

AHCs are doing many things to respond to the external forces we face: We are reducing expenses, reorganizing our practices, joining with integrated health systems and partnering with community physicians. We are investing more in generalist practices and revising clinical education, and we are developing case management for best practices and emphasizing outcomes measurement.

Despite these successful efforts at significant cost control, AHCs like Washington University Medical Center will continue to have higher costs because of the types of patients we treat (severely ill and medically disadvantaged), the residents who are in training and the comprehensive and intensive services we offer. The future quality of health care for all Americans could suffer unless change at academic health centers is undertaken in a thoughtful, supportive manner.

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