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(Volume 1 of 6)

104th Congress
1995-1996

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ADMINISTRATION'S MEDICARE CHOICES AND COMPETITIVE PRICING DEMONSTRATION PROJECTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

JULY 12, 1996

Serial 104–71

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ADMINISTRATION'S MEDICARE CHOICES AND COMPETITIVE PRICING DEMONSTRATION PROJECTS

FRIDAY, JULY 12, 1996

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

The Subcommittee met, pursuant to notice, at 11:17 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 2, 1996
No. HL-20

CONTACT: (202) 225-3943

Thomas Announces Hearing on the Administration's Medicare Choices and Competitive Pricing Demonstration Projects

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 the Health Care Financing Administration's (HCFA) demonstrations regarding Medicare health plan choices and competitive pricing. **The hearing will take place on Friday, July 12, 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 from HCFA, private health plans, and independent experts. 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, Medicare beneficiaries are provided health insurance coverage principally through a Federally administered, public fee-for-service program. However, beneficiaries are also able to receive their Medicare benefit through enrollment in private health maintenance organizations and other plans that contract with HCFA. At present, over 4 million Medicare beneficiaries, out of a total of 37 million, have chosen to receive their Medicare benefit through enrollment in privately administered health plans. These privately administered plans frequently offer advantages to Medicare beneficiaries in the form of reduced financial liability for cost-sharing with respect to deductibles and copayments, or in the form of enhanced benefits relative to the basic Medicare benefit package offered through the public program.

Comprehensive legislation to further the objectives of expanding the availability of privately administered plan offerings to Medicare beneficiaries, and making available to Medicare beneficiaries the latest innovations in benefit design that are enjoyed by workers in employer-sponsored health plans and through the purchase of private health insurance, were a major part of the Medicare provisions in the Balanced Budget Act of 1995, which was vetoed by the President.

Last year the Administration announced that it would conduct a "Medicare Choices" demonstration designed to explore ways to expand the availability of managed-care plans for Medicare beneficiaries and to test new ways for the Federal Government to pay private health plan contractors for the provision of health insurance coverage to Medicare beneficiaries.

In announcing the hearing, Chairman Thomas stated: "Expanding the range of choices in health plan designs available to Medicare beneficiaries continues to be an essential objective of this Congress. I am extremely interested to see that the Administration is now pursuing proposals advanced in the Congress last year and look forward to exploring in some depth the Administration's design and conduct of the Medicare Choices demonstration."

FOCUS OF THE HEARING:

The hearing will focus on the key aspects of the design of the Medicare Choices demonstration, including selection criteria for health plans, designation of test markets, and review of the Government's testing of new methods for paying participating health plans, such as competitive bidding for the offering of Medicare coverage by private health plans.

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, Friday, July 26, 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 on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/ or over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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NOTICE -- CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 11, 1996
No. HL-20-Revised

CONTACT: (202) 225-3943

Change in Time for Subcommittee Hearing on the Administration's Medicare Choices and Competitive Pricing Demonstration Projects

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the Administration's Medicare Choices and Competitive Pricing Demonstration Projects scheduled for Friday, July 12, 1996, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will begin instead at 11:00 a.m.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL-20, dated July 2, 1996.)

Chairman THOMAS. The Subcommittee will come to order. Today the Health Subcommittee will examine the Clinton administration's managed care demonstration initiatives for Medicare. After almost 4 years in office, it is noteworthy that the administration has recognized that the Medicare Program must be modernized.

Medicare has much to learn from developments in the private sector, obviously. These demonstration initiatives indicate a new willingness on the part of the administration to borrow from the successes of the private health care market and provide Medicare beneficiaries additional high quality, less expensive health care choices. In light of Medicare's fiscal crisis, it is not coincidental that the administration is now adopting an agenda for Medicare which offers beneficiaries the types of choices that were included in the bill this Congress passed in its efforts to save Medicare. It is just too bad the President chose to play politics with Medicare and veto that bill last year.

It should also be mentioned that concerns have been raised about specific aspects of these demonstration initiatives. Personally, I am reserving judgment about these initiatives and I look forward to learning more about the details of the demonstration program from the administration as well as hearing the views of interested parties from the health care insurance fields.

It is my expectation, however, as the demonstration program is developed it will be designed to bring private innovations and resources to bear for Medicare beneficiaries in a real market setting rather than simply extending the long arm of government into private health care delivery. Additionally, we do not want Medicare as it evolves beyond simple old-fashioned fee-for-service insurance to cause unneeded distortions or dislocations in health care delivery by the manner in which the government provides for private sector coverage of Medicare beneficiaries.

The demonstration initiatives, I think, reflect a significant step forward by this administration. Nevertheless, I would hope the administration will pay close attention to today's discussions and at least be receptive to making any midcourse corrections which might be indicated by information generated by this hearing.

I recognize my colleague from California, the Ranking Member, Mr. Stark, for any opening remarks he might make.

Mr. STARK. Thank you, Mr. Chairman, for holding this hearing on the various Medicare managed care demonstration projects. I agree the administration is to be congratulated for pursuing projects to test ways to improve Medicare. I am not sure that the criticism of the administration at this point is warranted.

These demonstration projects simply attempt to test the kinds of ideas that were in the House-passed budget bill, with the all-important difference that the administration's proposals include some consumer and quality protections against massive balance billing. Unlike our House plan, the administration does not lock seniors into plans for 1 year at a time and cut traditional Medicare so that providers will end up forcing people into these untested plans.

There is a right way and a wrong way to make change, and I think the direction in which the administration is moving is going in the right way. I look forward to hearing from both the adminis-

tration witnesses and those providers who will have their own critical comments, I am sure, concerning which way these programs move.

Thank you.

Chairman THOMAS. Thank you. As usual, any Members who have additional written statements will be a made a part of the record, without objection.

Our first witness is Hon. Bruce Vladeck, Administrator of the Health Care Financing Administration. Bruce, welcome. Your written testimony will be made a part of the record and we can begin the proceeding in any way you see fit.

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

Mr. VLADECK. Thank you very much, Mr. Chairman. I will just give a very brief oral statement summarizing some of the points in my written statement. I do appreciate the opportunity to appear before you today, focusing on two programs that are central to our agenda of expanding the managed care choices available to Medicare beneficiaries while maintaining the existing structure of protections on quality and consumer choice.

Without inserting myself into the dialog between the Chairman and the Ranking Member, I would add that the administration believes there is considerable common ground between the Medicare reform proposals supported by the Majority in this Congress last year and those proposed by the President and supported by essentially all of the Democrats. We would hope that even as the legislative clock continues to tick forward that there would be an opportunity to rebegin the discussions to identify those areas of common ground so that we can move more quickly to address some of the longer term problems of the Medicare Program.

Having said that, let me get to the more specific subjects at hand. Permit me to begin by noting that HCFA's use of its demonstration authorities has had a profound effect on the evolution and success of the program for many years. Medicare's hospital prospective payment program, its hospice benefit, its other preventive benefits, and the Medicaid home and community-based waiver program all began as demonstrations. Of course, our current managed care programs are very much rooted in a series of demonstrations that began in 1980.

Since 1985, when we moved from the demonstration mode to the operational mode for managed care, we have experienced more than a tenfold increase in the number of Medicare beneficiaries enrolling in risk plans, and a sevenfold increase in the number of plans with which we have contracts. Nonetheless, I think there is a common ground and considerable consensus that the Medicare managed care program has not kept pace with some of the changes that have occurred in the private sector.

There are three areas of particular focus. First, there is wide belief that the types of managed care choices available to Medicare beneficiaries should be expanded. Second, there seems to be general consensus that beneficiaries need reliable, comparative information to assist them in making informed decisions about their choices. And third, there does seem to be almost universal consen-

sus that our payment methodology, the so-called AAPCC which bases payment on our experience in the fee-for-service population, needs to be delinked from fee-for-service costs in a particular community.

Changes along these lines were incorporated, again, in all of the Medicare reform proposals which were considered by the Congress last year. In the absence of signed legislation, our broad demonstration authority allows us to test potential improvements in all of these areas. I will focus today on two demonstrations, our so-called Medicare Choices Program and the competitive pricing demonstration.

First, on Medicare Choices. The goal of Medicare Choices is to provide beneficiaries with additional delivery system choices, and especially to address the problem of the unavailability for most beneficiaries of Medicare managed care choices in rural areas. We are using the Choices demonstration to pilot test new options which will give us experience and expertise in a wide variety of implementation issues, if and when appropriate changes in the program are enacted.

After a process that began with 372 expressions of interest, we now have 25 award candidates: 9 provider service organizations, 8 provider-owned HMOs, and 8 other managed care organizations, including 5 in rural areas. They represent a range of alternative payment options, including risk corridors, partial capitation, and blended payments. We expect all 25 of these plans to be certified and ready to enroll beneficiaries by the beginning of next year; some, we hope, will be ready well before then.

Should we be authorized in the future to contract on a permanent basis with PPOs or with PSOs directly, the lessons learned from Medicare Choices will significantly facilitate implementation.

Second, on competitive pricing, for years health care financing experts, including many in the HMO industry, have encouraged us to move from our current payment system to a more market-based rate. However, it is not at all obvious how to set market-based prices for Medicare managed care. There is a complex series of questions, and the best methodologies are not immediately obvious.

Recognizing the need to seriously examine this approach and how complicated it is, we have invested significant resources in developing a demonstration project. We worked with a number of outside contractors; we consulted with experts both from the academic sphere and from the industry. We conducted a number of surveys and focus groups on issues of consumer information and plan enrollment in order to design this demonstration.

It has three essential interrelated components: Beneficiary education, third party enrollment and counseling, and market-based rate setting.

In beneficiary education, we will contract with an independent third party to prepare and distribute educational materials to all Medicare beneficiaries in a specific market. These materials will explain the features in both Medicare fee-for-service and managed care and will provide comparative information on managed care plans as well as on Medigap options. They will not advocate managed care or fee-for-service Medicare, and certainly not any particular plan in comparison to others. They will also clearly state that

beneficiaries do not need to take any action to continue their current coverage and that the materials are there for information purposes.

The second component is third party enrollment and counseling. The independent third party contractor doing beneficiary education will also conduct all HMO enrollment and disenrollment activities and staff a toll-free counseling call center through which it will provide information to beneficiaries. This component of the demonstration reflects the trend among many private and public payers and responds to feedback we have received from beneficiaries indicating they would prefer having access to a third party when learning about or making managed care choices.

The third component is market-based rate setting. Under this demonstration, Medicare's payment rate will be based on bids submitted by all Medicare managed care plans in the demonstration site. Plans will bid on a standardized benefit package representing the most common denominator plan offered in the area. The rate derived from these bids will replace the current AAPCC. We have reserved the right to set the rate at a level that will assure that beneficiaries have access to more than one plan at the current community level of premiums.

In determining potential demonstration sites, we targeted those markets with relatively high AAPCC rates, relatively low Medicare managed care penetration, relatively healthy private sector managed care penetration, and enough Medicare HMOs to make competition feasible. In this process, however, we made one important mistake. After we identified Baltimore as the most appropriate initial site, we did not adequately consult with interested parties at the local level.

Fortunately for us, Mr. Cardin has shown some exceptional leadership in calling together for a series of meetings, which he has chaired with others from the congressional delegation, representatives of State government, representatives of Baltimore's managed care and other health care providers and the business community, as well as beneficiary groups to help us work through the issues raised by the demonstration. These meetings provide a level of reassurance that we will not proceed until we have convinced most of the affected parties that what we are doing makes sense and has addressed their needs and concerns.

In conclusion, Mr. Chairman, you and I and many witnesses before this Subcommittee over the years have expressed the belief that Medicare needs to learn from the private sector by expanding choices, helping beneficiaries to make informed choices, and reforming our managed care payment methodology. Each of these is a complex task with no obvious solutions. We are fortunate that our demonstration authorities allow us to test a variety of ways of making these important changes as we move Medicare into the 21st century.

Of course, I am happy to answer any questions you might have. Again, I appreciate the opportunity to appear before you today.

[The prepared statement follows:]

STATEMENT OF BRUCE C. VLADECK
ADMINISTRATOR
HEALTH CARE FININCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTRODUCTION

Good morning. I am pleased to be back to testify before this subcommittee. As was the case last time I appeared before you, my subject today involves demonstration projects of the Health Care Financing Administration (HCFA). Last time, the subject was long-term care. Today, my testimony will focus on two projects -- the Medicare Choices demonstration and the Competitive Pricing demonstration -- central to our agenda of expanding managed care choices available to Medicare beneficiaries while improving our payment methodologies.

BACKGROUND

Over the past three decades, HCFA's use of its demonstration authorities has had a profound impact on the evolution and success of the Medicare and Medicaid programs. Through support, development and testing of innovations in payment, delivery, access and quality, HCFA has contributed significantly to major program reforms and improvements. Let me just mention a few examples.

As the result of a program of research and demonstrations begun in 1976, Medicare moved in 1983 from cost-based reimbursement for hospital care to a prospectively determined per case payment based on diagnosis. The prospective payment system saves billions of Medicare dollars annually while the Diagnostic Related Group (DRG) classification system on which it is based is used today by half of the State Medicaid programs, CHAMPUS, and many private insurers, managed care plans, and other countries.

When the hospice movement was still in its infancy, HCFA initiated a Medicare and Medicaid demonstration to determine whether hospice could maximize patient autonomy during the last weeks of life and allow terminally ill patients to die with as much dignity as possible and relatively free of pain. Largely as a result of this successful demonstration effort, legislation established hospices as authorized Medicare providers. In 1994, about 270,000 Medicare beneficiaries used hospice care.

Beginning in the mid-1970s, HCFA sponsored a series of innovative Medicare and Medicaid demonstrations throughout the country to test the use of community-based services as substitutes for more costly institutional long-term care. These demonstrations served as the framework for the legislation authorizing the Medicaid waiver program under Section 1915(c) of the Social Security Act, under which home and community-based services may be covered.

HCFA's managed care programs were also rooted in extensive demonstration efforts. Beginning in 1980, HCFA tested the use of capitation payments for HMOs participating in Medicare. This pioneering effort demonstrated to plans, Congress, and the executive branch that HMO participation in Medicare on a capitated basis made sense for both beneficiaries and the program. Since HCFA implemented the Medicare managed care program in 1985, both the number of beneficiaries enrolling in risk plans and number of risk plans contracting with Medicare have

increased steadily. In 1985, only 309,000 beneficiaries were enrolled in risk plans whereas today over 3.6 million are enrolled in these plans, an increase of over ten-fold. Similarly, in 1985, only 32 risk plans contracted with Medicare. Today, 218 risk plans contract with Medicare.

There is general consensus among this Administration, the Congress, managed care plans, beneficiary advocates, and other providers that the Medicare managed care program should keep pace with private sector innovations while still ensuring that beneficiaries receive high quality care. For our purposes today, let me cite three areas that receive frequent mention. First, many believe that the types of managed care choices available to beneficiaries should be expanded to provide as many options as the commercial sector does. Within our current statutory authority, HCFA has recently expanded beneficiaries' managed care options to include a point-of-service option HMO. However, making additional choices such as provider sponsored organizations (PSOs) or preferred provider organizations (PPOs) widely available to Medicare beneficiaries is not possible under current law. Both the Administration and the Congress' balanced budget proposals include provisions which would allow Medicare to contract with these managed care organizations on a permanent basis.

Second, there is agreement that beneficiaries need reliable, comparative information on the managed care plans available in their local market areas in order to make informed decisions regarding enrollment. Again, there is common ground in the Administration and Congressional proposals. Both plans would require the Secretary of Health and Human Services to disseminate comparative information on managed care options at initial Medicare eligibility and during annual open enrollment periods. The Administration's bill also requires that information on Medigap plans be included in the comparative materials.

And third, most observers believe that the current payment methodology for managed care plans is flawed and should be improved. Under current law, the payment methodology is based on the Adjusted Average Per Capita Cost (AAPCC), generally referred to as "the AAPCC". Under the AAPCC methodology, payment levels for HMOs are derived from the utilization and cost experience in Medicare's fee-for-service population. There is general agreement that Medicare's payments to managed care plans should be "delinked" from fee-for-service costs in particular localities. In addition, recent research by HCFA confirms previous research findings that, because the current payment methodology does not adequately take into account the better health status of beneficiaries enrolled in Medicare HMOs, the Medicare program pays more for these beneficiaries than it would if they had remained in fee-for-service Medicare.

Congress has given HCFA broad demonstration authority to test potential improvements with which to address concerns like these. My testimony today will focus on two such demonstrations: Medicare Choices and the Competitive Pricing demonstration.

MEDICARE CHOICES

The purpose of Medicare Choices is to test the receptivity of Medicare beneficiaries to a broad range of managed care delivery system options and to evaluate the suitability of these options for the Medicare program. Our goal is to provide beneficiaries with additional delivery system choices and to increase options available to beneficiaries in rural areas. In addition, the Medicare Choices demonstration will help to develop approaches to a wide range of implementation issues--including payment methods, certification requirements and quality monitoring systems--which would be associated with some of the new Medicare managed care choices piloted in this demonstration. In developing the design specifications for Medicare Choices, HCFA and its contractor consulted extensively with interested parties including managed care plans.

In order to minimize unnecessary investment of resources by applicants, HCFA used a two-step application process to select the managed care plans participating in the Medicare Choices demonstration. HCFA first asked plans to submit a pre-application statement of interest and a brief project description. After reviewing the pre-applications, HCFA then requested selected organizations to submit more detailed proposals.

During the pre-application process, HCFA encouraged a broad range of managed care organizations, including PPOs, PSOs and HMOs, to submit innovative managed care proposals, such as point-of-service and primary care case management systems. We also encouraged applicants to propose alternative payment methodologies such as risk corridors and blended capitation payments and to indicate a willingness to test risk adjustment methods.

HCFA targeted nine cities as well as rural areas. The nine target cities were Hartford, CT; Sacramento, CA; Jacksonville, FL; Atlanta, GA; New Orleans, LA; Columbus, OH, Philadelphia, PA; Louisville, KY; and Houston, TX. These sites represent areas with high managed care penetration in the commercial sector but low Medicare HMO penetration. We also accepted innovative pre-applications from interested organizations outside these target areas. We received 372 pre-applications, representing nearly every State in the nation.

From these 372 pre-applications, HCFA selected 52 managed care plans for further consideration; we requested these plans to submit final applications to HCFA by December 15, 1995. Plans invited to submit final applications offered a wide range of managed care delivery models and proposed a variety of payment methodologies.

We selected "award candidates" based on geographic factors, innovation of design, and ability to meet eligibility requirements. We selected 25 award candidates for final consideration -- nine PSOs, eight provider-owned HMOs or providers with HMO partners, eight HMOs or other managed care organizations.

The 25 award candidates submitted a variety of payment proposals -- thirteen requested 95% of the AAPCC, five requested risk corridors around the AAPCC, seven requested other payment

models such as partial capitation, blended payments, or capped fee-for-service payments. Sixteen of the 25 indicated an interest in testing a risk adjustment method. Five of the 25 award candidates are located in rural areas.

Award candidates are currently in the final steps of the Medicare Choices demonstration award process, which includes negotiations regarding payment methodology. Once these remaining details are worked out, HCFA will review plans to determine whether they meet standards regarding access, beneficiary protections, financial solvency, and quality assurance. While generally expecting plans to meet current law standards for Medicare HMOs, HCFA will evaluate plans participating in the Medicare Choices demonstration on a case-by-case basis.

HCFA expects plans to be certified and ready to enroll beneficiaries in 1997, but some may be ready to enroll beneficiaries sooner.

Both the Administration and the Congress support expanding Medicare managed care choices to include PPOs and PSOs and support similar provisions regarding PSO State licensing , solvency, and quality requirements. In the past, demonstrations have provided valuable information on implementing such program expansions. If HCFA is authorized in the future to contract with PPOs and PSOs on a permanent basis, the lessons learned from the Medicare Choices demonstration will significantly facilitate and accelerate implementation.

COMPETITIVE PRICING DEMONSTRATION

As I mentioned earlier, the current payment methodology for managed care plans is flawed and should be improved. For years, health care financing experts encouraged Medicare to move from our fee-for-service based method to one that relies more on a "market-based" payment rate. The managed care industry appeared to agree as well. The Group Health Association of America (now the American Association of Health Plans) testified before this Subcommittee in February 1995 that "payment rates are tied to the Medicare fee-for-service costs in a given area, and do not give the Medicare program the benefits of market dynamics present in the private sector." GHAA further stated that "Medicare payments to health plans should eventually be 'market-based'." In its 1995 Annual Report to Congress, the Physician Payment Review Commission (PPRC) recommended that "payment rates for Medicare health maintenance organizations established through competitive bidding ultimately should replace payment rates based on adjusted average per capita costs in markets with a sufficient number of HMOs bidding to achieve price competition."

However, developing a market-based rate is a complex endeavor and the best methodologies are not immediately obvious. Recognizing both the need to seriously examine market-based rate setting and the intricacy of the task, about two years ago HCFA began to invest significant resources in developing a demonstration which we refer to as "competitive pricing."

HCFA conferred with many experts when designing the demonstration's bidding process, including consultants at Abt Associates, a firm with a long history in health care financing policy; academics recognized as authorities on competitive pricing at the University of Minnesota; additional consultants with expertise in managed care; and other technical experts, including representatives of the managed care industry and the beneficiary population.

In developing the education and enrollment aspects of the demonstration, we worked with BENOVA (formerly knows as "Health Choice"), a contractor specializing in marketing and consumer education in the private and public sectors. We also convened two expert panels specifically to help develop the education and enrollment design specifications, one comprised of managed care plans and the other of beneficiary-oriented representatives. In addition, another contractor, Research Triangle Institute, conducted numerous focus groups in several states to determine beneficiaries' preferred methods of receiving information on health insurance options and their response to prototype educational materials. We also conducted 35 individual interviews with Medicare beneficiaries in four locations to more carefully examine their reactions to the prototype educational materials and to determine whether beneficiaries understood the most important elements included in these materials.

Components of the Demonstration

The competitive pricing demonstration focuses on two of the three concerns outlined in my introduction: altering the payment methodology for Medicare managed care plans and improving the ability of beneficiaries to make informed choices about their Medicare options. The demonstration has three essential and interrelated components: beneficiary education, third party enrollment and counseling, and market-based rate setting.

Beneficiary Education. HCFA will contract with an independent third party to prepare and distribute a comprehensive set of brochures to all Medicare beneficiaries in a specific market explaining the features of Medicare fee-for-service and managed care programs. The printed materials will highlight issues to consider when choosing between these two delivery systems. The materials will also include a chart comparing the benefit packages and premiums for all Medicare managed care plans in the beneficiaries' local market area in addition to comparisons of Medigap options. It will also include a list of HCFA-sponsored education seminars and informational videos and the number of a toll free counseling call center. The materials will not advocate managed care or fee-for-service Medicare. The materials will clearly state that the beneficiary does not need to take any action and are intended only to provide information.

Third Party Enrollment and Counseling. The independent third party contractor will also conduct all HMO enrollment and disenrollment activities and staff the toll free counseling call center. This neutral third party will provide objective information to Medicare beneficiaries who call seeking more information on their Medicare choices, as well as enroll beneficiaries who want to choose a managed care plan by mail or by telephone. In the competitive environment of this demonstration, managed care enrollment through a neutral third-party will help to ensure that

plans do not encourage healthier beneficiaries to enroll and discourage sicker beneficiaries from enrolling in their plan. In addition, while we believe that favorable selection into Medicare HMOs results in part from beneficiary self-selection, we are interested in learning if using a neutral third party has an effect on favorable selection into Medicare HMOs.

Another reason third party enrollment is an important part of this project is that HCFA's recent focus groups have found that Medicare beneficiaries would prefer having access to a third party (as opposed to a plan trying to "sell them something") when learning about and/or making managed care choices.

Several years ago, HCFA successfully piloted a beneficiary education and third party enrollment program in Portland, Oregon. In fact, some of the Oregon plans continued to contract with this third party after the demonstration ended. Third party enrollment is a mechanism used by many public and private sector purchasers, such as 22 State Medicaid programs, the CALPERS program, which covers over 1 million California state and local government employees, and many large employers.

Market-Based Rate Setting. Under this demonstration, Medicare's payment rate will be based on bids submitted by all Medicare managed care plans in the demonstration site. Plans would bid on a "community standard" benefit package, representing the most common plan offered in the area. The rate derived from bids will replace the current AAPCC rate. The same demographic factors now applied to the AAPCC (age, sex, Medicaid, and institutional status) will be applied to this market-based rate to adjust payment to establish the payment rate for individual beneficiaries in the first year of the demonstration. HCFA plans to apply new risk adjustment methodologies after the first year.

We have not determined yet precisely how we will set the Medicare payment based on submitted bids. We are committed to assuring that beneficiaries have access to more than one plan at the current premium level. For example, if most or all of the plans in the demonstration site are currently offering a "zero" premium option, we would set the Medicare payment rate so that several plans could continue to offer such an option.

Site Selection

In determining potential demonstration sites, we targeted those areas with a relatively high AAPCC rate, relatively low Medicare managed care penetration, and enough Medicare HMOs to make competition feasible. We are confident that we have been thorough and careful in gathering together the resources appropriate to design the demonstration. However, we also realize that we made a important mistake after we identified Baltimore as the most appropriate initial site for this demonstration. We did not adequately consult with interested parties at the local level.

Under Mr. Cardin's leadership, HCFA is now in the midst of a series of meetings, chaired by the Congressman, with others from the Maryland Congressional delegation, Baltimore managed care

plans, beneficiary representatives, Baltimore business representatives, and representatives of the State government. The purpose of these meetings is to discuss the issues and concerns raised by these parties, something we should have done earlier, but are glad to be doing now.

I'd like to take this opportunity to thank Mr. Cardin for his positive and constructive action after Baltimore was announced as the first potential demonstration site and to reiterate Secretary Shalala's commitment that we will not proceed with the demonstration until members of the Maryland delegation are comfortable with the demonstration's design and timetable.

Clarification of Demonstration's Parameters

The design and implementation of this demonstration is a complex undertaking and, hence, there are many areas where misunderstandings can occur. While it would not be possible to cover all areas, I would like clarify some of the demonstration's parameters.

First, no plan would be excluded on the basis of its submitted bid. The purpose of the bidding process is simply to set the Medicare payment amount on the basis of the managed care marketplace, rather than using the AAPCC rate. Indeed, the use of the phrase "competitive pricing" in lieu of "competitive bidding" is intended to convey that we are only setting the price, not using the bidding process to exclude any interested parties.

Second, beneficiaries will have the option of remaining in fee-for-service Medicare or enrolling in a managed care plan. No action on the beneficiary's part is required to stay in fee-for-service Medicare. The beneficiary's enrollment in a managed care plan will be completely voluntary. The contractor conducting third party enrollment will not be rated or compensated based on the number of beneficiaries enrolling in a managed care plan. The purpose of the education and information is to assure that beneficiaries understand all their options.

Third, managed care plans will be able to market to potential enrollees as they do today through mailings and radio, newspaper, and television advertisements. Their ability to deliver their message to potential enrollees will not be hampered. This demonstration simply provides comparative information on plan choices so that beneficiaries will be able to make informed choices and conducts enrollment and disenrollment through a neutral party, instead of through the plans.

Finally, the managed care industry has for many years expressed an interest in experimenting with a metropolitan statistical area (MSA) wide rate, and we had indicated that we would consider using one MSA-wide payment rate. However, concerns have been raised that this could discourage plans from providing services to individuals in Baltimore City, which has the highest county-specific rate in the region. We have indicated that we are flexible on whether to use one rate for the Baltimore MSA or to adjust the bid for county differences.

CONCLUSION

Mr. Chairman, you and I and many witnesses before your Subcommittee have expressed our belief that Medicare needs to learn from the private sector by expanding the range of managed care choices available to our beneficiaries, giving beneficiaries the information they need to make informed choices, and reforming how Medicare determines its payment rate to managed care plans to incorporate local market forces. But these are complex problems and no one knows the right solutions at this time. Fortunately, our demonstration authorities allow us to test how to make these important and needed changes. We believe we have worked responsibly with experts and affected parties to craft demonstrations that will allow us to move Medicare into the 21st century.

I would be happy to answer any questions you may have.

Chairman THOMAS. Thank you very much, Bruce.

Ordinarily, we operate by a fairly strict 5-minute rule as we go through this. But I think there is probably less partisan concern on this issue than anything we have discussed. So I am going to try to maintain as flexible a structure as I can so that we can get the information on the record that will be helpful to us in understanding some of the rationale behind the choices that HCFA made and, in fact, beginning at the beginning, the statutory authority that HCFA has.

The reason I would start off questioning that way is because in January of this year, you were quoted in a BNA article that you thought you needed additional authority to carry out the kind of demonstration that you are interested in. In the President's fiscal year 1997 budget package, there was a request to amend the existing statutory demonstration authority to specifically permit waiver of section 1876.

Let me say at the beginning, I personally believe that, given the broad demonstration authority that is on the books, you have the ability to do it, but obviously since the statement was made and the President's budget asked for specific authority, I think it is worthwhile for you to explain why that occurred.

Mr. VLADECK. I appreciate the opportunity to do that, Mr. Chairman.

Let me first say that we have been advised by our Office of General Counsel that section 402(A)(1)(a) of the 1967 amendments to the Social Security Act provides, in their view, a more than adequate authority to proceed with demonstrations of this sort. Nonetheless, there are at least three reasons why we sought specific legislative authorization for such a demonstration.

The first is, as you might note from the design of the Medicare competitive pricing demonstration, in the President's bill both this year and last year, we argued very strongly that in order to get a fully functioning, level playingfield, fair market for Medicare beneficiaries, we had to include Medigap or Medicare supplemental policies under the same set of rules as capitated plans. It is clear that the existing authority does not extend to Medigap where our regulatory oversight authority is very limited. A statutory authorization might permit their inclusion in such a demonstration.

Second, it has been our experience relatively routinely in the past, that as we sought to proceed with a demonstration, one or more affected parties sought to intervene through the judicial system to prevent it. While we think we would ultimately prevail under existing law, we believe that a much more explicit, specific recent congressional authorization would place us in a stronger position and save us steps in the event of litigation.

Third, frankly, we are just always more comfortable when we have a specific congressional expression of interest in moving in a particular direction than when we do not. Since all of these issues were very much addressed in the proposed legislation, we thought we should not try to hide from the Members of Congress or anyone else our intention to proceed in this direction.

Chairman THOMAS. And obviously, with the degree of change in this kind of a demonstration project, especially in the competitive pricing one rather than in the Choices one, although to a certain

extent it applies there, as well, you are going to be setting up a situation in which existing contractors may choose not to participate and you will be creating new ones that currently could not exist without the agreement in the demonstration project.

I am interested less right now in your entrance structure—we will talk about that in 1 minute—than I am in your exit structure, if people choose to leave. I did not see this in your testimony and I assume you have contemplated the downside. Obviously, in markets such as the Baltimore area, you have such a small number of folks that you are dealing with, you may have problems down the road, 3 to 5 years, in a market expected to expand significantly of its own accord that probably does not need the full structure of a demonstration project.

But have you sat down with the folks who modeled this to figure out what happens with the confusion and disruption for the beneficiaries if somebody pulls out?

Mr. VLADECK. We have talked about that and we have given it a lot of thought. To take an example, it contributes to our selection of Baltimore as a desirable initial site. In Baltimore, we have seven HMOs with either existing or pending contracts with the Medicare Program. At the moment, they serve a total of slightly fewer than 13,000 Medicare beneficiaries. So it is our feeling that if, as a result of the prices established in a competitive process, several of them withdrew from the market, there would still be available to beneficiaries a broad range of choices among competing plans.

Now, there is a risk, obviously, that some number of beneficiaries would not be able to stay in the same plan if a particular HMO chose not to renew its contract because of the new price. But again, there are a small enough number of folks involved so that we believe we have done what we can to minimize the risk.

Obviously, anytime we seek to reduce prices in any service Medicare pays for, there is always the risk that certain providers will drop out of the program.

Chairman THOMAS. I guess, Bruce, I am less concerned about that. If it is truly competitive and they cannot compete, I have no problem with that. That is what we are looking for.

My concern is that you have set up an artificial structure in order to run a demonstration in which someone complies with all of the rules but cannot compete, given the way in which you have artificially changed the market, and who then feels they must leave and understands, then, there is no ability to come back in within, what is it, a 5-year period? How do you justify refusing a contract to someone who, except for the demonstration project that you have imposed on the area, would otherwise meet the criteria and could compete?

Mr. VLADECK. The only basis that I could see, Mr. Chairman, for a plan that otherwise would seek a contract refusing to participate is that they thought the price was too low.

Chairman THOMAS. We will get into that as we talk about specifics, because I do not think it is just price that concerns a number of people about the way in which you may wind up modeling it.

For example, as you set up what you believe to be the competitive bid in the competitive pricing demonstration, you then lock in not just—and correct me anywhere if I am wrong in my under-

standing of the methodology—you do not just lock in the price, you lock in, in essence, the package.

Mr. VLADECK. The base package, sir.

Chairman THOMAS. The base package that was out there constructed in the competitive way. If they are above the price in terms of the competitive package, which, I believe, all of them waive any of the costs, which is an attractive way to get people into the program. But do they also add additional benefits, drugs and perhaps vision? That if they are above that competitive price, the only area you let them make adjustments in is requiring the beneficiaries to pay the difference.

You do not allow the plans to make adjustments in the package during the demonstration period, and it just seems to me, of what value is a demonstration of a competitive pricing package if the only variable is to add cost to the beneficiary without allowing the plan to mix and match those bonus benefits that they thought were attractive at one time but which obviously could be adjusted to keep them attractive, notwithstanding the higher price.

I understand the need to control the parameter of a test, but what you have done is basically thrown out, to me, the key ingredient of the HMO model for competitive price testing, and on that basis one would say, Look, I am above the number. You will not let me adjust the benefit package. It is dollars only. I am a loser. I am out of the game.

I do not know how you do not wind up dwindling to the one who either knew how to play the game or wound up lucking out. It is like ten little Indians. You will start off with a number of programs, but because you do not let them do what inherently they need to do to be competitive in the marketplace, the only adjustment being price, I do not see how you wind up with a significant study on competitive pricing.

Mr. VLADECK. Let me make two responses to that, if I may, Mr. Chairman.

Chairman THOMAS. Yes.

Mr. VLADECK. The first is, all of the experts and others we have talked to about this issue in preparation for this——

Chairman THOMAS. Let me say at the outset, as we get into these, the reason I am doing all this is that I am criticizing the fact that you do not have a perfect plan.

Mr. VLADECK. Yes.

Chairman THOMAS. Everybody needs to understand that.

Mr. VLADECK. And I hope you will understand that I am not suggesting that we do have a perfect plan yet.

If you are going to establish a competitive price, one of the critical issues is that it be for a standard product, that you are not comparing prices between apples and oranges, to use the conventional metaphor. If consumers are to make choices among different plans, then you have to separate out the question of what the price is for something that is standardized versus the prices for additional things which could still be offered in the marketplace at additional cost.

Second, I think it is a little bit oversimple to suggest that a plan can respond only by reducing its benefits package if it has an existing cost structure that at a given level of benefits is in excess of

the price that would be set competitively. Presumably, one of the other ways it could respond, since the competitive price is supported by at least one competitor in the same market, is to become more efficient in its operations or to reduce its overhead.

Chairman THOMAS. Or to put it in a slightly different way, become more attractive by becoming more standardized.

Mr. VLADECK. No, sir. I think——

Chairman THOMAS. I think that would be attendant.

Mr. VLADECK. I think the competitive advantage will be for the plan that at the government rate can further expand its benefit package at zero premium or the market-level premium. The plans that can do that will be the plans that produce the standard package most efficiently.

Mr. CARDIN. Would the Chairman yield on that?

Competitive pricing presents a challenge to the managed care community because there are no plans that operate in Baltimore today that offer a sole option which charges a fee to the beneficiary. That has not been successful competitively.

I think what the Chairman is raising is a concern that has been mentioned frequently by the managed care operators and that is if they come in with a bid that is higher than the competitive price that is selected by HCFA, that operator is going to have an extremely difficult time operating in the Baltimore market because their only option under the original configured pilot program is to charge a fee to the beneficiary. It is at least perceived by the managed care operators as unlikely that they could be competitive in the Baltimore market if they have to charge a fee for the basic program. Some operators are willing to charge a fee for a supplemental benefit, but for the basic benefit, they do not believe they can be competitive.

You can look at it two ways. One, it may cause the managed care operators to be very careful in the bids that they submit and to submit the lowest possible bid. However, as the Chairman has mentioned, the risk here is that there will be a significant number of managed care operators that may be effectively unable to compete in the Baltimore marketplace, giving a limited number of choices to our seniors, and I think that is the tradeoff that we are facing.

Mr. VLADECK. Let me say two things about that, if I may, Mr. Cardin.

First, that concern is, in large part, why we explicitly rejected the notion of setting the price at the lowest bid or even at some mathematically determined function of the bids that are submitted. It is our intention, and this is one of the things we are testing, to try to set a price at such a level that there will still be significant competition among enough plans that can maintain a zero premium for the standard benefit package. This is one of the things we are testing. If none of the bids permit us to do that, then we may not be able to proceed with competitive pricing. If all of the bids come in at the same level, we may have a different kind of legal problem, but that is one of the things we are trying to find out.

Second, one of the reasons we picked Baltimore is because of the average difference between the 95 percent of AAPCC that we are

paying the plans and their costs of producing the basic Medicare benefit package—not the community standard package, but the benefit package with deductibles and without the additional benefits. We estimate that there is a difference of almost $75 a month at the current time between what we are paying for the standard package and what it is costing the average plan in the Baltimore market to produce that.

We think that $900 a year, depending on where we set the price, ought to offer a considerable opportunity for plans which may have initially bid above the price to still provide the community benefit package at a lower rate and at zero premium.

Chairman THOMAS. But, Bruce, you introduced the Baltimore question, and it seems to me that you can find that kind of pricing differential in a number of communities.

Mr. VLADECK. Yes, sir.

Chairman THOMAS. So that cannot be the primary reason you chose Baltimore. My problem is that if, in fact, the way you are setting up your structure, and I agree you have to pare away reality to get some comparisons, it sounds to me like efficiency and cost cutting are two of those that you are focusing on as key factors. Why in the world would you choose the largest population community in a State which denies those plans one of the most effective and primary cost cutting tools, which would be hospital rates, given the uniqueness, as the gentleman from Maryland reminds me almost on a daily basis, of the single-payer system in Maryland?

I guess if we are looking for a place to test this business of cost cutting and efficiency, you have tied not one but almost both hands behind these organizations' backs, given the uniqueness of the location. So there has to be a reason why you chose Baltimore, and do not tell me it is because that is where your headquarters is.

Mr. VLADECK. We thought about that, because this is a very staff-intensive process, and we do not have a lot of——

Chairman THOMAS. You mean that is the reason?

Mr. VLADECK. No, it is not the reason.

Chairman THOMAS. All right.

Mr. VLADECK. But it was a consideration. This is a very staff-intensive process, as some of the Members know, and we do not have any travel money this year. But the issue of the rate setting is, as you know, and as I am reminded every day in this job, every community is unique on some dimension or another. No two are exactly alike.

We think in some ways, again, from the point of treating something as an experiment, that the hospital rate setting program in Maryland clearly has not in any way deterred or delayed the development and expansion of managed care in the private sector in the State of Maryland. It certainly is not an obstacle to the State's moving ahead with a very ambitious Medicaid managed care program. It certainly has not, under the current rules, discouraged HMOs from seeking to enter the Medicare business in Maryland.

We have formal communication as well as informal communication from the folks at the rate setting commission, who are very comfortable with this demonstration. Now, it is true, we have picked a site in which the HMOs have one less tool with which to lower their costs than they do in some other communities, although

I think the Maryland folks would tell you that is because the rate setting commission process in Maryland has already gotten savings as substantial as any the plans could achieve on their own.

Mr. MCDERMOTT. Mr. Chairman?

Chairman THOMAS. I am less concerned about the difficulties of doing it in Maryland, and I know the gentleman from Maryland has had some great concerns not only in the way it was set up and who was involved but what may occur within the State. That is not my concern.

My concern is that if this is a test and we are only going to have three of these locations, the primary one you have chosen, the initial one, the one that is going to be focused on a lot, has a structure so different than anywhere else that I am trying to determine how much value for purposes of comparison with other areas in the country choosing Baltimore in Maryland with the all-payer rate on the hospital structure will help us in terms of the value of this demonstration across the United States. That is my concern. I will leave the difficulty in Maryland to the gentleman from Maryland. I am concerned about the universal value of the demonstration project because of that.

Mr. MCDERMOTT. Go ahead.

Mr. VLADECK. Do you want to add to this, because I could respond to Mr. Thomas.

Mr. MCDERMOTT. I do not understand what the argument here is, why that makes it more difficult in Baltimore. In an HMO, you have physicians' services and you have nursing services and you have in-home health services along with a variety of other things and you have hospital services. This is one setup in which the hospital services are factored out of the equation, so you can see whether the cuts can be made in the provider services, whereas in San Francisco or in some other place, there is no fix, so maybe the costs can be cut in hospitals.

I think Baltimore is a good place to have an experiment because it is the only place in the country where you have the hospitals factored out. That is not an issue in their ability to cut costs. I might be mistaken in my understanding, but——

Mr. VLADECK. Let me, if I just might——

Mr. CARDIN. Before you respond, if I might, I want to disagree with the premise by both the Chairman and Dr. McDermott in that it seems to me that managed care companies advertise that they save money by managing care, not by discounting. I just take exception to the fact that discounting saves money. I think it just shifts the costs of the services in the country and a good managed care company will save money by managing care and utilization and not by seeking to get a discounted service.

I would hope that, particularly when we look at the way the Federal Government buys services, that we would be as competitive as anyone else in what we pay.

Mr. VLADECK. Thank you. If I may just add a point, we spent a lot of time on this issue. There are no three metropolitan areas in the United States which one could claim in this instance, or probably most others, were representative of the circumstances in the Medicare Program throughout the country.

For a variety of reasons, it is probably not appropriate to go through the entire process of naming names of all the other metropolitan areas we looked at, but there are certain characteristics that Maryland does not have or Baltimore does not have. Just for example, we have a metropolitan area that is all within one State in Baltimore. Lots of the bigger metropolitan areas are not.

We have a metropolitan area where, compared to others, the variation in costs between inner city and the immediate suburbs is not as great as they are in some of the Northeastern cities. The Baltimore MSA does include some more outlying areas, which is a problem we are trying to address.

We could go on and on with the list, and I would be happy to go through City *x* has all these characteristics, but on the other hand, it does not have these characteristics.

Mrs. JOHNSON. Mr. Vladeck, if I may, I am looking at a letter from the Health Services Cost Review Commission in Maryland in which they say a more salient question is whether the results from a demonstration in an area with hospital rate regulation will be generalizable to areas without hospital rate regulation. Managed care organizations in other States have one cost reduction strategy unavailable to Maryland plans, the ability to negotiate hospital discounts.

Barbara Kennelly and I have a very nice urban/suburban area that did not get the right to go ahead with this kind of a demonstration, so there are succinct urban areas available that do have this.

Negotiating discounts is not just a matter of cost shifting. It is a matter of incentivizing institutional settings to learn from the private sector many of the cost control mechanisms that, frankly, have not been common in nonprofit hospitals and now are being adapted.

Furthermore, many of the cost control mechanisms that can be best used in hospitals are dependent upon having a far better and more integrated care system for postacute care. So if you are going to look at managed care network development, I honestly do not see how you can do that well excluding hospitals, not only from the point of view of costs but from the point of view of integrated care and continuity of care and varied settings of care.

So I am very concerned about that, and I am apparently not the only one. Apparently the Baltimore rate commission was also concerned about the applicability of the results you are going to get from Baltimore to other systems across the Nation. They say that specifically in this letter to you.

Mr. VLADECK. Again, Mrs. Johnson, every area has unique characteristics and there is no single site or even a small number of sites from which one could safely generalize everywhere in the country.

Mrs. JOHNSON. I understand that. It is just that Maryland is the only State left in the Nation that does rate regulation. Connecticut went through it for many, many years. We felt very strongly that we had overwhelming evidence of its downside. It did not work for us. It cost money, it did not save money.

So it is concerning to me that with so few demonstrations you would pick a site that is so different from the way the rest of Amer-

ica runs their health system, and maybe because of Maryland's unique geography and the structure of their health care industry. I do not know that, but I am concerned about your decision here.

Mr. MCDERMOTT. It would seem to me what I am hearing, Mr. Vladeck, is that you have picked the wrong site, and the reason given for that is that Baltimore is not like anyplace else in the United States. It has a hospital rate setting mechanism. I would——

Chairman THOMAS. I would tell the gentleman that is not the only reason, but that is one reason.

Mr. MCDERMOTT. A major reason, and that is the reason submitted in the letter from the local area. You cannot generalize off of us because we are different.

Chairman THOMAS. Right.

Mr. MCDERMOTT. I suspect that you are going to run into the same buzz saw any place that you select as long as you have a provision that after HCFA selects the rate, anybody who is above the rate has to charge a premium. I think that is the real reason the Maryland HMOs do not want to get in and compete. They do not want the market to set rates. The HMO people, I think, will resist being put into a competitive position where they have to submit a bid and then if they are too high, they have to charge their customers a premium. I think you just have to face that fact right now, that no matter where you go in the country, you are going to run into the same buzz saw from the HMO operators.

Mr. VLADECK. If I may, Mr. McDermott, let me just say that I think every community is unique in one dimension or another. The marketing companies spent a lot of time trying to find a demographically typical census tract so they could test Olestra. We went through a somewhat analogous process at the much larger unit of analysis of the metropolitan area, which is the market for HMOs. There is not a representative community for the Medicare Program for these purposes, so that is true.

If I may just comment on your other observation, this is not an issue we have encountered solely in the case of HMOs. It is true that in many aspects of the Medicare Program, folks endorse in principle the concept of greater marketplace competition or more market-based pricing. Yet when we have tried to introduce competitive pricing for durable medical equipment items, for example, or clinical laboratory services, which were much more homogeneous than HMOs, the existing providers opposed it. Across a wide range of the sorts of things that Medicare purchases, in every instance, the existing providers have opposed market-based pricing.

So we are very much cognizant of this opposition in the provider community.

Chairman THOMAS. I stand in awe at my friend from Washington's ability to divert just enough off of the target to miss it. I do not disagree with anything that has been said in terms of people trying to compete in the marketplace, but again, the concern is the uniqueness of the packages that the HMOs offer, and they are shaping those packages based upon their belief of where they want to be able to outdo one another in a competitive structure. What you are doing is creating a demonstration which homogenizes them to a very great extent, to the point——

Mr. MCDERMOTT. In——

Chairman THOMAS. Just 1 minute. To the point that above the competitive bid, not below, above the competitive bid, the only option is the price change, except for what you call the internal efficiencies and the rest.

We are going to hear testimony, for example, from the Memorial Sisters of Charity Health Plans. They, in their testimony, outline their HMO program. They are very proud of the fact that they eliminate the Medicare deductibles and coinsurance. They have nominal copayments specific to certain services, removal of Medicare's limits on numbers of covered hospital and skilled nursing facility days, enhanced benefits with a preventive wellness emphasis and an outpatient prescription drug benefit, and an annual vision and hearing exam with benefits for eyeglasses and hearing aids.

That is the package they have shaped that they think is a good market package. If they wound up in your study above that competitive bid, do you not think, to get a true feeling for a competitive structure for HMOs, they ought to be able, if they are above the competitive bid, to adjust that package?

Mr. VLADECK. Mr. Thomas, the package that we have defined for the Baltimore demonstration is the package that all the plans are offering in the existing market.

Chairman THOMAS. I understand that.

Mr. VLADECK. The market has produced convergence of benefit packages. That is what the existing market does, it drives the plans toward convergence of packages. All we are saying is, we want to set a price based on the standard package in the existing market.

Chairman THOMAS. But what you are doing is taking an existing market, determining what you believe to be the competitive price, whatever formula you use, and then telling people, the next year, that is the competitive price. And your mix of last year, if it does not bring you to that competitive price, cannot be changed if you are above it except to add dollars.

Mr. VLADECK. During this period.

Chairman THOMAS. If I knew that that was what was going to occur, the whole essence of the HMO operation is I will make an adjustment on the vision or the hearing. I will change it because the market has now changed. You are changing the market by virtue of coming in, arbitrarily setting a "competitive price" based upon last year's model and telling everybody this is now the model. You keep saying "we," government is going to come in and freeze the market. It may have been a competitive market at one time, but you do not allow the competition to see where the shifts will occur if you are above the competitive price except in the dollar game, which to me is not worth much of a study.

Mr. STARK. Mr. Chairman.

Chairman THOMAS. Certainly, the gentleman from California.

Mr. STARK. Bruce, let me just come back to see whether I think we may be getting a little off the issue here. The demonstration, as I thought I understood it, has two principles. One is to figure out a way for the government, HCFA, to pay a managed care plan for the basic plan. Now, there may be some reasons you have to pay for more, but for the basic plan. And two, to cover issues of

quality and consumer protection, and we will not hear any of that from the HMOs testifying today.

The bells and whistles that they add to these packages I will not say are of no concern to HCFA or to us, but that is not what you pay for. You have something in there that says if they are over, they have to offer extra benefits, but the fact is that, in law, we are charged with providing a basic package of benefits. So if HMO A wants to offer eyeglasses and whatever else, that really is not our issue. They are marketing gimmicks, for the most part. They use these additional frills to attract beneficiaries. As you indicated, in some markets, those have become almost standardized additions, but you still are not required to pay for them, as I understand the law.

So what you want to accomplish, and this is a rhetorical question, is to find a way for you to price that basic package, be it in San Francisco or Baltimore or Wapakoneta, Ohio, so that you have a way to, either through bidding or through some other calculation, price the basic package. The quality and consumer protection issues probably are mostly to protect the consumers from unscrupulous insurance peddlers, and perhaps some physicians, I do not know, but that is an issue that ought to apply evenly in whatever market you are in.

So the idea of whether or not plans have to charge extra or cut benefits, it really does not make any difference to what you are trying to do in the experiment, unless I am missing something. I think there is pretty universal agreement, we are paying too much under the AAPCC. We are too high. You are looking, I think, for a logical and empirical way to get that lower. How low, you do not know, I suppose. Am I missing something here?

Mr. VLADECK. No. In fact, I think that is very helpful, Mr. Stark, in helping to explain this issue a little bit further, or to try to explain it, because all this stuff is very complicated. But there are two problems going on that are interrelated and, I think, that are involved in this conversation.

In theory, the AAPCC payment to an HMO is supposed to cover the basic Medicare benefit package. In fact, because we are paying too much in most of the markets in which we have Medicare HMOs, beneficiaries, for no additional premium, are receiving additional benefits.

Mr. STARK. Right.

Mr. VLADECK. The question is, and this is a question we all talked about last year, how do you get from here to there since there are several million Medicare beneficiaries out there at the moment who, by opting into HMOs, have gotten additional benefits at no cost to themselves because we are overpaying the HMOs. The fact is that if you had a more efficient and equitable mechanism for pricing HMOs, those beneficiaries would not be getting as generous a set of benefits at the price they are now paying.

At some point, it is likely that, as a matter of policy, we are going to have to address this question. It is not a decision we are going to make, and it is not a decision we are going to make using our demonstration authority. That is a decision that Congress and the executive branch are going to have to make together: What to

do with those 3 million folks who are now getting additional benefits.

For purposes of this demonstration we are going to take the market's benefit package at the current market price, which is our AAPCC, and see, if we lower that price, how many plans are able to stay in that market at that package. That is exactly correct.

Mr. STARK. Thank you.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman, and thank you, Mr. Vladeck.

I want to commend the administration for at least attempting to broaden their horizons with respect to Medicare and the delivery of health care to senior citizens in this country. But this whole discussion reminds me of a discussion of industrial policy, where the government attempts to guess what the market is and what the market demands and create policy to make it happen.

I am just wondering how much we will learn from these demonstrations and if we will learn the right things, because you do seem to be, with all of your parameters and your guidelines, locking in a market situation. And as you know, the market seldom locks itself into anything. It is fluid. It changes from day to day, much less year to year, and you have, I think, a 3-year demonstration project where you are going to lock in a market circumstance that happens to be in place now.

I just want to urge you to reassess the flexibility that you allow those players in the marketplace during this demonstration. I am afraid if we lock in what we perceive to be the market for 3 years, we may not learn the right things. We may, in fact, think we learn that this does not work and the market cannot work when, in fact, we have not allowed the market a chance to work.

Under our plan, of course, we had a lot more flexibility. The market was pretty wide open, as a matter of fact, and I think we would have learned more under our proposal than we will under yours. But admittedly, I do not know enough about yours to say that to a certainty, so I am willing to listen some more and I do commend you for your efforts to try to learn how to open up Medicare.

But those are my concerns and I just wonder if you have any thoughts about those.

Mr. VLADECK. I appreciate that, sir. Let me just say, we are not seeking to lock anything in for 3 years. What we do is we absolutely reserve the right to redefine the benefit package or the price from year to year as the bidding process evolves.

The trick about the standard package really has to do with how to get the right kind of bidding process going. If people who bid too high can play games with their product after the price is established, then that is like saying that when HCFA goes to buy computers and specifies Pentium PCs with 20 megabytes of RAM, a producer who came in with a bid over our price could say, Let us just give you one with 16 megabytes and we will meet your price. In any bidding process, you have to define the standardized product of what the bid is for.

But it is a 1 year at a time situation, absolutely. In competitive pricing you want competitors in the marketplace to look at what the others are doing. You do not want them to collude, but you

want them to bid based on their expectation of what all their competitors are going to do. And the best way to learn about that is to look at what they did last year. So it has to be a very dynamic process.

Mr. MCCRERY. Why would you not, though, just establish as the basic plan the Medicare benefits that are specified in law today and then allow the plans to offer whatever over and above that they wish?

Mr. VLADECK. Because that would run a significant risk of leaving a large fraction of those 12,000 beneficiaries who are now in Medicare HMOs in the Baltimore area, worse off.

Mr. MCCRERY. What do you mean——

Mr. VLADECK. One reason we are not just turning it over to the market is because real markets have downsides, and we are not prepared to put beneficiaries significantly at risk for purposes of testing a new approach.

Mr. MCCRERY. Why would they be worse off? Just explain that.

Mr. VLADECK. Because now, beneficiaries are getting about 70 dollars' a month worth of additional benefits over and above the Medicare standard benefit package because of the way we set our prices at the moment. If we get bids for a price of the basic benefit package, the plans that had the greatest need to stay in the market would bid most of that $72 away and any beneficiary, to keep what they now have, would have to pay a premium.

Mr. MCCRERY. Why could they not switch plans?

Mr. VLADECK. Because there would not be any plans in the market at that point that could do it at zero premium.

Mr. MCCRERY. Why is that?

Mr. VLADECK. Because, as far as we know from the ACR, adjusted community rate, calculations and so forth, the supplemental package is worth something like $70 a month and there are plans that are currently providing the existing Medicare benefit package for $70 a month less than where we would expect the bid price to come out.

Mr. MCCRERY. Essentially, though, I think what you are saying is you do not trust the market to work, so you want to build in governmental parameters to make it work the way you think it should, and——

Mr. VLADECK. No, we think every market works in a way——

Mr. MCCRERY. That is a legitimate approach. I disagree with it, but I think that is what you are saying. I just fail to see how you can conclude that if you allow flexibility above the basic benefit package of Medicare benefits that are required under law today, you will not have a marketplace that responds to demands, and if you already have in place seven plans that offer a benefit package that is, in fact, above the required Medicare benefits today, I would be very surprised if the market were to all of a sudden in toto drop all of those extra benefits. Somebody is going to try to attract more people by offering those benefits and then somebody else will have to and somebody else will have to. That is how the market works.

Maybe I am missing something, but it seems to me that you are concluding that the market will work in a way that I am not familiar with.

Mr. VLADECK. Let me just try this one more time. We are now paying a certain amount of money per month in Baltimore which the plans see as an attractive price because they are still entering, and they are providing the basic benefit package plus about 70 dollars' a month worth of extra services.

We believe that if we set the price at the current cost of providing Medicare benefits, then a plan would need either to reduce its expenses by $72 a month per member or reduce the package of what it is providing or increase its premiums. We believe—and it is one of the reasons why we are not prepared to just dump this all in the market—that the way most markets would work is that those plans that had a strong base of existing members who were tied to physicians and health systems they like would transfer those costs to the beneficiaries and the others would reduce benefits, because that is what is happening in the private market.

If we were going into an area in which anything above the basic Medicare benefit package was already being paid for by requiring a premium from beneficiaries, then people would not be worse off as a result, and that would be fine. But in the majority of markets where the existing prices have led to additional benefits and no premiums, it is very hard to do this and not leave beneficiaries worse off.

Mr. MCCRERY. This whole thing is hard, and again, I commend you for trying to swim through all this and reach some logical conclusion, and I will cease after this——

Mr. VLADECK. One of the things I think we have made clear all along is that if we live long enough to get an initial site up and running, we do intend to test competitive pricing in several sites. We have always reserved the right to fine tune and alter and change the model as we develop experience moving from site to site, and we will certainly take very much to heart all the issues that you have raised as we think about how a second generation or second model might be constructed.

Again, this is hard, and I think those are all very real kinds of concerns and questions. I hope circumstances permit us to test a variety of different approaches over a relatively short period of time.

Chairman THOMAS. We have a number of——

Mr. MCCRERY. One closing comment. It seems to me that if we could somehow wave a wand and figure out what the true value in price terms of the current fee-for-service Medicare package is, then we ought to just say to the market, we are going to pay this much per person and let the market respond as to the benefit package over and above the basic package that we all think should be required. That is, to me, the best way to see how the market is going to work, and if you can get efficiencies, which we are all looking for, the market will provide those, not the government. So, to me, that is—and maybe that is what you are trying to get out of all of this, but it just seems to me to be rather a convoluted way to do it.

Mr. VLADECK. Mr. McCrery, I think that is what Congress thought it was doing when it set the AAPCC at 95 percent of the community fee-for-service price. I think they either had an exaggerated perception of our ability to adequately adjust for risk or just

overshot the mark by a little bit in their desire to encourage entry of managed care plans.

Chairman THOMAS. It was an attempt to figure out where we are supposed to be. We did that with a number of standards in the environment and the rest, and then as you get closer to it, you take a look at how realistic you are and you try to adjust, and that is what you are doing.

Obviously, we still want to talk about the Medicare Choices demonstration. The study structure there, frankly, is a whole lot easier and, I think, better, and we will get to that.

I want to introduce one additional complication as we go along, because no one has mentioned the third party broker structure rather than the plans themselves enrolling, and, of course, I think the plans sometimes think that rather than just a pure sales job, there is an educational job about the new culture in which someone is about to enter and they believe that is an important aspect of getting people off on the right foot. The third party broker may or may not provide that beyond the pure education.

So at some point, we want to spend just a little bit of time talking about that, what experiences we have had, if there have been adjustments in this third party broker structure as opposed to other models that you have seen. But other Members want some comments about the competitive bidding and I believe the gentleman from Georgia, Mr. Lewis, wanted to get in for 1 minute.

Mr. LEWIS. Thank you very much, Mr. Chairman, and Mr. Chairman, I will be very brief.

Mr. Administrator, first of all, let me congratulate you for trying to be creative. I think you are taking the right approach. It is good to try new ideas, but they must be tried first on a small group with a lot of flexibility so that our seniors will not be harmed. I think well-thought-out demonstration projects are good and necessary first steps. I would especially like to compliment you on your efforts to develop a way to provide seniors with impartial information about the health plans that are available.

It is my understanding that some of these demonstration projects will focus on improving monitoring the quality of care provided. Could you discuss some of these ideas?

Mr. VLADECK. The monitoring of the quality of care, sir, is that the question?

Mr. LEWIS. Yes, sir.

Mr. VLADECK. There are several dimensions to that. As part of our evaluation of the Choices demonstration projects, we have been working with the RAND Corporation to develop new technologies or processes by which, from a standardized information set collected at each encounter between a patient and the health care system, we could develop sort of a computerized early warning and monitoring system. We hope to have that system ready to test at about the same time that the first of the Choices sites begin operation.

That will be in addition to, not to the exclusion of, our existing quality assurance techniques. Our existing techniques take essentially two forms. First, we have very detailed requirements for the internal quality assurance processes that the plans themselves maintain; and we monitor their operation of those quality assur-

ance processes very intensively. Second, the PROs, the peer review organizations, for years have had responsibility for monitoring the quality of care in Medicare HMOs. It is only within the last few years that they have begun to recognize the special characteristics of HMO care and have begun to develop the tools and techniques that are necessary to look at quality in an HMO setting, and that will continue.

We will also continue some of the other monitoring we do of disenrollments, of changes in patterns of enrollment, and of the grievances and appeals of beneficiaries. That provides something of an early warning system for us about quality.

So I guess that is a long answer when the correct short answer is, we will keep in place our existing mechanisms while conducting the Choices demonstration and the competitive pricing demonstration, and we will test new techniques based on expanded information provided us by the plans and some research on quality measurement we have been doing with the RAND Corporation, UCLA, and folks elsewhere around the country.

Mr. LEWIS. I know the Chairman will want to move to the whole area of Choices, but it is my understanding that you will be working with one of the Medicare Choices projects in Atlanta.

Mr. VLADECK. Yes, sir.

Mr. LEWIS. I would be very much interested in learning more about what is going on there.

Mr. VLADECK. Perhaps, in addition to a very short answer, we can arrange a separate briefing, if you would like, to go into substantially greater detail. But so far we have had very limited Medicare managed care activity in Atlanta. Atlanta, like much of the Southeast, has been relatively late to large-scale commercial enrollment.

Perhaps because of that, a number of HMOs, insurers and provider-based organizations in Atlanta, saw the Choices demonstration as a way to get into managed care while, at the same time, addressing some of the concerns they have about payment mechanisms, or risk, or the nature of the insurance market or other matters concerning which the existing laws seem to create problems for them.

We still have a concern, I have to tell you, with some issues having to do with the relationship between our program and the policies of the State Department of Insurance and the Insurance Commissioner, and we are working very intensively with them to try to——

Mr. LEWIS. What you have in Atlanta, is this considered a modified provider service network, or——

Mr. VLADECK. We actually have a sort of an array of participants in Atlanta. Some of them are insurance-based organizations. Some of them are provider-based organizations. We have some existing HMOs that are seeking to change the way they do business for Medicare. We have the organization based at St. Joseph's Hospital, which is very much a provider-based system, although they are in partnership with an insurance company. We have the Georgia Baptist Health Care System, which is almost purely a provider-based system.

One of the nice things about the way this program is evolving in Atlanta is that we have different kinds of organizations, all of which have been involved in health care in the Atlanta area over the last several years. Some are from the provider side, some from the insurance side, and all of them are seeking to provide a comprehensive range of choices in that market. We are kind of excited by the prospect.

Mr. LEWIS. I must tell you that St. Joseph's and Georgia Baptist are two great providers and institutions in the heart of the city.

Mr. VLADECK. We are very pleased by the kind of response we got from Atlanta and we are looking forward to being very actively involved there.

Mr. LEWIS. We have something coming up in Atlanta in the next few days.

Chairman THOMAS. You do?

Mr. LEWIS. It is a little game going to be getting underway a week from today, you know.

Chairman THOMAS. It is kind of exciting.

Mr. LEWIS. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, and thank you, Mr. Vladeck, for your patience and perseverance through all of this. Having worked through some of this in our work on the Medicare Preservation Act, I know that it is almost hopeless for those of us who have to spend only periodic times dealing with this, and yet it is extremely important that we figure out how to do it.

I am concerned about this aspect of your competitive pricing demonstration project. I hear what you are saying about not wanting to go into the market with a premium that is lower than you are already paying people in that market for a zero premium risk contract which provides actually more than Medicare benefits. You seem to have a good grasp of how much of the money you are paying those HMO risk contracts goes for the basic benefit plan under Medicare and how much goes for additional benefits.

Under that 95 percent of AAPCC reimbursement rate for the HMO risk contract, you are able already to factor out what is the basic benefit plan cost and what is the additional cost. Why do you not just go into the market at that level and let people see how much more they could provide? Then you really get a sense of competitive pricing. Why would you limit those who provide additional benefits to only dollar issues rather than benefit issues?

Mr. VLADECK. Mrs. Johnson, I mean this as a compliment and I hope you will understand it as such. That is exactly the question the Office of Management and Budget raised with us as we worked on designing this demonstration.

I think we are giving serious thought to the idea of actually asking for two bids from each plan, one for the existing market-level benefit package and one for the standard Medicare benefit package. The concern is that we do not want to leave current enrollees worse off, so we want to set a price that will buy, at least from some of the plans, the current benefit package, not just the basic benefit package.

And frankly, we and others are concerned that if we are too explicit about that difference, then the pressures on us will be overwhelming to move immediately toward that price on the basic benefit package. This is true not only in Baltimore, where there are only 12,000 folks affected, but in southern California and south Florida where there are hundreds of thousands of beneficiaries affected. And as I said, at some point, we are all collectively going to have to address what to do about the beneficiaries who are now receiving more than the basic benefits at zero premium.

Mrs. JOHNSON. Yes, I appreciate that.

Mr. VLADECK But we do not intend to do that as part of this demonstration.

Mrs. JOHNSON. But if you did—originally, I was sitting here thinking, why do you not do that? Why do you not ask for the competition at that level? I guess I do not clearly understand the relationship between the reimbursement rates that we have established and a demonstration project. If you asked for competitive bids at that level, that does not prevent you from continuing to reimburse the HMO risk contracts at the higher level for the higher benefit package, but it might incentivize them to offer something at the lower benefit package. Then the question is, what do you do with the rest of the money? You could give beneficiaries the choice of a rebate or of access to long-term care insurance or something like that.

I understand that that is difficult. That is why I at least wanted to know, why will you not let, then, plans offer more benefits for the current price than an HMO does if they can? Why are you going to anchor them to dollars when you do not anchor the HMO risk contract with a dollar anchor?

Mr. VLADECK. If I understand correctly, and I have to ask the experts, under the tentative rules we have talked about for the first competitive pricing site, once we establish the community standard benefit package and once we establish the government price, we are saying to plans whose bid price was higher than the price we set that they have to make up the difference in a premium. However, if a plan bid below the price we set, then they can pocket the difference or they can invest that into further benefits, and——

Mrs. JOHNSON. But, you see, I think since the project for us all is only to slow the rate of growth of Medicare premiums, I do not think the issue should be, how do we take back. The issue should be, how do we clearly get the value for our dollar. If you go to the market with the lower benefit package, too, retaining the current reimbursement rate, then the problem you have is how do you require those plans to provide value for the dollars above the benefit plan. If they do not want to provide value for that, then there are some other options there. You could string them out.

But it seems to me that to go into the market with a competitive pricing demonstration project that does not hit this pretty squarely is going to leave us with a notch problem. It is better to address that in the demonstration project now, knowing that we do not need to cut the 95-percent rate. In fact, one of the things we did in the Medicare Preservation Act was to beef up, perhaps irrationally—those of us from some parts of the country think it was done irrationally—the rural AAPCC so that we do buy a good benefit

package, and then slow the rate of growth in that benefit package so you put pressure on that benefit package that is offering more than Medicare benefits, which is why people will crosswalk into it.

So I do not want to cut those benefits; that is our current reimbursement rate. But I do not see your demonstration plan structure giving us the information we need about what the competition would be if we reimburse for the benefit structure, knowing that we also are capable of reimbursing for more than the benefit structure. So I just leave you with those thoughts. I know you hear what I am concerned about.

Then let me ask you one other question about the Georgia market. In many parts of the United States, because this is true of Connecticut and not true of Boston. I do hope one of your demonstrations will be in Boston. I do not know whether it is. I know Hartford did not get one.

Mr. VLADECK. No.

Mrs. JOHNSON. That is really unfortunate, because they went from one to four zero premium plans in 3 years and they have the long experience of the Harvard HMO and that is too bad. That would have been useful, because the Northeast is a different kind of environment.

But in the underdeveloped managed care plan areas, could you not start there with the basic benefit plan premium, so you do not have the two-tiered system? Do you have any HMO risk contracts in Atlanta?

Mr. VLADECK. We do have some existing ones. In some of the low-rate areas where we have been in the Medicare HMO business for a while, like the Pacific Northwest or the Twin Cities, we have publicly supported legislation to raise their payment rates on the theory that the way the current system was working was perhaps inequitable to them. So to go into those markets in the first round and to say, We want to drive down the price by the use of the marketplace, did not strike us as a particularly wise strategy.

Mrs. JOHNSON. No, but it does make it even more important in terms of the usefulness of these results that in that market, you have a price that is only package oriented, but that you have in other markets, like in the Northeast, you have a way of making comparability. So you have to do something about having a price that is package oriented, that is current Medicare benefit oriented or you will not have comparability. How you deal with the disparity, I think, is a better problem to try to resolve temporarily than not to have the competition or the competitive experience of the Medicare basket rate.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Washington, I think, wanted to inquire.

Mr. MCDERMOTT. Listening to Mr. McCrery and Mrs. Johnson and myself and all the rest of us, I would like to ask a couple of definitional questions, because I have a little problem here. A senior citizen today, if they get Medicare, they receive the services under that plan, and then they can buy a supplemental policy. This supplemental policy can be a cheap one or a fancy one, depending on how much money they have or what they think their health needs are going to be. So I think of the Medicare package that we

have today as the basic package and the supplemental being the additional services that are bought beyond that.

What I do not understand is you are talking about a basic package and additional benefits. Are these "additional benefits" the same as the supplemental package that seniors buy from AARP or somebody else?

Mr. VLADECK. Let me try to explain, Dr. McDermott. Some of this really is a regional difference.

Chairman THOMAS. Bruce, as you answer that question, though, would you put some percentages on it, because I know it is not 100 percent that purchase some kind of additional coverage. If you could go through if you are able, the percentage of beneficiaries that purchase Medigap policies and the percentage eligible for additional cost-sharing or premium contributions because of Medicaid eligibility, so we have an idea of the universe.

Mr. MCDERMOTT. He wants to make it more complicated.

Mr. VLADECK. Let me start with the following and I hope these folks here will hit me or something if I get any of these numbers badly wrong.

Chairman THOMAS. I apologize for trying to make it more realistic rather than complicated.

Mr. MCDERMOTT. Complete.

Mr. VLADECK. The issue is as follows. If you take the benefits to which Medicare beneficiaries are entitled under the law with the existing very significant copayments and deductibles and caps on how many hospital days can be covered and so forth, that is what we refer to as the basic Medicare benefit package.

All but about 12 percent of Medicare beneficiaries purchase or have purchased for them some additional coverage. About 10 percent of beneficiaries receive additional benefits through HMOs, which is where most of this last discussion focused.

About three-quarters of Medicare beneficiaries purchase or have purchased for them supplemental insurance policies, Medigap policies with the ten varieties, all of which pay most of the coinsurance and deductibles for covered services and relieve some of the limitations on the utilization. Variations in policies largely have to do with additional benefits of which prescription drugs are the most important and the most expensive, rather than reduced out-of-pocket expenses.

About 12 to 15 percent of Medicare beneficiaries have very extensive coverage of their copayments and of additional benefits by virtue of their eligibility for Medicaid, and then about 10 percent——

Mr. MCDERMOTT. So their Medigap policy is essentially Medicaid?

Mr. VLADECK. Medicaid, that is correct.

Mr. MCDERMOTT. Yes.

Mr. VLADECK. And then about 10 or 12 percent of beneficiaries have no additional coverage at all.

Mr. MCDERMOTT. So they are simply bad debt to the system in whatever place.

Mr. VLADECK. Or they are paying out of pocket. They tend to be very much concentrated in the income band immediately above Medicaid eligibility. These are primarily folks who cannot afford supplemental insurance policies.

In the HMO side of Medicare, the rules for the risk contracts do not allow plans that provide the basic benefit package for a cost less than we pay them to pocket that difference. They are required to use that difference either to provide additional benefits at no additional charge or to buy down the part B premium, which is an out-of-pocket expense for beneficiaries that has not been part of this discussion, or some combination of both. About 60 percent of the Medicare HMOs provide the standard Medigap policy plus some additional benefits without any additional premium to beneficiaries because they are filling that gap between what they are being paid and their costs of producing the basic package.

Mr. MCDERMOTT. So they produce the basic Medicare package and then they buy—essentially, they are buying a Medigap policy. I mean, that is what that money is. The "additional benefits" are a Medigap policy for 60 percent of the people.

Mr. VLADECK. For 60 percent of the plans.

Mr. MCDERMOTT. The plans.

Mr. VLADECK. Sixty percent of the plans with which we have contracts is actually a higher proportion of beneficiaries, because, obviously, the so-called zero premium plans are the most attractive. But this is almost purely a regional phenomenon. In those parts of the country where the AAPCC, our basic price, is high by whatever measure, most of the HMOs are providing additional benefits at zero premium. That includes southern California, most of Florida, and many of the Northeastern cities. In those areas——

Chairman THOMAS. So another way of saying it, though, so people can come through the back door, is that at the 95 percent of AAPCC, the HMO can give you all of the basic benefits, we can throw in a Medigap policy, and we do not charge you any premium and maybe put drugs in, as well.

Mr. VLADECK. That is correct.

Chairman THOMAS. That is the other way of looking at it.

Mr. VLADECK. That is correct. And in the Twin Cities——

Mr. MCDERMOTT. And Seattle.

Mr. VLADECK [continuing]. And in Seattle and in Portland and in those few rural communities that have Medicare HMOs, in order to get the basic Medicare benefit package through an HMO, a beneficiary has to pay a significant premium or the HMOs do not want to have risk contracts with us at all and exercise the option they still have under the law to be reimbursed on a cost basis. This is increasingly the case in the Twin Cities.

So that is why there are about three separate layers of complication associated with this question, because in the high AAPCC areas, like Baltimore or like southern California, we have three sets of issues. One is that beneficiaries currently get expanded benefits at no additional cost to themselves if they enroll in an HMO. Second, we think that occurs in part because we are paying too much in our rate in those communities. But third, one of the arguments for why we are paying too much is the argument we hear from people from Seattle or Minneapolis, that we are paying too little in those communities. Yet we also tend to believe, and I think the savings taken in legislation suggests that we are, on average, overpaying at 95 percent of AAPCC.

Mr. MCDERMOTT. But it is nationwide. Nationwide, you are overpaying.

Mr. VLADECK. The average payment is too high, but clearly, it is too low in some communities and higher than too high in other communities.

Chairman THOMAS. But you also have to say, rather than say the Baltimore experience, the Maryland metropolitan area experience gives you a swing of almost $200 between the highest and the lowest AAPCC within that demonstration area, so the margin that an HMO has to work with given the very short geographic differences between that $200 difference means you really have a tough time in certain areas offering anything that is reasonable and in other areas you have enormous windfall.

Mr. VLADECK. As I think we have pointed out, in other instances, the pricing differences within the Baltimore MSA are less than average for MSAs around the United States. In fact, one of the other criteria we looked at and one of the other reasons we gravitated toward Baltimore was because, as compared to the Los Angeles-Riverside County market area or the metropolitan New York market area, that $200 a month difference is less than it is in many larger markets.

Chairman THOMAS. It just occurred to me, and I apologize, I did not pick up on the subtleties, we will reexamine the HCFA travel budget. [Laughter.]

Mr. VLADECK. I appreciate that——

Chairman THOMAS. I did not realize that was where you were headed at the beginning.

Mr. VLADECK [continuing]. Your assertion of jurisdiction in that regard, but I am not sure everyone feels that way.

Chairman THOMAS. I do learn, though.

Quickly, on the third party broker, what you learned, why you are doing it, if you have changed it at all from past experience.

Mr. VLADECK. Let me just say that we first got into the question of third party brokers in our meetings with private employers, particularly those who had sought to undertake relatively large scale or rapid conversion of their retirees to managed care plans. We clearly still have significant selection problems in the Medicare HMO program. There are lots of reasons for it and I do not want to imply motivation at all.

To some extent, perhaps entirely, that is a function of the characteristics of beneficiaries in terms of who was interested in managed care and who was not. But to some extent, I would assume that if HMOs were rational and if those that were publicly owned were protecting the interest of their stockholders, they would also shape their marketing and enrollment activities in a way that is more likely to attract better risks.

Particularly when you introduce the kind of dynamic to the marketplace that a lower price does, we are concerned about the extent to which one of the responses to this change in price would be selective marketing or selective enrollment. We have had a lot of experience with this issue on the Medicaid side, where almost half of the States with Medicaid managed care programs are now using third party brokers, and so we thought it was appropriate to test it at this point.

Chairman THOMAS. Prior to turning it over to the gentleman from Maryland, you have two additional competitive bid pricing sites. We were listening to some of your criteria. My friend and colleague from California indicated that he was still in the running, based upon the criteria that you announced. Have you, in fact, settled on the two additional sites?

Mr. VLADECK. No, we have not. We have a list. We have learned from our experience in Baltimore. Once we identified potential sites, we went to the industry at the national level and asked if we could identify such a community, either from our list or theirs, in which all of the plans would be willing to volunteer to participate in such an experiment, since that would have been our preference. We were unable to identify a city where that was the case. We then——

Chairman THOMAS. Did you spend a lot of time on that search?

Mr. VLADECK. I do not know how energetically they acted, but we waited a number of weeks for the response. We have several other sites in mind, but we have learned from Baltimore that before saying anything in public, it is probably prudent and wise to consult extensively with folks from that community. We have not yet begun those consultation processes in any other community.

Chairman THOMAS. As you sharpen your model from the Baltimore experience, I would urge you to touch bases with us as you move forward to suggest areas that you might be looking at for modification so we can follow the progress, as well.

Mr. VLADECK. We would appreciate that very much, sir.

Chairman THOMAS. Thank you.

The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

It might be useful, since Baltimore has been mentioned quite frequently, to just share with the Subcommittee some of the conversations that have taken place in Baltimore. It is true that we were not involved in the initial decision to select Baltimore and we have raised significant objection to that process, but I want to compliment HCFA in meeting with us and working with us since the initial release of Baltimore being selected as the initial site.

I think it is clear from the testimony today that the current pricing mechanism for the managed care plans needs to be changed, that using 95 percent of an average rate that varies so greatly among even small areas is not the best way to compensate for bringing managed care to our Medicare beneficiaries. So we welcome looking at a new pricing mechanism.

Members of the Subcommittee have pointed out why Baltimore would be good or bad. Many of the issues that have been raised will be present regardless of what site is selected, and I think that is clear. But there are two unique aspects to Baltimore that we want to make sure are discussed before moving forward in Baltimore, and one has already been mentioned. That is the all-payer rate structure and whether the all-payer rate structure is the right location for the first initial program.

The second is timing, and it has not been brought out yet, Mr. Chairman, and I think it is important to point out that the Maryland Legislature approved a plan that will bring all Medicaid eligibles into HMOs and enrollment will start in January of this year.

We are using a third party contractor to bring in the Medicaid population, so there will be a significant change in the Maryland HMO community. There is a great deal of concern by our State as to whether they can have a successful integration of the Medicaid population into HMOs at the same time that there is a Medicare pilot program moving forward. That issue is being presently addressed by HCFA and the State of Maryland.

I might tell you, it is anticipated that the legislature in January will be considering expanding that program to include also long-term care, so it is a significant change taking place in Maryland. There is concern as to the capacity of the State and the managed care operators to handle a pilot program all at once and we need to keep this Subcommittee informed as to how those discussions are progressing.

The other issues that have been brought up, I think, are very important. We have talked about the competition and competitive pricing. That is going to be true wherever this type of a pilot program is started and we need to make sure that, in fact, we will have competition and a significant number of plans offered to our seniors.

The AAPCC rate differential in Baltimore concerns me because it would be very easy to go and try to enroll a person, an elderly person who lives right across the Bay Bridge, where the AAPCC rate is so low, where you are going to be now using an average rate which would reward significantly a plan that enrolls individuals in that area. This is true in Baltimore, but I believe is true in many other areas.

The consumer protection issues, the use of third party brokers, these are all matters that need to be fully addressed before moving forward with a pilot program regardless of where that pilot program takes place.

The integration of our seniors who currently have multiple options available and the confusion that will just normally be associated with any new program need to be addressed. In Baltimore, we are one of the sites that have a waiver, where our seniors currently are receiving more benefits than just the normal Medicare benefits under a cost program. That is present in five locations in the country. We want to make sure the seniors that are enrolled in that program are not confused with this new effort.

So there are a lot of problems that have been raised that will occur regardless of what site a pilot program moves forward with that need to be addressed before we move forward.

So, Mr. Chairman, I appreciate your giving me, at least, this opportunity to explain to the Subcommittee. I want to thank HCFA for the close working relationship that we have now established. It seems to me that if we proceed in Baltimore, there will be some modifications to what has been already advertised. It is extremely important that this Subcommittee be kept informed of what is happening in Baltimore, or other sites, because I do think an awful lot depends on this program being done in a successful manner if we are going to be able to move forward in giving more options to our seniors in managed care. Thank you.

Chairman THOMAS. I thank the gentleman for his comments.

I think HCFA understands now that perhaps what they thought was a typical kind of a project, although innovative and novel, has, in fact, generated a great deal of interest. These folks are not trying to make sure it fails, but, in fact, to try to make sure that it succeeds, because decisions that are partially overdue need to be made, and frankly, as we were going through our look at changes in the program, we were desperately searching for the kinds of tools that you will be looking for in these demonstration programs. Had we had them available, a risk adjustment mechanism, an ability to compare and contrast in a way that would allow us a dollar profile, we all believe we could have done a much better job in trying to restructure. So we are very interested in a positive way in what you are doing.

Do you want to go into the competitive bidding, because we are going to go to Choices right now.

Mr. MCDERMOTT. Could I just ask one thing on this?

Chairman THOMAS. Yes. Go ahead.

Mr. MCDERMOTT. Mr. McCrery asked a question about why you did not go into the market, and Mr. Cardin just said something which triggered a thought in my own mind. My father is 91, went to church and came back with an envelope from an HMO that had been handed to him by one of the other people there. And my father said, "She said to me, 'Ask your son if this is good for me to get into.'"

One of the things that I would like to hear you talk about is what the downsides of competitiveness are and what consumer protections exist for Medicare beneficiaries enrolled in HMOs. Mr. McCrery was suggesting maybe we should just let the market be a little freer. It is sort of managed competition, if you will, and you did it for consumer protection reasons, I suppose. I do not know.

Mr. VLADECK. Let me, if I may——

Mr. MCDERMOTT. Because people 91 years old may have a hard time deciding on which HMO to join.

Mr. VLADECK. Let me respond, not exactly to your question but to the illustration, in a sense. We find, through formal opinion research as well as just through people we talk to less formally, an enormous desire on the part of beneficiaries in those communities where there is a lot of managed care marketing going on for help in figuring this out. That is where the third party information is needed—not just the videos or the brochures that are done by a third party, but the counseling, the 1–800 number, the neutral party who will tell people, if you want to do *x*, here is what you want to do. Here is the upside and the downside of each of these choices.

In terms of the risks, there are three, I think, and Mr. Lewis got to some of them. Obviously, we want to have an absolute floor that we are continually raising in terms of the benefits and the quality of service and protection of beneficiaries. We believe in continuous improvement, not only on our own part, but on the part of the people from whom we buy services. We think one of the dynamics of better quality measurement, which is certainly true in the most successful private sector firms, is that once you think you can measure your quality performance, you keep raising the bar all the time. Those are sort of preconditions.

The third thing, and the hard thing, has been that as you put economic pressure on the system, how do you structure the market in such a way that providers' responses have to be in the direction of getting more efficient or getting better, rather than in the direction of reducing what they are providing for that price or finding a way to shift it to someone else, either in out-of-pocket costs or in noneconomic costs, such as waiting times, difficulties getting through on the phone, whatever, to the beneficiary.

That is the hard part, and if you put the question at that level, it is one that every large purchaser has all the time and one that we have lived with not only in the managed care setting, but in the other areas of Medicare where we have tried to reform payment.

One of the issues on prospective payment for hospitals was, if you lower the price, what is going to happen? The answer appeared to be, to a considerable extent, hospitals raise their prices to folks who are not constrained, and when they ran out of those folks, hospitals began increasing their productivity, which was what we had hoped to get 10 years ago.

So the issue is when you reduce the price you pay to someone, there are a lot of different ways he can respond. How do you channel circumstances so the response is in the direction of greater efficiency or a better product rather than in the direction of a reduction in the quality or the diversity or the characteristics of what is being provided? One way you do that is by putting a floor on what is provided in qualitative terms as well as in benefit package terms, but the other way has to do with the way in which you structure the bidding process. That is what we have been trying to figure out.

Mr. MCDERMOTT. Thank you.

Chairman THOMAS. Let me explain part of my problem with that, using DRGs as an example. Clearly, on diagnostically related groups, you have a narrow band, but you basically put a dollar amount on it and then let them figure out how to accomplish what was required within that dollar amount.

To me, a better analogy to the HMO market would be to say, This is what we have to spend. What can you do for us? Understanding the basic package is a given, what can you do for us at that price, and let then the HMO figure out how they make the efficiencies or offer various products.

By your predetermining that efficiency is the goal that you are shooting for, and locking all of the other variables into place, I do not know that since we are now outside of a narrow, defined group to the larger picture that all we get are people dropping out of the marketplace. Because the only way I can make an adjustment under that model is to add dollars, and dollars is the most important motivator. That is back to my original concern about that model that you structured, and I understand the difficulties.

Mr. VLADECK. I would argue that the model you are suggesting, where we say, Here is our price, is very close to what we have been doing over the last 10 years. When we tell HMOs, You must provide the basic benefit at that price and provide whatever else you want; that is what we have been doing under the AAPCC.

Chairman THOMAS. I understand, but the dart you threw landed at 95 percent and you built in the problem of the difficulty of the

AAPCC to begin with as the base from which you took the 95 percent. So you created a uniform charge off of an inequitable base, and I do not know that that gave us a whole lot to deal with in that.

For example, I would much rather you went in and you said, all right, here are your options. You are going to get 95 percent, 94, 93, 92, 91, or 90, we do not know which yet. What can you give us for those prices, and then pick one kind of an approach. There are a number of ways to deal with this. But my concern is, above the average or the competitive bid structure, you can only play with dollars, and that is a basic difference.

Now, let us move to the Medicare Choices demonstration, because I think from a model point of view, one, it is easier to deal with. Two, it is also kind of exciting because you have a couple of dozen areas that you are dealing with which will give us faster a better understanding of the diversity that is out there.

Where are you in terms of the kind of different delivery models and the risk payment adjustment models that we are playing with here, or what do you hope to get out of the Choices demonstration study?

Mr. VLADECK. Of the 25 sites or organizations of providers with whom we are hoping to consummate Choices demonstrations, I am trying, of course, to——

Chairman THOMAS. On those 25, if you simply threw them up on a map of the United States, are there any obvious holes?

Mr. VLADECK. The answer is yes, I think, as Mrs. Johnson suggested.

Chairman THOMAS. The Northeast?

Mr. VLADECK. The Northeast is underrepresented. I am trying to visualize this. Philadelphia is more mid-Atlantic. There is nothing north of Philadelphia except a rural provider in New York State that is a very interesting model. So we have upstate New York filled in there on the map.

Chairman THOMAS. OK.

Mr. VLADECK. I think we did pretty well in that regard. I believe of the 25, only 2 are proposing to use the existing payment methodology without some modification.

Now, there is a whole variety of sorts of modification. Some of them want the existing payment methodology with just more sophisticated risk adjustors, and this will be our first empirical test of the risk adjustors on which we have been working. Some of them want to talk about a more shared risk kind of arrangement. Some of them want to talk about a partial capitation or a partial risk model, at least in the startup years. So we do——

Chairman THOMAS. And you are calling those risk corridors?

Mr. VLADECK. Risk corridors is what I would call shared risk.

Chairman THOMAS. Yes.

Mr. VLADECK. In other words, somewhere between cost and full risk would be shared risk between the buyer and the seller. So pretty much the full range of noncompetitively bid pricing suggestions that have been analyzed seriously for Medicare capitated plans are being tested in one or another of these sites.

Chairman THOMAS. On the side of structure, you obviously want to get as much innovation as possible so you are providing for a number of waivers for groups that might come in.

Mr. VLADECK. Actually, the waivers are primarily of two kinds, relative to our existing rules.

Chairman THOMAS. Obviously, 50–50.

Mr. VLADECK. They are of two kinds. The 50–50 rule and the 5,000 minimum commercial enrollment rule are the only major categories I can think of. There will be some——

Chairman THOMAS. One of the things we ran into as we were looking at the Choices structure was the fact that you have existing State licensing structure that may or may not allow for some degree of diversity. My assumption is you are going to allow for models that would not otherwise be real world if they had to go through the licensing.

Mr. VLADECK. That is correct, although we are actually finding, at least in some of the States, that the perceived rigidities of the State licensure process are not as great as had been perceived. In other words, we have reserved the right to contract with an entity that does not have a separate State license as an entity. On the other hand, everybody is better off if the entity is appropriately licensed in the State, and as I suggested in my colloquy with Mr. Lewis, in Georgia and in Pennsylvania and in several of the other States, our involvement has caused the State insurance commission or the State insurance department to respond more flexibly than the providers initially perceived they might.

Chairman THOMAS. So we have a group of folks who may or may not conform to certain rules but clearly probably get certain rules, like the 50–50, and they are moving into the two dozen markets and they are going to obviously be in competition with folks who have met all those other standards. Some of them will already be entities that are dealing with risk contractors under the other rules. Where are you going to deal with, for want of a better term, cannibalism, piracy, their structure taking from an existing structure that they service beneficiaries, because they know about them and can almost do a fairly decent selection if they have a hospital profile on them.

Mr. VLADECK. Real markets—I do not mean to sound sort of silly about this—but real markets are messy. What we are seeing, for example——

Chairman THOMAS. But we are creating an advantage for this entity by waiving the rules. It is not a real market.

Mr. VLADECK. Except the alternative way of saying that is we are reducing barriers to entry that are created by our existing rules and thereby not acting in a protectionist fashion toward existing participants in the market. As a transitional——

Chairman THOMAS. I accept that. It is going to be messy and there are going to be some painful areas and some people are going to complain.

Mr. VLADECK. Yes.

Chairman THOMAS. I have a bigger question, and that is, what is it, a 5-year study?

Mr. VLADECK. Choices, I think the contracts, which are annually renewable, are three to five, depending on the market.

Chairman THOMAS. Three to five? My biggest fear is you are wildly successful. We have created all of these incubator models. We have nursed them through early infancy and childhood. Are we going to require them somewhere along the way to mature into a structure that would meet the standards if it were not for the test?

I mean, if we are successful in some markets and then walk away, you have a model that could not exist in the real world that has thousands of beneficiaries plugged into it. What is your exit strategy, I guess is what I am saying.

Mr. VLADECK. That is an issue we always have with demonstration programs.

Chairman THOMAS. Yes, but this one may be——

Mr. VLADECK. And I think the answer is, if we have not 3 to 5 years from now managed to change the law on Medicare managed care, the exit strategy for these projects will be, in some ways, the least of our problems.

We have had a lot of experience working with this Subcommittee and with other parts of the Congress. In fact, this type of situation came up the last time I was before this Subcommittee. We have undertaken demonstration projects because there was an apparent consensus of a broad direction in which public policy ought to move, but a lack of certainty about the details; and so we set out to test something. For whatever reason, the public policy process did not move as quickly or in the direction, and we so have, for example, four social health maintenance organizations which everybody likes, which have enrollees who are very happy and well served, for whom we have to keep extending the demonstration authority. That is a risk inherent in this process.

Chairman THOMAS. Or waivers, as we have discussed.

Mr. VLADECK. Or waivers. That is a risk that is inherent in the demonstration process.

Chairman THOMAS. And then the problem of the inevitable failures of those models that are not as successful as we would like. Since they came into existence by virtue of the incubation structure anyway, are you planning on requiring those who are otherwise real world to absorb the expense of bringing those beneficiaries back into the structure, or is Medicare going to assist in dealing with those failures so that there is no financial risk for people who are otherwise doing what you have told them to do in the real world?

Mr. VLADECK. No. I think it is fair to say, although maybe it is not a fair policy, that all of the organizations that are participating in the Choices demonstration are at full risk for the basic failure or success of the program. For example, they are at risk to the extent that they may invest substantial resources in developing a new payment method, or substantial resources in enrolling a lot of folks in a PPO which does not then become permanent, or in a risk adjustor which is then discarded. We have never promised and are not in a position ever to compensate them for any of the losses associated with that.

Chairman THOMAS. In attempting to look at these new models, have you had any discussion with any groups or entities about difficulties with other aspects of the law, antitrust or other areas, that you can begin to build some understanding of perhaps some adjust-

ments that need to be made in other areas of the law to better allow these folks to do what they believe and you believe that they would like to do?

Mr. VLADECK. Yes. One of the things we have not perhaps adequately conveyed and that is relevant to both these demonstrations but it is particularly relevant to part of the Choices demonstration is how much learning about the implications of applying a theoretical concept in the real world occurs and how important that is both to the provider community and to ourselves.

For example, all of us have spent an enormous amount of time over the last year and a half in thinking about the implications for policies, for laws, of provider-sponsored organizations and networks, their antitrust implications, their payments, and so on and so forth, all of it around a set of hypotheticals.

Chairman THOMAS. And the risk, where does it fall and on who.

Mr. VLADECK. We hope that if we have half a dozen functioning Medicare contracts with functioning provider service networks, that the next time we are looking at broad policy, we will have somewhat more experience on which to base those discussions. Many of those discussions will be around problems or issues or questions that we do not anticipate at all at the moment, I would expect.

Chairman THOMAS. That, to me, will be the most successful aspect of it, that we find out what it is we did not expect to find out.

The gentleman from California.

Mr. STARK. Bruce, I just wanted to get on the record a clarification. There was a story in the New York Times on Monday dealing with the issue of HMO financial incentives to doctors to not order tests or refer patients to specialists. I think that the headline was inaccurate. So the question I pose to you is to ask, is it not correct that you have not shelved the proposed rules but you intend to put them into effect?

Mr. VLADECK. I believe there was a double negative in the question, so let me just try to answer not with a yes or no.

Mr. STARK. Please.

Mr. VLADECK. On March 28, we published a final rule with comment having to do with physician incentive arrangements in managed care plans, and there were a variety of effective dates associated with those requirements. For the provision of stop-loss insurance for physicians capitated under certain kinds of arrangements, we have agreed that it is a better reading of the law that the effective date of implementation should be January 1, 1997, rather than May 28, 1996. Other than that, we have changed none of the policies or specifics or decisions that are contained in that final rule of March 28.

Mr. STARK. So those regulations will go into effect?

Mr. VLADECK. They will go into effect on a rolling basis, depending on the various effective dates of the various provisions.

Mr. STARK. As was published——

Mr. VLADECK. As was published on March 28.

Mr. STARK. And you will enforce them vigorously?

Mr. VLADECK. Vigorously.

Mr. STARK. Like a Doberman pinscher?

Mr. VLADECK. I am not sure that is the analogy I would particularly propose.

Chairman THOMAS. I was going to say a Saint Bernard, but that is OK. [Laughter.]

Mr. STARK. Thank you very much for that clarification.

Mr. VLADECK. Thank you, sir.

Mr. STARK. I thank the Chairman.

Chairman THOMAS. I think the gentleman from Washington has a parochial question.

Mr. MCDERMOTT. We will not get into which dogs we look like, right? [Laughter.]

You are preparing to do a demonstration project in Seattle, which I am eager to see the results of, but it roughly looks to me that the purpose of this project is to develop a better set of risk adjustors. Is it possible to do that? What I do know is that you are having some difficulty in getting enough participants to actually have a study. You had four HMOs that said they would come in and then one dropped out and so now you are down to three. If anybody else drops out, it is not a good demonstration. Is that a fair assessment of what is happening?

Mr. VLADECK. I think that is entirely true and it gets back to the question of keeping volunteers in these programs. It is both true and ironic that in those communities in the United States that were the earliest to experience widespread managed care penetration, both in the private sector and Medicare, many of the best established plans have the most difficulty coming up with new data systems and new informational processes that have to be part of any kind of demonstration.

Mr. MCDERMOTT. Are you saying because they are so lean and mean that they do not have the money to give you the kind of encounter data you want, or are you implying something else?

Mr. VLADECK. No. I am really implying that the older group model plans traditionally did not maintain encounter data, in part Because they were not in the fee-for-service business, whereas the newer IPA kinds of plans or some of the insurance-based plans that came out of a different world were much more likely to have encounter-specific data from the outset. That has been part of the issue.

Mr. MCDERMOTT. Does that suggest, then, that the design of your model is one that will exclude all the not-for-profits that started a long time ago and really will only be accessible by those new HMOs that have come on in the last 6 or 7 years?

Mr. VLADECK. No. With the help of the largest, oldest, most sophisticated nonprofit plan in the Seattle area, we had hoped to test various ways of getting at encounter-level information to permit us to test that whole idea and find out whether we really needed to have it, whether there are other ways to get that information, how standardized we need it, and so forth.

But I think it is safe to say that we cannot envision a fair test of any change in the market in the greater Seattle area without Group Health, to be specific, because they are so significant a provider to our beneficiaries. We have been working very closely to try to develop a demonstration that makes sense for all the plans and still meets some of our needs for information and still keeps the plans interested.

Mr. MCDERMOTT. Just so I can understand why you selected Seattle, was it the long history?

Mr. VLADECK. No. I believe this was largely a self-selected——

Mr. MCDERMOTT. They came forward and said——

Mr. VLADECK. Again, 3 years ago, we went to what was then the Group Health Association and said, we share your discomfort with the AAPCC. We are interested in testing changes to it and basically said, we will approve any budget-neutral demonstration that protects beneficiaries and tests any other payment method. The Seattle project was the most developed and sophisticated one we got, and even that is barely budget neutral.

Mr. MCDERMOTT. So they described the——

Mr. VLADECK. This was something that was initiated by the plans in Washington State themselves.

Mr. MCDERMOTT. They put it together and brought it to you and you approved it, and then the people sort of figured out that they did not have the capacity to produce the data that they had promised.

Mr. VLADECK. I do not want to jump to that conclusion. We are still working on that.

Mr. MCDERMOTT. All right. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. If there are no other questions, I want to thank you very much, Bruce.

We have a series of votes on the floor and I think the most efficient way to deal with this will be to recess the Subcommittee until 2 p.m. Those who need lunch or want lunch can get it at that time, and if there are any inconveniences by virtue of moving the rest of the panels back, please let me know and we will try to accommodate you. Otherwise, the Subcommittee stands in recess.

[Recess.]

Chairman THOMAS. The hour of 2 having arrived, the Subcommittee will reconvene.

The first panel, Mr. Agar, Mr. Ryan, Dr. Braden, Mr. Womer, thank you. I apologize. Sometimes control of the time is not our own.

I would tell all of you that any written testimony that you may have submitted will be made a part of the record and you may begin to inform the Subcommittee in any way you see fit for the 5 minutes that you have available. We will begin with Mr. Agar and then move across the panel.

STATEMENT OF J.H. MICHAEL AGAR, PRESIDENT, HEALTH PLANS OF PENNSYLVANIA, INC.; AND VICE PRESIDENT, MANAGED CARE, CROZER-KEYSTONE HEALTH SYSTEM, MEDIA, PENNSYLVANIA

Mr. AGAR. Thank you very much, Mr. Chairman.

Chairman Thomas and Members of the Subcommittee, my name is Michael Agar. I am vice president for managed care for the Crozer-Keystone Health System and president of its wholly owned subsidiary, Health Plans of Pennsylvania. Crozer-Keystone is a finalist in HCFA's Medicare Choices demonstration program and we are very proud to have been selected and are working hard to make it a success.

Crozer-Keystone is a not-for-profit integrated delivery system that provides a broad continuum of care to the 550,000 residents of Delaware County and surrounding communities. Health Plans of Pennsylvania is the system's managed care arm. It currently manages full risk patients from other payers and is in the process of being licensed as a risk-bearing entity by the Pennsylvania Department of Insurance.

The elderly are the largest users of our medical, rehabilitative, and social services. We have 95,000 Medicare beneficiaries in our immediate area and we have made significant investments in ensuring that Medicare recipients have access to those services. We have created the Crozer-Keystone Institute for Senior Health, the Silberman Center, and the Institute's ElderMed Program serves 40,000 members who are provided with health education, wellness, and outreach programs.

This rich array of services for the elderly, when combined with Crozer-Keystone's complete continuum of care, is why we know our facilities, doctors, and hospitals can do the best job of integrating and coordinating the care of our patients and of managing their care to ensure quality while using the techniques of managed care to increase efficiency and cut costs.

Our goal is to demonstrate that we can build on the existing relationship with our senior community to overcome their concerns about managed care and to focus on keeping them healthy while providing superior service when they get sick. We are known in our communities, we belong to our communities, and we are trusted by our communities.

Crozer-Keystone's Medicare Choices demonstration project is designed to be another innovative and creative service to offer to our senior community. It features zero premium. It has a point-of-service option. Ours will be one of the first products available in our area. We will also offer members a number of health education opportunities with rewards to encourage healthy behavior.

We will do an annual health risk assessment on every member. If the assessment shows that a member has diabetes, for example, we will schedule the member for the system's diabetes education class. Upon successful completion of the class, the member will be rewarded with enhanced benefits, such as eyeglasses, hearing aid, or exercise program membership.

I want to point out that it would be extremely difficult for Crozer-Keystone to offer a Medicare product in our market without the HCFA designation. Currently, an insurance license is required in Pennsylvania and in other States in order to offer a risk product. However, we are not an insurance company. We are a provider-sponsored organization. The HCFA designation has given us top priority with the Commonwealth's Departments of Insurance and Health. It is making it possible for us to receive the necessary certificates of authority to launch our Medicare Choices Program within HCFA's desired timeframes. Without this designation, this process would have taken years, not months.

The ability of Crozer-Keystone to directly contract with government programs is critical to our continued ability to provide high-quality and innovative care to our communities. As you continue your efforts to balance the Federal budget, it is clear that the rate

of annual increases for Medicare will be reduced. Combine these reductions with new insurance, entrance into the field of government-sponsored health care, businesses taking anywhere from 15 to 30 percent of the premium for their own use, and you have a situation that could dictate reductions in service to patients.

And there is no guarantee that these entities, once in the Medicare business, will stay in. For example, several HMOs in the Philadelphia area have recently said they are going to go out of the Medicaid business because the rates are getting too low. These are our patients in our communities. We are not going to go anywhere. We have to take care of them and we want to do it with the best resources available and with the most efficient use of these resources possible in this era of fiscal constraint.

In conclusion, we at Crozer-Keystone feel fortunate to be chosen as part of this program. We are committed to making it work because we believe that direct contracting is the key to the future successful health care delivery for many local health care providers. We commend the Subcommittee for passing legislation last year that would have allowed that to happen and look forward to working with you to bring the benefits of PSOs to more Americans by passing similar legislation at the earliest possible time.

Thank you very much. I would be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF
CROZER-KEYSTONE HEALTH SYSTEM
BEFORE
THE COMMITTEE ON WAYS AND MEANS
HEALTH SUBCOMMITTEE
Presented by
J. H. Michael Agar
Vice President, Managed Care, Crozer-Keystone Health System
and
President, Health Plans of Pennsylvania, Inc.

Chairman Thomas and members of the subcommittee, my name is J. H. Michael Agar. I am vice president for managed care for the Crozer-Keystone Health System and president of its wholly owned subsidiary, Health Plans of Pennsylvania, Inc. (HPP). Crozer-Keystone is a finalist (one of nine integrated delivery systems nationally) in the Health Care Financing Administration's (HCFA's) Medicare Choices demonstration program. We are extremely proud to have been selected for this program and are working hard to make it a success.

BACKGROUND ON CROZER-KEYSTONE HEALTH SYSTEM

Crozer-Keystone Health System is a not-for-profit, integrated health system that provides a broad continuum of care to 550,000 people in Delaware County and surrounding communities. Our system includes 100 employed primary care physicians, three community hospitals, one tertiary medical center and four long-term care facilities.

Health Plans of Pennsylvania is the system's managed care arm. It currently manages full-risk patients from other payers and performs the tasks of premium sufficiency analysis, network development and maintenance, customer services, provider training and relations and utilization management. HPP is in the process of being licensed as a risk-bearing entity by the Pennsylvania Department of Insurance.

As the elderly are the largest users of our medical, rehabilitative and social services, Crozer-Keystone has made significant investments in ensuring that Medicare recipients have access to those services. With the creation of the Crozer-Keystone Institute for Senior Health, our programs and services take every aspect of the senior citizen's physical, mental and emotional well-being into account. Our Silberman Center provides a variety of senior services including adult day care, geriatric assessment, outpatient mental health services and physical therapy. The Institute's ElderMed Program provides health education, wellness and outreach programs to more than 40,000 members. Our $40 million, 180,000-square-foot Healthplex is a 21st Century wellness, health and prevention center. Opening in September of this year, it will serve as the focus of our wellness efforts.

This rich array of services for the elderly, when combined with Crozer-Keystone's complete continuum of care, is why we know our facilities, doctors and hospitals can do the best job of integrating and coordinating the care of our patients, and of managing their care to ensure quality while using the techniques of managed care to increase efficiency and cut costs.

HCFA's designation of us as a Medicare Choices finalist, coupled with the national publicity surrounding the awards, gives the program an imprimatur that engenders a spirit of enthusiasm and cooperation both within and outside of Crozer-Keystone.

Our goal is to demonstrate that we can build on our existing relationship with our senior community to overcome their concerns about managed care, and to focus on keeping them healthy while providing superior service when they get sick. We are known in our communities. We belong to our communities. We are trusted by our communities.

MEDICARE CHOICES PROGRAM

Crozer-Keystone's Medicare Choices demonstration product is designed to be another innovative and creative service offered to our senior community. There are 95,000 Medicare beneficiaries in our immediate market and more than 650,000 in the greater Philadelphia region. Under the Medicare Choices program, our Medicare plan will offer three special features:

1) **Zero premium.** The beneficiary who enrolls in our plan will pay no additional premium to the Medicare program.

2) **Point-of-service option.** Ours will be one of the first point of service products available in our area. It's a flexible benefit plan that allows beneficiaries to choose from an extensive number of in-network physicians, with an option to use any physician of their choice with a modest co-payment. Market research indicates that this will be an attractive benefit.

3) **Rewards for healthy behavior.** We will also offer members a number of health education opportunities with rewards to encourage healthy behavior. For example, we will do an annual health risk assessment on every member. If the assessment shows that a member has diabetes, we will schedule the member for the systems diabetes education class. Upon successful completion of the class, the member will be rewarded with enhanced benefits such as eyeglasses, a hearing aid or exercise program membership.

It would be extremely difficult for Crozer-Keystone to offer a Medicare product in our market without the HCFA designation. Currently, an insurance license is required in Pennsylvania and other states in order to offer a risk product. However, we are not an insurance company. We are a provider-sponsored organization (PSO) -- a group of local health care providers joined together to deliver high-quality health care in our community.

While we should be subject to stringent requirements and standards, we -- and many other delivery organizations that want to develop PSOs to serve seniors -- must be able to offer a risk product without doing the administrative and regulatory contortions necessary to fit into a regulatory system that recognizes only insurance companies as managed care providers.

The HCFA designation has given us a top priority with the Commonwealth's Departments of Insurance and Health; it is making it possible for us to receive the necessary certificates of authority to launch our Medicare Choices program within HCFA's desired time frames. Without this designation, this process would have taken years, not months.

The Medicare Choices program is demonstrating that PSOs can offer seniors the care they need in an efficient and cost-effective manner.

ABILITY TO CONTRACT WITH THE GOVERNMENT IS CRITICAL

The ability of Crozer-Keystone to directly contract with government programs is critical to our continued ability to provide high quality and innovative care to our communities. As you continue your efforts to balance the federal budget, it is clear that the rate of annual increases Medicare will be reduced. Combine these reductions with new insurance entrants into the field of government-sponsored health care -- businesses taking anywhere from 15 percent to 30 percent off the top -- and you have a situation that could dictate reductions in service to patients.

And there is no guarantee that these entities, once in the Medicare business, will stay in. Several HMOs in the Philadelphia area have recently said they are going to get out of the Medicaid business because rates are getting too low. These are our patients in our communities. We aren't going anywhere; we have to take care of them, and we want to do it with the best and most efficient resources available in this era of fiscal constraint.

Many of the features of a PSO such as ours are being looked at in the Medicare Choices program. In essence, PSOs can help reduce federal expenditures for Medicare by eliminating the insurance middleman -- that 15-30 percent taken off the top by many managed care organizations, for example. More importantly for patients and providers, PSOs are provider-run -- clinical decisions are made by providers and their patients, not by a faceless numbers cruncher at the end of an 800 number.

CONCLUSION

Mr. Chairman, to balance the federal budget and tame the federal deficit, you must reduce the growing cost of entitlement programs. Motivating Medicare beneficiaries to receive their care in a provider-sponsored, managed care environment will cost Medicare less, improve the health of beneficiaries, and build on long traditions of community-based health care delivery.

It will ensure that the dollars Congress allocates to support our seniors through Medicare is spent on their care, and not on insurers' profits. We hope the Crozer-Keystone Medicare Choices program and the other provider-sponsored organization programs provide you with solid evidence that this approach meets the dual objectives of higher quality and lower cost.

We at Crozer-Keystone feel fortunate to be chosen as part of this program. We are committed to make it a success, because we believe that direct contracting is key to the future of health care for many local health care providers. We commend this subcommittee for passing legislation last year that would have allowed that to happen, and look forward to working with you to bring the benefits of PSOs to more Americans by passing similar legislation at the earliest possible time.

Chairman THOMAS. Thank you very much, Mr. Agar.
Mr. Ryan, et al.

STATEMENT OF TIMOTHY J. RYAN, VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, MEMORIAL SISTERS OF CHARITY HEALTH PLANS, HOUSTON, TEXAS; ACCOMPANIED BY ALBERT BRADEN, III, M.D., REGIONAL MEDICAL DIRECTOR, UNIFORMED SERVICES FAMILY HEALTH PLAN, SISTERS OF CHARITY OF THE INCARNATE WORD HEALTH CARE SYSTEM, HOUSTON, TEXAS; AND DOUGLAS X. WOMER, JR., VICE PRESIDENT, MANAGED CARE AND BUSINESS DEVELOPMENT, SOUTHEAST TEXAS REGION, SISTERS OF CHARITY OF THE INCARNATE WORD HEALTH CARE SYSTEM, HOUSTON, TEXAS

Mr. RYAN. Thank you. Chairman Thomas, I am Timothy J. Ryan. I am the chief financial officer of the Memorial Sisters of Charity HMO in Houston, Texas. I would also like to introduce Dr. Al Braden, a health plan participating physician, and Doug Womer, the regional vice president for the Sisters of Charity of the Incarnate Word of Houston, Texas, who have accompanied me here today.

We at Memorial Sisters of Charity have worked hard to develop a strong program and I appreciate the opportunity to speak to you this morning about our commitment to the Medicare Choices demonstration project.

Memorial Sisters of Charity HMO is a provider-owned health plan and that is part of an integrated health care delivery system and that system is sponsored by two of the strongest nonprofit integrated health systems in southeast Texas, Memorial Health Care System and the Sisters of Charity of the Incarnate Word Health Care System.

Both Memorial and Sisters of Charity have a long history of providing innovative and quality health care to special populations, including Medicare and Medicaid. We have a commitment to community service, and this shows in that 45 percent of our admissions in Memorial and 41 percent of the admissions in Sisters are for Medicare or Medicaid beneficiaries. Indeed, our organizations, our parent organizations, as we refer to them, have been around in the region, Memorial for 95 years, and Sisters of Charity of the Incarnate Word, 130 years.

Both of our parents organized the HMO and organized what we refer to as the health plans, which includes an HMO, where we obtained the license in December 1995 and an insurance company, where we obtained the license in May 1996, and a management company so that they could pursue their mission to provide quality health care to the residents of southeast Texas.

The MSCH health plans filed as an integrated delivery network in our application for HCFA for the demonstration project submitted in August 1995. This filing was really a representation of who we are and what we are. We are primarily deliverers of health care. We have organized ourselves in such a way to be able to pursue our mission to deliver health care and to be able to engage in the business of delivering health care.

Our mission is to minimize administrative overhead and maximize the dollars available for the delivery of health care. We do not have stockholders. We do not have to send dividends or report our earnings off to people outside of our community. Our mission and our goal is to provide the quality care and provide the tools available for our providers to deliver quality care to our members.

On project management, the MSCH HMO will administer the Medicare Choices demonstration project. This gives us flexibility regardless of the regulatory rules. The use of the HMO entity ensures HCFA that the assumption of risk under the demonstration program complies with all Federal and State laws.

In delivering the health care services, the MSCH HMO benefits from broad geographic coverage of its extensive hospital and provider network. Our parents' hospitals and physicians are very experienced in the delivery of very high quality care. MSCH HMO has established the infrastructure to manage the risk that the physicians and hospitals and other providers are undertaking.

The HMO will have to support the providers in managing this risk, and we have four major ways that we do that. We obtain reinsurance protection so that for catastrophic cases, we will have other entities with very substantial resources there to provide help.

We have an installation of a multimillion dollar information system to provide data on the delivery and assessment of care. This, we feel, is a very integral part of our ability to be able to manage the risk. It can identify those individuals who need special care. My predecessor on the panel mentioned diabetes and our information system will be able to identify from claims those individuals who have diabetes and send out reminder notices to notify the providers that we need to make appointments and we need to get those people in to be able to deliver special care to them.

We were chosen by HCFA because we met the criteria that was requested. We have developed an urban and a rural delivery component. We will cover 15 counties in southeast Texas, 14 which are considerably rural. We will participate in the test phase and implement an alternate reimbursement mechanism. We have been notified that MSCH was selected for the award and are currently awaiting a confirming site visit, and that is our current status.

MSCH HMO is truly excited about being involved in the Medicare Choices demonstration project. We spent a great deal of time and money in preparing for this project and have established a positive working relationship with HCFA. This project allows MSCH to shorten the length of time that it would have taken us to get our goal, and our goal is to provide the care, and it is the common goal of providing senior citizens with quality health care.

With our rural service areas, MSCH HMO will provide the benefits of Medicare managed care to beneficiaries who have historically been excluded from membership by current HMOs operating in the Houston area because of residencies outside of the HMO's marketing service areas. Earlier in the day, Mr. Vladeck spoke of the discrepancies between the AAPCC in urban and rural areas.

Some of our attractive features, I think you went ahead and mentioned those earlier, so I will skip over that.

Also included as part of our MSCH standard Choice 65 health plan is a self-referral option, which allows members limited access

to providers other than their selected primary care physician for consultive services and diagnostic testing. In addition to PCP access, the self-referral option offers an attractive element of physician choice and we believe that it allows our members a little peace of mind, that they are not trapped inside an HMO.

During the first year of the demonstration project, we will shadow price the Johns Hopkins University/Lewin Group risk adjustor mechanisms. We will be paid from the AAPCC in the same manner as any risk contracting HMO or competitive medical plan. Memorial Sisters of Charity HMO will work with HCFA to gather data at no cost to the government and test the risk adjustor system to ensure that it works. In the second year, upon review, MSCH HMO will activate the risk adjustor mechanism and the resulting capitation payment.

We are not seeking reinsurance from HCFA, nor will we be asking for a risk sharing arrangement or a partial fee-for-service payment. We believe that our proposed plan is a straightforward pricing approach which will allow HCFA to engage in a very clean test of the risk adjustor mechanism over a diverse service area.

We are ready to launch the demonstration project. I would like to thank you, Chairman Thomas, and the Subcommittee for the invitation to speak. I would like to thank Congressman Archer and his staff for their hospitality and support. Memorial Health Care System and Sisters of Charity of the Incarnate Word Health Care System have committed the resources necessary to launch the Medicare demonstration project immediately and remain committed to offering managed care choices to the senior residents of southeast Texas while supporting HCFA's endeavors to control medical costs for the Medicare-eligible population.

Thank you again. I would be happy to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF
MEMORIAL♥SISTERS OF CHARITY HMO
BEFORE
THE COMMITTEE ON WAYS AND MEANS
HEALTH SUBCOMMITTEE

Presented by
Timothy J. Ryan, CPA
Chief Financial Officer
Memorial♥Sisters of Charity HMO

Mr. Chairman and members of the Subcommittee, my name is Timothy J. Ryan and I am Chief Financial Officer of Memorial♥Sisters of Charity HMO. I also would like to introduce Dr. Albert Braden, a health plan participating physician and Douglas X. Womer, Regional Vice President of Sisters of Charity of the Incarnate Word, who have accompanied me here today. We at Memorial♥Sisters of Charity HMO have worked hard to develop a strong program, and I appreciate having the opportunity to speak to you this morning about our commitment to the Medicare Choices Demonstration.

Memorial♥Sisters of Charity HMO
Memorial♥Sisters of Charity HMO *(MSCH HMO)* is a provider-owned health plan and part of an integrated health care delivery system jointly sponsored by two of the strongest, non-profit integrated health systems in Southeast Texas: Memorial Healthcare System *(MHS)* and the Sisters of Charity of the Incarnate Word Health Care System *(SCH)*, Houston, Texas.

Both MHS and SCH have a long history of providing innovative and quality health care to special populations, including Medicare, Medicaid, the under served, and residents of rural areas. In fact, forty-five percent *(45%)* of admissions in MHS and forty-one percent *(41%)* of admissions in SCH are Medicare and/or Medicaid beneficiaries. MHS and SCH have served the region for more than 95 and 130 years, respectively.

MHS and SCH formed MSCH HMO with a significant start-up capital commitment to advance their strategies for developing a truly integrated health care financing and delivery network. On December 15, 1995, the Texas Department of Insurance granted MSCH HMO a license to operate as an HMO. Subsequently, Memorial♥Sisters of Charity Insurance Company was granted its insurance license on May 8, 1996.

MSCH Health Plans filed as an Integrated Delivery Network *(IDN)* in our original application to HCFA for the Demonstration Project, submitted August 11, 1995. This IDN filing represented the healthcare delivery organization and was appropriate due to the timing of the RFP and the post application awarding of our HMO license by the State of Texas. Today MSCH HMO is operational and functional as an HMO with substantial reserves in excess of Texas Department of Insurance requirements. Although MSCH HMO is structured as a *"For Profit"* Limited Liability Corporation *(LLC)*, our mission is to minimize administrative overhead and maximize the dollars available for the delivery of care to the residents of Southeast Texas. We have worked closely with our physician and hospital partners to develop a benefit plan and delivery system focused on the full continuum of health care services including wellness/prevention programs to ensure timely and appropriate access to care.

Although we just received our HMO license this past December we are ahead of our commercial enrollment projections submitted in the Medicare Choices Demonstration application.

Project Management
MSCH HMO will administer the Medicare Choices Demonstration project. The use of the HMO entity ensures HCFA that the assumption of risk under the demonstration program complies with all Federal and State laws.

In delivering health care services, MSCH HMO benefits from the broad geographic coverage of its extensive hospital and provider network. MSCH HMO has established an infrastructure to manage the *"risk"* physicians and hospitals are undertaking through: (1) obtaining reinsurance protection (2) the installation of a multi-million dollar information system to provide data on the delivery and assessment of care (3) physician participation as members of the HMO Board of Directors and (4) a physician directed medical management process. MSCH HMO is a network model primarily contracting for physician services through a number of Physician Organizations *(PO)*. The physician-governed POs reflect the established patterns of treatment in the communities served by MHS, SCH and affiliated hospitals. This network includes 27 hospitals and more than 1,200 physicians to potentially serve a Medicare population estimated at 432,000.

Chosen By HCFA

MSCH HMO was selected as a final Medicare Choices candidate because it met the criteria requested in the Department of Health and Human Services' Request for Proposal. In addition, MSCH HMO agreed to the following:

- Develop an urban/rural delivery component;
- Offer a Self-Referral Option allowing out of network benefits when members choose to see physicians other than their selected Primary Care Physician; and
- Participate in the test phase of alternative reimbursement mechanisms.

MSCH HMO was notified on April 15, 1996 of its selection by the Health Care financing Administration *(HCFA)* for a site visit for the Medicare Choices Demonstration Project. MSCH HMO is the only HMO selected by HCFA to serve Harris County, Texas *(Houston)* which includes more than 256,000 Medicare beneficiaries. In addition to Harris County, MSCH HMO will provide health care coverage in fourteen other Southeast Texas counties.

MSCH HMO is truly excited about being involved in the Medicare Choices Demonstration Project. We have spent a great deal of time and resources in preparing for this project and have established a positive working relationship with HCFA. This is an excellent example of the federal government working with private industry for one common goal -- providing senior citizens with quality health care in a cost-efficient manner.

MSCH HMO will provide the benefits of Medicare managed care to beneficiaries who have historically been excluded from membership by current HMOs operating in the Houston area because of residencies outside of the HMOs marketing service area.

MSCH HMO's proposed benefit structure will incorporate several features to make its Choice 65 plan appealing to Medicare beneficiaries:

- elimination of Medicare deductibles and coinsurance;
- nominal copayments specific to certain services;
- removal of Medicare's limits on numbers of covered hospital and skilled nursing facility days;
- enhanced benefits with a preventive/wellness emphasis and an outpatient prescription drug benefit; and
- annual vision and hearing exams with benefits for eyeglasses and hearing aids.

Also included as part of MSCH HMO's standard Choice 65 plan is a Self-Referral Option which allows members limited access to providers other than their selected Primary Care Physician *(PCP)* for consultative services and diagnostic testing. In addition to PCP access, the Self-Referral Option offers an attractive element of physician choice.

All of these standard benefits come at no additional cost to Choice 65 members beyond their Medicare Part B monthly payment.

Alternative Forms of Reimbursement

MSCH HMO has agreed to utilize the Johns Hopkins University/The Lewin Group *(formerly Lewin-VHI)* ACG/PACS risk adjustor mechanisms. During the first year of the demonstration, MSCH HMO will accept risk payment derived from the AAPCC in the same manner as any risk contracting HMO or Competitive Medical Plan. MSCH HMO will work with HCFA to gather data and test the risk adjustor system. In the second year, upon review, MSCH HMO will activate the risk adjustor mechanism and the resulting capitation payment.

MSCH HMO is not seeking reinsurance from HCFA, nor will it be asking for a risk-sharing arrangement or partial fee-for-service payment. MSCH HMO believes its proposed straightforward pricing approach will allow HCFA to engage in a very clean test of the risk adjustor mechanism over a diverse service area.

MSCH HMO Is Ready To Launch The Demonstration

We would like to recognize the help of U.S. Senator Kay Bailey Hutchinson and her staff to get a HCFA site visit review as soon as possible due to our state of readiness. We are disappointed that we have not been able to confirm an actual date for a visit. Memorial Healthcare System and Sisters of Charity of the Incarnate Word Health Care System have committed the resources necessary to launch the Medicare Demonstration Project immediately and remain committed to offering managed care choices to the senior residents of Southeast Texas while supporting HCFA endeavors to control medical costs for the Medicare eligible population.

Again, thanks for the opportunity to discuss this important project with you. I will be happy to answer any questions that you may have.

Chairman THOMAS. Thank you very much, Mr. Ryan.

Both of you were here when we talked to Bruce earlier.

Mr. AGAR. Yes.

Chairman THOMAS. So you got the drift of the group's focus. I think you appreciate that we were looking at it obviously as practitioners rather than any kind of a partisan structure. So the questions that I would ask I think any of the Members would be interested in. Just because there is one of us, do not think that you are going to be slighted on the questions. I guess if I had to choose one to be here, I would probably choose me.

Mr. Agar, you talked about the benefit of being in the demonstration program because it allows you to, in essence, short circuit the procedures in the State of Pennsylvania for getting licensed. Both of you really are PSOs, right, in terms of structure, although you call yourself an HMO from a delivery service. Mr. Ryan, are you basically a PSO?

Mr. RYAN. Yes. Our organization is primarily interested in the delivery of health care services.

Chairman THOMAS. Right. You may or may not know, we wrestled with this whole business of how to take this new entity in a different world under our legislation and deal with insurance commissioners, given the broad range of experience and interest and, frankly, sophistication, to a certain degree, of all of the States' insurance commissioners. We came to the conclusion that really, to make these work, if you created them, you were going to have to have some kind of a Federal role—these were Republicans who came up with the idea that you had to have a Federal role in terms of approval.

Mr. Agar, you said it was months rather than years. What was the kind of working relationship with the Pennsylvania Commission? Was it, we have to do it because HCFA said we did, so you could be in the demonstration project but do not come back here in the real world and expect to get what you are getting, or was it a kind of a learning curve, where you were talking about what you were trying to do, they were interested and wanted to try to work with you?

Mr. AGAR. Basically, the only thing that is short circuited is time in this process. We are going through all the steps anyone else would have to go through. But being a demonstration program that HCFA had a timetable for, they were willing to work with us to do this in time to——

Chairman THOMAS. And I am looking more to the attitude of the people you were working with at the State level. They were supportive——

Mr. AGAR. Yes. They were very supportive and had worked very hard to do this.

Chairman THOMAS. And the kind of questions they asked were reasonable and appropriate, not——

Mr. AGAR. They were all the questions they ask of an insurance company.

Chairman THOMAS. Right.

Mr. AGAR. For example, we have——

Chairman THOMAS. Did you find some of the questions were not as responsive as you had hoped they would have been to what you are trying to do?

Mr. AGAR. Fundamentally, I think that we know we have to be held to the exact same standards as any other group going into this business. I think the point where things turn is on how you define statutory net equity.

For example, we have assets of about $380 million. Not one penny of that is counted in our statutory net equity of our wholly owned subsidiary and I think that is the area that needs work, because I do not think that is necessarily correct because we are providers of care. We are not intermediaries between the patient and the providers of care.

Chairman THOMAS. One of the ongoing debates, and that is why I am asking you the question, and Mr. Ryan, I will ask you in terms of the Texas experience, is that I think it is very much an open debate as to whether provider-sponsored organizations are a distinction without a real difference or if, in fact, people who have the professional skills are part of the structure and, in essence, have a professional sweat equity commitment so that you do not need the kind of financial profile that you would if you had to purchase all of those services as an insurance company or another structure. So we are trying to figure out if this is simply a different folk running the show or if it is a different show.

You are telling me, Mr. Agar, that the tests that Pennsylvania put you through were basically a test that an insurance company would go through. Did they talk about the belief that since you have a different makeup with the professionals as part of that risk obligation structure that perhaps their financial profile analysis was somewhat archaic or that they would have to rethink it?

Mr. AGAR. At the very senior level of the department, that type of thinking, along with the Governor, is taking place. But at the operational level where people have to execute, they have to follow the rules that are in place.

Chairman THOMAS. We are looking for sympathy and understanding. That is what we are looking for. We are not looking for any bent rules.

Mr. AGAR. At the bureaucratic level, not much. They understand cash very well.

Chairman THOMAS. Yes. Old dogs, new tricks.

Mr. Ryan, do you have knowledge, or do any of the gentlemen with you have knowledge? You already have a State licensure?

Mr. RYAN. Yes, sir. We have an HMO license and a separate insurance company license.

Chairman THOMAS. So you have all these different entities. You fit in a little better.

Back to structure. Mr. Agar, are you going to, in the package that you envision—I think I just have a little more of a working knowledge of Mr. Ryan's package because he laid it out and I used it as an example—are you going to have beneficiaries have any out-of-pocket expense contemplated?

Mr. AGAR. In the two major areas, let me give you a clear example for physician visits and hospital visits. For physician visits in-network, there is a $5 copay. For hospital, there is no charge. If

they decide to go out of—they can self-refer out-of-network for physicians. They have to pay $35 a visit. They can go to any hospital they want if it is precertified based on medical necessity and the charge there will be $375.

Chairman THOMAS. Per——

Mr. AGAR. Per stay.

Chairman THOMAS. Per stay?

Mr. AGAR. Per stay.

Chairman THOMAS. As an out-of-service——

Mr. AGAR. Out-of-network.

Chairman THOMAS. I am asking you this question, Mr. Ryan, because you exhibit a profile of a more generalized question that I asked Mr. Vladeck on a demonstration project and it should not, obviously, carry any implication that I believe it may occur, but it nevertheless is part of the problem of trying to set up a demonstration project. You folks already are risk contractors, is that correct?

Mr. RYAN. Yes, sir.

Chairman THOMAS. And you are proposing to go into a demonstration program by changing in any degree the structure that you now have as a risk contractor?

Mr. RYAN. No. I do not think we are going to change any of our structure, per se. The demonstration Choices project offers us the opportunity to achieve our goal or achieve our mission in a way—because our goals are similar. HCFA wants to——

Chairman THOMAS. No. I understand. What I want to find out is that if you have a beneficiary who is already under a risk contract arrangement——

Mr. RYAN. I am sorry. I misled you. We do not have a Medicare risk contract. We have the HMO license and the insurance company. We are out marketing to commercial enrollees, and if the Medicare Choices project had not come along, we would have pursued a CMP.

Chairman THOMAS. OK. And you are getting a 50–50 waiver?

Mr. RYAN. We have included a 50–50 waiver in our application.

Chairman THOMAS. But if you were to create some kind of a joint structure or if HCFA were to look at your overall operation as you move into the Medicare area, could you meet a 50–50 requirement if they looked at your overall business practice as you moved into the Medicare, and why are you seeking a 50–50 waiver given the business profile you already have?

Mr. RYAN. When we filed our application for the Medicare Choices demonstration, it was August 1995. We did not have the HMO license or the insurance company at the time. I believe that if we started today, we would meet the 50–50 waiver. But the rule that the 50–50 waiver is intended—the object of that rule is really to make sure that you do not have the creation of a separate substandard health delivery——

Chairman THOMAS. No. I understand the history of it, and it may have been needed at one time, but a lot of us think it is an anachronism, which is interesting, because every time we try to do a demonstration project, we waive the 50–50 rule and then we require it out in the real world when probably it is an anachronism.

You folks obviously talk to other people in your marketplace and they are becoming aware that the demonstration project will be

moving into both the Pennsylvania and the Houston area. Have you had any feedback from any of your "competitors" or other folks in the area about the fact that you do not have to comply with ordinary rules, or "How did you get in? Can I get in?" Has there been any discussion among folks in terms of this particular program?

Mr. AGAR. I am not aware of any. No, sir.

Mr. RYAN. We have not had any discussions. I do think that there is a quid pro quo. We are providing a lot of data. We are providing ourselves as a guinea pig to use the risk adjustor payment mechanism and that does entail a bit of risk that the payments will be less and that we will end up with less funds and less resources to provide that care.

Chairman THOMAS. How are you structuring yourself to deal with that financial risk? Are you using any of your other entities as a support or a fallback?

Mr. RYAN. What we refer to as our parent——

Chairman THOMAS. You are going to assume, and I agree with you, a relatively large financial risk on the Medicare enrollment. How are you dealing with that?

Mr. RYAN. We are sharing the risk with our providers. We have organized physician groups and the hospitals have organized. In Texas, you must separate those in risk sharing arrangements.

Chairman THOMAS. Right.

Mr. RYAN. Those providers will be sharing the risk. We will be providing a tremendous amount of information that will allow them to be effective in sharing that risk.

Chairman THOMAS. Can you spend a minute or two talking about how you determined the shared allocation on the risk basis in terms of the providers? Is there a set percentage? Is there a responsibility? Is there a specialty area? How do you deal with assigning risk?

Mr. RYAN. We did go through a responsibility grid that is about 26 pages long. We had the actuaries involved to determine what the traditional fee-for-service payment structure would look like and how services, how they have traditionally been delivered and how that allocation of resources traditionally——

Chairman THOMAS. I assume there was a discussion about how that really is not real world, and if we are going to look at it, we should look at it differently?

Mr. RYAN. We instructed our actuaries not to use the pie in the sky method but to actually get down and look at who is giving the care.

Mr. WOMER. There is a further test on that, because when the health plan then sends the contracts down to the hospital providers and the physicians, we then send that same data out to then another set of actuaries, independent of the health plans, and they come back, because we have to justify to the physicians that there is an equitable distribution of risk and capitation following that risk. So there are a couple of checks on that methodology.

Chairman THOMAS. Did you learn anything from this process that you did not know that may or may not be applicable to your other activities in terms of the relationship of providers in the structure?

Mr. RYAN. I think we are learning a great deal all the time as we go along, and it has been a very interesting process to get a large number of people, from the Sisters of Charity organization, from the Memorial Health Care Organization, from physician groups, together and talk about the common problems, because, essentially, these people have delivered health care in a microcosm or kind of separately.

The patient walks into their office. They do everything they can, and then they send the patient on. What we are trying to do is make sure the people have information as to what has happened to that patient before, what does that patient need now, and what is the result that we want.

Chairman THOMAS. Mr. Agar, any similar or dissimilar experiences on the risk? How are you dealing with the risk question?

Mr. AGAR. In a very similar manner, through actuaries based on what has actually been spent in the past and what we think we can do through utilization management. We have several years of experience with full risk Medicare contracts with other payers, where they pass the risk down to us and then we manage it. That gave us the insight and the experience to go forward with this process.

Chairman THOMAS. I would be interested in comparing the two profiles that you come up with.

Mr. WOMER. Mr. Thomas, this is not our first endeavor into risk. We have many contracts with the insurance companies for both commercial and Medicare risk, so our position——

Chairman THOMAS. I understand that, but the way you spin it off is slightly different, is it not?

Mr. WOMER. No——

Chairman THOMAS. It really is not?

Mr. WOMER. No.

Chairman THOMAS. Good.

Mr. WOMER. The models are consistent. The models are consistent by what primary care physicians take as the risk, what the specialists do, what the hospitals do. They are very consistent because what you are looking for when you are dealing in risk is to aggregate lives to offset adverse selection. So you want to keep your models as consistent as possible and that way all the providers in the community know exactly what the routine of care should be.

Chairman THOMAS. Some of our discussion in dealing with provider-sponsored organizations was that in the assignment of risk, if it was something that was slightly different and the focus has been shifted, that you would have either some new concerns or a desire to redistribute the traditional structure. But you feel that basically there was nothing new there.

Mr. WOMER. Yes, sir.

Chairman THOMAS. It was just a mechanical, in essence, arrangement and the signoff is that everybody agrees that what you are doing is appropriate with a third party check that, in fact, you are OK?

Mr. WOMER. That is correct. And Sisters of Charity, as an organization, has been dealing with a government at-risk program, the Uniformed Services Treatment Facilities. That program has been

around since 1981 and has been fully at risk under the Uniformed Services Family Health Plan. So this is more of the same business for us.

Chairman THOMAS. Thank you.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Mr. Agar, I notice that in your testimony, you mention that if you had not had the HCFA designation, you really could not have gotten into serving Medicare beneficiaries because you could not have gone through the contortions necessary to deal with the State regulatory system. I thought that was really interesting. Why is that?

Mr. AGAR. It is not so much the contortions. It is just that, like many State insurance departments, they are overwhelmed with applications and this was a way to get their attention and focus and cooperation so we could move through the exact same process they put the insurance companies through but do it in a reasonable amount of time.

Mrs. JOHNSON. So it is not that you do not have to go through the State process, but the State process is geared to insurance companies and managed care plans and you did not fit?

Mr. AGAR. No. It is just that——

Mrs. JOHNSON. Would it have been harder for you to go through?

Mr. AGAR. It is just that you cannot necessarily get their attention. There is a fair amount of feeling that the insurance companies do not want to see providers getting in this business. There may be some pressures there.

Chairman THOMAS. I would tell the gentlelady, we talked about this briefly and one of the points that Mr. Agar made—he is afraid, not to tell you what he told me, because he does not want to repeat himself, but you need to know it, because she has been involved and she missed your testimony—that in dealing with the Pennsylvania Insurance Commission, the top people and the Governor were understanding of the slight differences. The bureaucrats down who check the boxes wanted to check the insurance company boxes. We do not care what you call yourself. Meet these requirements. The folks up top were more understanding, so that there was a willingness to facilitate.

Mrs. JOHNSON. Thank you. That was interesting and I enjoyed your discussion. Thank you for being here today.

Chairman THOMAS. Thank you very much.

Do any of you have any final comments?

Mr. AGAR. Thank you very much.

Mr. RYAN. Thank you.

Chairman THOMAS. Good luck to you.

The second panel is Christine Boesz, the vice president for government programs, NYLCare Health Plans, and Janet Newport, vice president of government programs of FHP. I want to thank both of you for coming and your patience.

Any written testimony that you have will be made a part of the record and you may now inform us in any way you see fit in the time you have.

Ms. Boesz.

STATEMENT OF CHRISTINE C. BOESZ, VICE PRESIDENT, GOVERNMENT PROGRAMS, NYLCARE HEALTH PLANS, INC.

Ms. BOESZ. Thank you, Mr. Chairman and Members of the Subcommittee. My name is Christine Boesz and I am the vice president of government programs for NYLCare Health Plans. NYLCare is a wholly owned subsidiary of the New York Life Insurance Co. and we currently have 5 Medicare risk contracts serving over 65,000 Medicare beneficiaries in approximately 6 States.

I want to thank you for the opportunity to appear to discuss with you the Medicare demonstration programs that are currently under development. We are involved in both of them. We believe that one is well designed and collaborative and that one has some serious flaws and is a mandatory program. I want to contrast these two.

NYLCare is completely supportive of finding ways to improve Medicare through these demonstration projects. While we are proud of the health care that we provide to Medicare beneficiaries, we are acutely aware of the deficiencies in the present system of providing coverage to America's elderly. We see the problems as highly complex and the solutions as equally complex, but we do believe that carefully targeted demonstration projects are ways, and perhaps the only ways, to test emerging new ideas. We are also acutely aware of the difficulties that are faced by the Federal Government in determining a fair price to pay for the health care services.

NYLCare is not just theoretical in its support. As I mentioned, we have been selected both in Houston and in Atlanta to try two of the Choices. We have also been selected in Baltimore through the competitive prices, so we will talk a little bit about that.

First, I want to turn to the Baltimore situation. There, we believe that the HMOs are being forced on a mandatory basis to get engaged in a project that is seriously flawed. We believe that this has come about because the project was developed without participation of the affected people. HCFA has only just begun to meet with HMO representatives, and that has been due in great part to the efforts of Congressman Cardin and the Maryland congressional delegation, and we certainly thank them for their efforts.

One of the problems that we see, very briefly—they were discussed at length this morning, so I will be brief, is that only approximately 3 to 5 percent of the Medicare beneficiaries are currently involved. We are actually excluding 97 percent of the Medicare market in terms of how the pricing is established.

We certainly believe that the third party enrollment broker is very problematic in that the involvement of a broker interrupts the critical bond that an HMO must establish with their members during the enrollment process. We believe that if HCFA goes ahead with the pricing demonstration, it should be pricing only, that it should leave the enrollment to the HMOs, who, over the years, have actually worked with HCFA to develop procedures and training programs that guide us in this effort.

In fact, HCFA has extensive guidelines advising HMOs on how to market, how to protect the beneficiaries, and they actually monitor these processes on a very regular basis. The value added by an independent government contractor that has no accountability to

the HMOs, who serve the Medicare enrollees, only adds an intrusive layer of government bureaucracy that seniors must go through.

We are also concerned that the pricing is based on a single areawide rate and that it very possibly could be skewed because of the current range of the AAPCC. We are willing to work with HCFA on finding a way to handle this problem, but the way that it is designed right now does not give us any securities in that area.

We also want to point out that in the third party broker arena, it is very problematic in that employers have collective bargaining agreements and other employment contract areas that this will interfere with.

You talked extensively this morning why Baltimore is a poor selection. We believe that because of the hospital rate setting system, there is no generalizability to other States. Hospital costs represent approximately 56 to 57 percent of our costs, and so, therefore, we are limiting what we are actually competing on with respect to price.

The data reporting elements are cumbersome and we believe that HCFA does not have the systems necessary to handle the various types of data that they are asking us to submit.

Given all of these concerns, the implementation deadline is simply unreasonable. We are concerned that the project, as proposed, will affect the Medicare beneficiaries most of all. It has the potential to reduce choice, raise cost, and limit access. We are asking that you ask HCFA to stop the process and to work with us, as we will work with you, in designing a better competitive bidding project.

Very quickly, let me turn, if I may, to the Choices to point out some of the differences that we believe exist. Choices is also a competitive product. It is a competitive demonstration that involves new payment models. The difference is that the framework is voluntary. It is a cooperative, collaborative effort between us, provider-sponsored networks, and HCFA. The Choices demonstration stimulates entry of new plans into the marketplace, unlike the competitive pricing demonstration, which we are afraid will raise barriers and may even support the exit of some of the players.

We think that an important element of the Choices demonstration is that it focuses on new relationships between the various parties that need to be involved. We think that these relationships will offer new products to Medicare beneficiaries and new opportunities for providers to participate in new products.

The major difference, in summary, that I want to point out between the two programs is the position of the beneficiary versus HCFA, and that is the principal difference. In Choices, the beneficiary is at the center and the beneficiary's interests are being served. In the competitive pricing project, HCFA itself is at the center and the balance seems to swing over to HCFA's interest to just save dollars without sufficient concern for the beneficiary. I want to point out that Choices is not a cookie-cutter approach and it certainly shows the willingness of HCFA to work with the industry and vice versa in a very collaborative effort.

In conclusion, I would like to say, as more seniors move into the Medicare health care networks and as we continue to age as a Na-

tion, more alternatives to the present system are needed. We believe that the Choices demonstration is an excellent beginning. It has the support of private health care networks in seeking solutions to very vexing problems. The Choices demonstration is well positioned to contribute new approaches. In sharp contrast, the competitive pricing demonstration, as presently constructed, will not contribute to the solutions and, in fact, could do harm. I thank you very much.

[The prepared statement follows:]

STATEMENT OF CHRISTINE C. BOESZ
VICE PRESIDENT FOR GOVERNMENT PROGRAMS
NYLCARE HEALTH PLANS, INC.

Mr. Chairman, members of the Subcommittee, my name is Christine Boesz, and I am the Vice President for Government Programs for NYLCare Health Plans. NYLCare is a wholly-owned subsidiary of New York Life Insurance Company. New York Life is one of the country's five largest life insurers with policyholders from every state and with over $74 billion in assets. NYLCare is a national health care company providing health care coverage to 3.5 million Americans in every state. These health coverages are provided through health maintenance organizations (HMOs), preferred provider organizations (PPOs), and indemnity insurance. NYLCare's HMOs currently provide benefits under Medicare risk contracts to more than 65,000 senior citizens across the nation, a number that has doubled in the last year.

Thank you for the opportunity to appear before this subcommittee to discuss two Medicare demonstration programs under development by the Health Care Financing Administration (HCFA), the "Competitive Pricing" and "Medicare Choices" projects. These two demonstrations offer a contrast in two approaches -- one well designed and collaborative and one with flaws and mandatory. I will discuss the contrasts between the two.

NYLCare is completely supportive of finding ways to improve Medicare through demonstration projects. While we are proud of the health coverage we provide to Medicare beneficiaries, we are acutely aware of the deficiencies in the present system of providing coverage to America's elderly. We see the problems as highly complex, and the solutions as equally complex. Carefully targeted demonstration projects designed to explore new ways of providing health coverage to senior citizens are a sound way -- perhaps the only way -- to test emerging ideas. We also are acutely aware of the difficulties faced by the federal government in determining a fair price to pay for health services needed by the elderly.

NYLCare's support of Medicare demonstration projects is not merely theoretical. We have been selected to participate as a finalist in two of HCFA's "Choices" programs, a selection we consider an honor. The first is our plan in Houston, and the second is a teaming arrangement with the Morgan Health Group in Atlanta. I am excited about the possibilities presented by these programs, which I will address in greater detail later in this testimony.

However, we have grave concerns about HCFA's proposed competitive pricing program scheduled to begin in the Baltimore, Maryland area on January 1, 1997. We believe that the proposed project will hurt Medicare beneficiaries and will limit the expansion of Medicare health care network options in Baltimore and the surrounding areas.

I will first discuss our concerns about the Competitive Pricing Pilot program, and will then address the "Choices" program.

Competitive Pricing Pilot Demonstration Project

HCFA has proposed a competitive pricing pilot project that would force HMOs to obtain Medicare business based on a mandatory competitive bidding process. Under this process, HCFA would determine the price Medicare will pay HMOs for serving its beneficiaries. The goal of the demonstration is to test methods to replace Medicare's often criticized HMO payment system -- known as the adjusted average per capita cost (AAPCC) -- with a system that more fairly reimburses HMOs for services provided Medicare beneficiaries. The first site chosen for this project is Baltimore.

Project developed without participation of affected people

We believe the design process for that program has substantial flaws. This problem results from a process of developing the demonstration project that included no input from the effected parties, namely seniors, businesses, health plans, and physicians. All of these affected parties learned about this project just two months ago, in the beginning of May. HCFA has only just begun meeting with HMO representatives, due in

great part to the efforts of Congressman Cardin and the Maryland congressional delegation.

Project excludes Medigap fee-for-service carriers from pricing formula

The project mandates that all Medicare-participating HMOs participate, yet it excludes Medigap fee-for-service carriers from the actual pricing formula. Because only 9,000 of the 325,000 Medicare beneficiaries in the Baltimore area are enrolled in HMOs, the project effectively addresses only the payers that serve less than 3% of the population. A true competitive pricing formula would include the other 97% as well.

Third-party enrollment broker is problematic

HCFA plans to contract with a third party enrollment broker to enroll and disenroll beneficiaries. Health plans will not be permitted to enroll or disenroll beneficiaries directly. Forcing enrollment through a third party enrollment broker is not only unnecessary; it is fraught with logistical and operational problems that could lead to confused Medicare beneficiaries and to added Medicare program costs. The third party, which will have caused the problems, will remain unaccountable. The involvement of a broker interrupts critical bond that HMOs establish with their members during the enrollment process. HCFA should limit its pricing demonstration project to pricing only -- and leave enrollment to the HMOs, who over the years have worked with HCFA to develop procedures and training programs that help the HMOs' staffs handle the operational details of enrollment and disenrollment. In fact, HCFA has extensive guidelines advising on acceptable procedures and outcome-monitoring of our operations in these areas.

We all have learned that the education of a Medicare enrollee is crucial to a satisfactory relationship in a health care network environment. Specifically important is information on how to access services, when and where services are available, and how to seek assistance if there are any problems whatsoever.

The issue is accountability. I believe that the HMO has responsibility for explaining its benefits, its delivery system, any limitations, and how its services can best be used by the individual beneficiary. The value-added by an independent government contractor that has no accountability to the HMOs is not clear. At the same time, it adds an intrusive layer of government bureaucracy that seniors must go through. If the purpose is general education, that is a function different from sales, enrollment, service, and accountability for this continuum.

Pricing based on single, area-wide rate would skew bidding process

The program would establish a single payment rate for a seven county area whose current AAPCCs range from a low of $407 to a high of $614. HMOs which serve predominantly those counties in the low end of the range could submit winning bids that are higher than their current program payments. Conversely, those which serve predominantly counties at the high end of the range will be forced to bid at rates substantially, and unfairly, below the current payment levels of their counties. This could lead to marketplace distortion that could unfairly force HMOs to leave the Medicare market entirely, limiting choice for the beneficiaries.

Retirement plans threatened

This enrollment process also will have a major impact on employers and the relationship they have with their retirees. Applying this demonstration to beneficiaries in employment-based groups is unworkable and again shows the lack of understanding and analysis by HCFA of this important segment of the Medicare market. Many employers negotiate customized benefit packages under collective bargaining agreements or other employer-specific criteria. Furthermore, employers who operate nationwide usually offer the same benefits company-wide. This project jeopardizes this relationship. Many

employers use their own administrator to inform and assist retirees about the benefits afforded by the company. Adding another layer of government bureaucracy will only add to the confusion and possible distribution of misleading misinformation.

HCFA may require that HMOs in the demonstration suspend or waive their current arrangements with employer groups who have retirees living in the service area. The HMOs could not offer additional benefits to beneficiaries under any current arrangements they may have with the beneficiaries' employers. Employer groups, often through collectively bargained union contracts, require that health insurers customize benefits to a very high degree. Employers, and therefore employees, will lose choice. By forcing employer groups into a single set of benefits, this demonstration project would create an entirely impractical, unworkable situation. One of the largest employers in the Baltimore area is the federal government, which has developed a very different pricing formula, and is unlikely to allow any change for its Medicare eligible retirees.

A practicable approach to competitive pricing would be to waive employer groups from the process, so that it would address only the individual market.

Baltimore is a very poor selection

HCFA has outlined, very generally, criteria it used in selecting Baltimore. I would argue that, even if this were a well designed project, other sites around the country would be more appropriate and that Maryland has "special circumstances" which HCFA did not fully study or understand.

HCFA has said that the pilot should be conducted at a site at which the average AAPCC is higher than the national average. Yet, Baltimore's average AAPCC is $487.59, only $46.00 higher than the national average of $441.00. Several other sites have much higher average costs and would therefore be more appropriate selections.

HCFA has said that it wishes to have a site that has a reasonably-sized Medicare population. Baltimore's Medicare risk population is between 3 percent and 5 percent of the total Medicare eligible population. Other sites around the country have higher concentrations of Medicare beneficiaries than Baltimore, and should be far more likely candidates under this criterion.

Perhaps the most important reason why Baltimore is not an appropriate site for this project is that Maryland is the only state in the nation that has an all-payor system for hospital rates. HCFA has contended that the Maryland Commission in charge of the rate setting system has said that the demonstration project will have no effect on the system. This is not entirely true. The Commission has taken no position on the project. It does say in its June 26 letter to Congressman Cardin that ". . . the presence of hospital rate regulation would have to be considered when analyzing results from Maryland. . . ." We have the same questions about the generalizability of a Baltimore project. To our knowledge, HCFA has not performed any analysis to show that the results from a rate-setting state can be used to model potential results to a state without a rate-setting system to the 49 states that do not have such a rate-setting system.

The Baltimore area is the first of three areas chosen to take part in the project. Under the three-year pilot, expected to begin in early 1997, HMOs in the Baltimore area will only be able to compete for Medicare business through this mandatory competitive bidding process. Interested HMOs will submit bids to HCFA on a standard benefit package they wish to market to Medicare beneficiaries. If, in addition, they wish to market a more comprehensive benefit package, they also must submit a bid for that package to HCFA. It is not clear why or what relevance this has to the Medicare payment.

Up to half of HMOs will be forced to charge higher premiums

Under the design, "losing" HMOs, those with bids above the HCFA payment, would be forced to charge the Medicare recipient the difference. As a result, some, and perhaps many, seniors will pay higher out-of-pocket costs. Today, seniors in most

Medicare HMOs pay little or no premiums. Next year, under this project, more than 50% of the HMOs operating in Baltimore would be required to charge their senior members a premium. Under the proposed plan, the senior citizen in a "losing" plan may face a premium increase, experience unwelcome benefit reductions, and disrupt their continuity of care by having to switch to another HMO. The "losing" HMOs should have the choice of waiving that difference, particularly if the difference were so small that it would not be cost-effective to charge and collect it, and would only be a nuisance to the Medicare recipient.

Ultimately, the competitive pricing project would almost certainly have a perverse long term effect of reducing both competition and patient satisfaction in Maryland because it would impair the ability of HMOs to become economically viable in the market place.

Data reporting requirements are cumbersome

HMOs would be required to submit individually identifiable encounter data to HCFA on an ongoing basis. It is unclear if HCFA systems will be in place to receive this data. Serious problems currently exist with submission of data on the working aged enrolled under Medicare risk contracts and HCFA resources are heavily committed to preparing for implementation of the Medicare Transaction System (MTS). Systems for receipt of encounter data will need to be carefully structured, and testing of the transmission process will be essential. Additionally, we would question whether HCFA considered, in its criteria, that the State of Maryland will require HMOs to submit encounter data to the State. This raises questions of compatibility, redundancy, and purpose. HMOs face the burden of keeping different sets of data for different members.

It also is not clear why this data is needed in a real time experiment. We could submit encounter data in demonstration models to test bidding that simulates behavior and costs, a much less disruptive approach.

Implementation deadline is unreasonable

Implementation is scheduled to begin in early 1997. The proposed schedule for this demonstration exacerbates the problems above, leaving no time for participation of many parties in their resolution. The period is so compressed that it may lead to rushed implementation of the program before the HMOs can develop new benefit packages, adapt to a new enrollment process, and install the new systems needed to comply with the demonstration requirements. HCFA also needs time to develop many of these same systems. Successful implementation of this competitive pricing project, wherever it is conducted, will require the focused attention and commitment of all parties involved. The time table outlined by HCFA will not make that possible for the project scheduled for Baltimore. We are concerned that the project as proposed will affect Medicare beneficiaries most of all -- it has the potential to reduce choice, raise costs, and limit access to options that are being promoted in other parts of the nation. We ask that this Congress direct HCFA to stop this poorly designed project in its tracks and require HCFA to start over and work with all the stakeholders in designing a project that will work for senior citizens.

Choices Demonstration Project

The Medicare Choices Demonstration project is another matter. HCFA solicited applications from a wide variety of health care networks to test alternative payment methods and to provide Medicare beneficiaries with more delivery system choices. The objective of this demonstration is to evaluate the receptivity of Medicare beneficiaries to a range of health care network models and to determine the long term viability of these models. In this project HCFA asked for voluntary participation and selected participants who were willing to try innovative approaches in risk sharing, certification requirements, and quality monitoring systems. HCFA has indicated that, while Medicare money may not be saved initially, the development of this framework that would cut costs over time. The goal is to modernize Medicare and to offer more beneficiaries more choice.

Competition is clearly a goal of this Demonstration project. HCFA is negotiating payment models that include partial capitation, capped fee-for-service payments, and rates that blend payments between urban and rural areas so that Medicare beneficiaries living in rural areas have more options. NYLCare's HMO in Houston is looking into a blended rating methodology.

Framework of Voluntary, Cooperative Innovation

The Choices Demonstration is clearly built on a collaborative approach. Participation is voluntary. The parameters of competition are not dictated by HCFA, they are market driven. Choices health plan participants can compete on benefits and price. They are not limited in how they can compete with Medigap insurers. These are the attributes that should be included in all HCFA demonstrations.

The Choices Demonstration stimulates entry of new health plans into the marketplace. This is in contrast to the Competitive Pricing Demonstration, which seems destined to raise barriers, and may even support the exit of current Medicare risk contractors.

An important element of the Choices Demonstration that we support is the focus on new organizational relationships. Specifically, we believe that partnerships between provider sponsored organizations and health insurance companies may be able to offer new products to Medicare beneficiaries and new opportunities for providers to participate in Medicare health care network programs. NYLCare's teaming with the Morgan Health Group in Atlanta is evidence of our interest in exploring with HCFA the advantages and disadvantages of alternative models.

Beneficiary versus HCFA

The principle difference between the two demonstration projects is the focal point of competition. In Choices, the beneficiary is at the center and the beneficiaries' interests are being served. In the competitive pricing project, Medicare itself and its interests are at the center. In Choices, HCFA is willing to move incrementally, with reasoned caution about serving beneficiaries and saving Medicare dollars and working with the private sector. With Competitive Pricing, the balance seems to swing in HCFA's interest to save dollars without sufficient concern for the beneficiary and without an understanding of how Medicare managed care works.

Choices- Not a "cookie cutter" approach

HCFA is to be complimented on its vision in the design of the Choices Demonstration. The 25 selected health care network plans are evidence of HCFA's understanding of the importance of diversity and innovation as proposed by the organizations. Of the 25 plans, 16 have proposed testing health risk adjustment methods as a part of their payment approach, and 12 have proposed testing economic risk sharing with HCFA. While there is still much work to do to bring these proposals into operational status, they are a clear indication of willingness by the plans to work with HCFA. In turn, HCFA's willingness to work with a wide variety of organizations on complex delivery and financing issues shows a commitment to innovation that is crucial for finding solutions to the problems that confront the Medicare program.

Conclusion

As more seniors move into Medicare health care networks, and as we continue to age as a nation, more alternatives to the present system are needed. We believe that the Choices Demonstration is an excellent beginning that has the support of private health care networks in seeking solutions to very vexing problems. The Choices Demonstration is well positioned to contribute new approaches. In sharp contrast, the Competitive Pricing Demonstration, as presently constructed, will not contribute to solutions, and could, in fact, do harm.

Chairman THOMAS. Thank you very much, Ms. Boesz.
Ms. Newport.

STATEMENT OF JANET NEWPORT, VICE PRESIDENT, GOVERNMENT PROGRAMS, FHP, INC., COSTA MESA, CALIFORNIA; ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Ms. NEWPORT. Good afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to come here from California to testify at your hearing.

FHP is a multistate Medicare risk plan. We have almost 400,000 members in 8 States. We have been a longstanding Medicare participant in the Medicare risk program.

Today, I am testifying on behalf of the American Association of Health Plans and my testimony focuses on the Medicare Choices demonstration. Before I delve into my comments on the Choices demonstration, I would like to make a general observation.

We believe that managed care must be a part of the long-term solution of the Medicare financing issues that we all face, just as managed care has been an extremely important and effective part of the quality improvement and cost containment achieved in the private sector. Competition among health plans and providers has been and will continue to be a key part of this. As long as the Medicare system developed to achieve competition establishes level playingfields for health care competition, then managed care can be an active part of the solutions we all seek.

In testimony before this Subcommittee nearly 1 year ago, AAHP stated that, "Medicare can best be strengthened by giving beneficiaries the same kinds of choices that are already available to millions of working Americans, including Federal employees and Members of Congress." We believe that the Choices demonstration, if carefully structured, can be the first step in the process of updating the Medicare Program to offer these choices.

In that same testimony, however, we urged Congress to hold all Medicare health plan options to strong and comparable standards, not just to ensure fairness and a level playingfield for competitive plans but also to ensure that all beneficiaries can be assured that regardless of the option or the type of benefit they choose, their health plan has complied with a set of requirements which have been structured to ensure that their health care needs and interests are protected.

While we understand that demonstrations are designed to test various theories, and in this case new choices, the potential changes in some of the rules and procedures need to be carefully evaluated. The underlying purpose of a particular requirement should be carefully considered before waiving it in a particular case. HCFA should ask whether alternative safeguards are in place and whether beneficiaries will enjoy the same level of protection under a waived regulation as they do under current policy.

As AAHP warned in last year's debate, the greatest risks to Medicare reform lie in its initial stages. It will not take many failures to discredit new initiatives in the eyes of the public. We believe that this is also true for reforms implemented through demonstration projects.

In our view, the purpose of a demonstration is to identify a basic set of regulatory requirements that can then be applied to all plans serving Medicare beneficiaries and not to develop a series of carve-outs or special rules that deal with a particular organization's idiosyncrasies. Unless this is understood at the outset, HCFA will run the risk of creating demonstrations that demonstrate little except the advantages and failures of special treatment, potentially at the expense of existing choices in the market.

For example, some States have found that waiving of solvency standards for health plans participating in the Medicaid Program allowed a market instability and some plans have gone bankrupt, leaving Medicaid recipients without the appropriate health services.

In deciding which applications to approve and which waivers to grant, HCFA should take into account the impact that its decisions may have on the competitive environment in specific markets. In Houston, for example, one of the final candidates, as you have just heard from, is a provider-based organization with whom my plan contracts to provide services to a majority of our Medicare enrollees in that market. If, for example, the 50–50 rule is waived for this group, it would be allowed to enroll Medicare beneficiaries immediately, giving the plan every incentive to market itself to the beneficiaries it is already serving under contract with FHP.

It is important to note that rule changes in this case mean no real change necessarily in the facilities that are available to serve the Medicare population and will have marginal impact on the percentage of Medicare beneficiaries who may enroll in private plans. This needs to be evaluated, obviously.

AAHP and FHP appreciates the opportunity to present our views on this and I will be happy to answer any questions you have.

[The prepared statement follows:]

STATEMENT OF JANET NEWPORT
AMERICAN ASSOCIATION OF HEALTH PLANS

Mr. Chairman, I am Janet Newport, Vice President of Government Affairs of FHP, Inc., testifying today on behalf of the American Association of Health Plans (AAHP). AAHP (formerly GHAA/AMCRA) represents more than 1000 HMOs, PPOs, and similar health plans. Its member companies are dedicated to a philosophy of health care that puts the patient first by providing coordinated, comprehensive health care. Together they care for more than 100 million Americans. FHP has a long history of serving Medicare beneficiaries under the Medicare risk contracting program. Today, we serve 391,000 beneficiaries in eight states.

We very much appreciate the opportunity to participate in today's hearing and to share our views on the Medicare Choices Demonstration currently under development by the Health Care Financing Administration (HCFA).

During last year's debate over Medicare reform, the Association took the position that the program must be modernized to reflect the dramatic developments that have occurred in the private sector since Medicare was enacted over 30 years ago. In 1995, fee-for-service is no longer the predominant approach to coverage in the private sector. More than 60 percent of all working Americans with private health plan coverage now receive their care through HMOs and other organized systems of care. By contrast, only about 11 percent of today's Medicare beneficiaries are in HMOs.

In testimony before this subcommittee nearly a year ago, AAHP stated that "Medicare can best be strengthened by giving beneficiaries the same kinds of choices that are already available to millions of working Americans, including federal employees and members of Congress." We believed it then, we believe it now, and we believe that the Medicare Choices Demonstration, if carefully structured, can be the first step in the process of updating the program.

In that same testimony, however, the Association also urged the Congress to hold all Medicare health plan options to strong and comparable standards -- not just to ensure fairness and a "level playing field" for competing plans, but also to ensure that all beneficiaries can have the same confidence in their health plan regardless of the option they choose.

The current Medicare standards for risk contractors are designed to ensure that organizations entering the Medicare program have the organizational structure and operational capacity to provide health care to Medicare beneficiaries -- over the long haul, not for a year or two. While we understand that demonstrations, by their very nature, involve temporary changes at least to some rules and procedures, the underlying purpose of a particular requirement should be carefully considered before waiving it in a particular case. Current standards include requirements on:

- **Financial resources** -- Solvency and capitalization standards are designed to ensure that Medicare contractors have the financial strength and stability to provide care to the Medicare beneficiaries they enroll. Capitalization standards are particularly important for new plans, because it is common for new organizations that provide as well as pay for health care services to sustain losses in their early years of operation. This is due in part to the fact that they must absorb the start-up costs of creating a delivery system and the infrastructure that supports it. In addition, adequate solvency standards are particularly critical under the Medicare program because Medicare beneficiaries use services more frequently and intensively than younger populations.

- **State licensure** -- In addition to meeting federal Medicare program requirements, plans must be licensed in States in which they operate. This adds a level of local accountability to the federal regulatory safeguards that apply.

- **Quality improvement systems** -- Plans must have systems to monitor and assess quality of care and must provide mechanisms for a plan's providers to work together to address areas in need of improvement. Such systems include utilization review to ensure the appropriateness of services provided to beneficiaries. Clinical decision making is the

responsibility of the plan's health care providers, and it is through their efforts that quality is evaluated and sustained.

- **Delivery system** -- Plans must demonstrate that they have provider networks in place that will afford access to needed services for all enrolled beneficiaries.

- **Marketing** -- Plans must comply with fair marketing practices to ensure that beneficiaries have the opportunity to make informed choices among the options available to them.

- **Management systems** -- Administrators must be prepared to operate in many arenas -- member services, provider relations, enrollment and disenrollment procedures, coverage decisions, premium development, regulatory compliance, and other basic functions that support a delivery system.

- **Information systems** -- Plans must have data systems to carry out enrollments and disenrollments and to provide information on beneficiary satisfaction, the utilization of services, and other aspects of plan performance.

- **Enrollment composition (50/50 rule)** -- While the 50/50 rule, which requires plans to have a minimum commercial enrollment, is not a particularly good proxy for quality, it has assured some equivalence between plans available to Medicare beneficiaries and those available to the rest of the population.

After considering the underlying purpose of these requirements, HCFA should ask whether alternative safeguards are in place and whether beneficiaries will enjoy the same level of protection under the waiver as they do under current policy. As we warned during last year's debate, the greatest risks to Medicare reform lie in its initial stages, and it will not take many failures to discredit new initiatives in the eyes of the public. We believe that this is as true for reforms implemented through demonstration projects as it is for legislative initiatives.

In deciding whether to waive a particular requirement, agency officials should also ask themselves whether they would be prepared to extend the same treatment to other Medicare contractors if the demonstration is ultimately judged a success. In our view, the purpose of a demonstration is to identify a basic set of regulatory requirements that can then be applied to all plans serving Medicare beneficiaries -- not to develop a series of "carve outs" or special rules that deal with a particular organization's idiosyncracies. Unless this is understood at the outset, inappropriate waivers may be granted, and HCFA will run the risk of creating demonstrations that "demonstrate" little except the advantages and failures of special treatment. For example, in some instances states have applied lower solvency standards to Medicaid plans than to plans serving commercial members. The resulting financial instability of some of these plans has jeopardized health care services for Medicaid beneficiaries.

Finally, in negotiating contracts with demonstration participants and deciding which waivers to grant, HCFA should take into account the impact that its decisions may have on the competitive environment in specific markets. Even if the geographic areas selected by the agency had relatively low Medicare HMO enrollment, this would not necessarily mean little disruption would occur if a Choices Demonstration entered one of these areas.

In Houston, for example, one of the final candidates is a provider-based organization with whom my plan -- FHP -- contracts to provide services to our members. If the 50/50 rule is waived in order to permit this group to enroll Medicare beneficiaries immediately, it will have every incentive to market itself to the beneficiaries it is already serving under contract with FHP, rather than to seek out new enrollees. And if greater flexibility on benefits and favorable financial terms are added to the built-in advantage provider-based groups have because of their existing relationships with Medicare beneficiaries, it may well succeed. The result will be a shift of enrollment from FHP, which has invested substantial resources to enter the Medicare market in Houston, to a newly recognized organization -- but with no real change in the facilities that are

available to serve the Medicare population and little impact on the percentage of Medicare beneficiaries who enroll with private plans.

AAHP appreciates the opportunity to present our views about the Medicare Choices Demonstration. If it is crafted with care, we believe that this initiative can be a positive first step in the process of updating the Medicare program and expanding the options available to Medicare beneficiaries. We look forward to working with all concerned to assure its success, and I would be pleased to answer any questions you may have. Thank you.

Chairman THOMAS. Thank you both very much.

You were here earlier, I assume, while we were talking to Mr. Vladeck. So I hope some of your concerns were expressed by our questions, because, obviously, we have the same concerns. If you are going to take the time and the enormous energy to set up demonstration projects, you would hope that you would have the ability to get some results that you had, one, a level of confidence in, and two, you could replicate in other areas.

If you will indulge me for just 1 minute. I represent a very rural area, high desert, and the Bureau of Land Management wanted to run a test in the desert because in the spring, there is some green grass that grows briefly and then various sheepmen petition to be able to run their sheep on the desert where the grass is. There was some concern about the damage that may be done to the desert tortoise, and we believe the crows coming in from the population intrusion do far more damage. But the test that BLM wanted to run was that they created a number of styrofoam shells that looked like tortoises and they wanted to set the styrofoam tortoises out and then have the sheep go out into the desert and eat the grass to see what reaction sheep would have to tortoises.

Most of us know that tortoises, not being warmblooded, when the sun comes up, go hide under rocks and in their burrows and come out and move around. So I met with the sheepmen and we had a discussion about the conditions under which we would allow this experiment to occur and the first condition that the BLM would have to agree to would be that we would allow them to put the styrofoam tortoises out if they would allow us to put styrofoam sheep out, and then we could run a test that we thought was equitable and reasonable as to what was going on.

I think, in part, that is what you are saying. The concern that I had, especially in this larger demonstration model, is that if we are waiving all of these rules and some of these programs are successful, the only answer I got from Dr. Vladeck was that we hope within 3 to 5 years we have changed the rules so that these people who got the advantage under the rule would be, in fact, conforming with the rule at that time. That is probably not the best answer that he gave me from the number of answers that he gave me, some of which were very good.

So I, too, have a very real concern about the usefulness, and the point that I am going to continue to make to HCFA is that if every time you run one of these programs you waive the 50–50 rule, maybe it is time to waive the 50–50 rule. Get rid of it. We did that in the legislation that we offered because we thought maybe it was a rough model for quality at one time, but it is clearly an impediment.

Perhaps, Ms. Newport, you can give us an example, if you have any, of real world problems, if you are not going to get a waiver on the 50–50 rule, of decisions you have to make in the real world to live with the 50–50 rule as you try to run your business versus not having to worry about the 50–50 rule.

Ms. NEWPORT. Thank you. I really appreciate the opportunity. We have been a longstanding opponent of waiving the 50–50 rule or getting rid of it. We obviously have had more of a welcome reception on that position in recent years than we had before that.

For example, FHP is in an ongoing effort to expand our risk contracting program. When we do go into a new market, the requirement that we have to have a base commercial enrollment, notwithstanding years and years and years of experience and a good track record in running the risk contract benefit program for our members, forces us to start all over again. It does artificially limit the choices to beneficiaries that otherwise could be made available in a market much more quickly.

We do have systems in place to assure quality. We do have systems in place to inform beneficiaries fully of the choices and options that we provide within our program, which is not just one-stop shopping. We have several types of benefit programs we can offer. So I think it just is an artificial barrier to choice in markets.

Also, for example, if we have participation in Medicaid Programs in some areas, that works against expanding our choice into Medicare because both of those count against you, if you will, if you wanted to open up a different product line, if you want to call Medicare risk a product line. So I think it—the 50–50 rule—is just an artificial barrier to choice.

Chairman THOMAS. Ms. Boesz, do you have any comments at all?

Ms. BOESZ. I would agree with Ms. Newport in the sense that we have a number of new starts, particularly in States like Maine and in North Carolina, where we are in a joint venture with Duke University where we are being called upon to do Medicaid. It limits our ability to get into the Medicare risk contracting because of the Medicaid constraint. So it is a barrier.

Chairman THOMAS. Of the waivers that were discussed, obviously, the 50–50 rule, the 5,000 minimum, and the State licensure, what we heard from Mr. Vladeck that it was not as difficult as they might have thought initially in terms of the State license aspect and that what we got was basically bumping the queue to allow them to be processed sooner. Our discussions when we were contemplating moving into the Federal level was a degree of opposition from insurance commissioners or the appropriate agency in the State to some of these newer structured entities.

If you had to create a hierarchy of waivers between, say, the 50–50, 5,000, or the jumping the queue on the State licensure, could you give me which one is the most valuable, maybe, from a business point of view that you do not have to meet?

Ms. NEWPORT. I think having a 50–50 waiver would be the most valuable.

Chairman THOMAS. The 50–50 would be one?

Ms. NEWPORT. Yes. I think that we go into States all the time and just as part of doing business, some States have larger standards, if you will, in terms of the breadth and depth of the application you have to send in. Some are less so. Licensure requirements differ all over the board, but more States are becoming more sophisticated about that. But that is not something that is not duplicated in the HCFA application process.

Chairman THOMAS. Ms. Boesz, I am having some difficulty understanding how HCFA, in its former multiple locations in the Baltimore area now and its very nice—I am trying not to call it a Taj Mahal—in its very nice new building in Baltimore, and the reason they were interested in part, I guess, in Baltimore, is that they are

there, so that they do not have to spend money, but how could you then have people who are in the State, in the community, in the metropolitan statistical area planning a model for that area and not factor in the concerns that you have and the amazing statement to me from the gentleman from Maryland that the State was planning on moving its entire senior structure into a market which admittedly was just relatively few thousands out of a multihundred thousand senior market? How does that happen?

Ms. BOESZ. I am sorry, Mr. Thomas. I cannot explain what HCFA's thinking was on that. Mr. Cardin's point was that the State is moving the Medicaid Program, not the seniors.

Chairman THOMAS. But some of them are seniors.

Ms. BOESZ. Some of them are seniors, yes, that is true.

Chairman THOMAS. And you do not have as mature an HMO market for Medicare or the seniors, and the sheer impact, either freezing it under that demonstration program or, in fact, folks electing not to be in the market, has got to have an impact on the State's ability to move into that area.

Ms. BOESZ. And it will. It absolutely will have an impact, and that concerns us.

Chairman THOMAS. I think the reason I asked the question was that staff told me that you may have had some experience with HCFA in your professional career in the past?

Ms. BOESZ. Sir, I have. Yes. I did have some experience, but I still cannot explain this particular phenomena.

Chairman THOMAS. Could you give, just for the record, the basis of your experience? If it was a brief few months, then obviously you do not have the ability to understand HCFA.

Ms. BOESZ. My experience with the Agency was over the last 10 years. I was in the managed care program and I was the Director of the office that handled the managed care risk contracts.

Chairman THOMAS. How long have you been away from HCFA?

Ms. BOESZ. One year.

Chairman THOMAS. It is amazing, what happens in 1 year sometimes.

Ms. BOESZ. Yes.

Chairman THOMAS. I want to thank both of you. Obviously, this Subcommittee, clearly on a bipartisan basis, is concerned. We want these demonstration programs to be a success. Frankly, I think the Choices one, notwithstanding the concerns about the waivers, because that is going to give us at least an opportunity to see the pluses and minuses of the waivers in removing or not removing, but the study model for the Choices is far superior to the competitive pricing, which, to me, is another one of those gigantic misnomers which attempts to create a competitive pricing model by freezing at one time a model that may or may not have been competitive and then not allowing the participants to adjust to the new competition.

We are hopeful that we can work with HCFA in improving that model, not for the other two sites but before they impose it in the Maryland area. I guess my confidence is that in Dr. Vladeck's testimony, he indicated that Mr. Cardin had final say and that no other demonstration programs would go forward until Mr. Cardin OK'd the Baltimore area program. I guess I am jealous, but I think that

Mr. Cardin has waived that power so that Dr. Vladeck does not have to get his approval. I have told him to retain it for a while so we will be able to work with those interested parties who, I believe, have very real concerns, because all of us want a successful program.

This sounds to me like not only will we not be able to use the data as extensively as we would like, but the location of the demonstration may, in fact, leave a toxic waste site in terms of health care delivery that we would not want to participate in.

I want to thank you both very much.

Ms. NEWPORT. Thank you.

Ms. BOESZ. Thank you, Mr. Thomas.

Chairman THOMAS. The Subcommittee stands adjourned.

[Whereupon, at 3:25 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF CHIEF MASTER SERGEANT JAMES D. STATON, USAF (RET.)
EXECUTIVE DIRECTOR
AIR FORCE SERGEANTS ASSOCIATION

Mr. Chairman and distinguished committee members, thank you for this opportunity to participate in your deliberations on expanding managed-care options for Medicare beneficiaries. Although your focus is primarily on private-sector options, there is a demonstration program that you could support that would affect hundreds of thousands of Medicare-eligible military retirees. I am speaking of Medicare subvention.

Under current law, military retirees are thrown out of TRICARE, DOD's health care program, upon reaching age 65. Although AFSA is unhappy about important aspects of the program, it still represents a less expensive alternative when compared with other health care options. Unfortunately, the only other option available to over-64 military retirees is Medicare. *Military retirees are the only federal retirees who lose their health insurance at age 65.* Some retirees may still use Military Treatment Facilities on a "space-available" basis, but with the downsizing of the military infrastructure, even the Department of Defense (DOD) admits that all of that care will eventually be eliminated.

These changes are in stark contrast to the fact that all retirees were promised, in exchange for a lifetime of service, they would receive free, lifetime health care in the military health system. However, even the replacement of that promise, TRICARE, with its cost-shares and enrollment fees, pushes them out at a certain age. That is discriminatory and morally wrong.

The most widely accepted alternative is Medicare subvention. With subvention, over-64 retirees could use Medicare to cover the cost of participating in TRICARE Prime, an HMO program. However, because of budget-scoring technicalities, it has been difficult to obtain even a demonstration program of subvention. While there is some agreement within the administration that statutory language is not needed, it would simplify matters to have that language.

There are two bills, H.R. 3142 and H.R. 3151, that would authorize subvention demonstration programs. Even as these bills languish, DOD and the Health Care Financing Administration (HCFA) are in negotiations to work out the details of a subvention demonstration. *Any subvention authorization language must come out of the Ways and Means Committee. I urge this subcommittee to approve a demonstration project and push for its approval in the full committee.*

With subvention, DOD would charge HCFA 93 percent of the average cost of care for Medicare patients in a given region. That is *after* DOD covers the $1.2 billion worth of health care for Medicare-eligibles that it now covers annually. This is a complete winner for DOD, HCFA, the beneficiaries and the taxpayers. *Mr. Chairman, quite frankly, there is no good reason for subvention not to happen.*

Mr. Chairman, AFSA believes that the time to act is very, very soon. With Congress planning to adjourn in early October, it is imperative that you and others on the committee work for approval of legislative language that would allow DOD and HCFA to go forward with a subvention demonstration. Military retirees deserve far more than they have received, and no less than this.

TESTIMONY OF
LISA ADATTO, VICE PRESIDENT, PRINCIPAL
BENOVA, INC.

FOR THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
JULY 12, 1996

Mr. Chairman and Members of the Subcommittee:

I am pleased to submit this testimony for today's hearing record on behalf of Benova, Inc., the nation's oldest and most experienced firm serving as enrollment brokers for health plans for Medicaid and Medicare programs. I am vice president and a founding principal of the company.

In this testimony, I will explain why Benova urges this committee to support the demonstration project proposed by the Health Care Financing Administration (HCFA), as a result of our considerable experience with unbiased, third-party educational and enrollment programs. We believe these programs can help meet our nation's health care objectives, including better control of health care costs.

Benova, Inc. is a corporation founded in 1982 and based in Portland, Oregon. We have approximately 225 employees and offices in Oregon, Connecticut, Oklahoma, California, Ohio and Virginia. We are an enrollment contractor who has worked extensively with state Medicaid programs, employers and HCFA to provide unbiased third party education and enrollment services, and consulting services in designing prototype education and enrollment programs.

As noted, we support the HCFA demonstration projects, and believe that a model program incorporating unbiased information and enrollment is highly worth testing. We are convinced a third party enrollment program is technically feasible, cost effective, and provides a better level of service to beneficiaries. In addition, we believe that use of a third party will assist in meeting national health care objectives both by driving competition and by reducing biased selection into managed health care plans. Our belief is that third party enrollment contractors can work effectively with the HMO industry and assist HMOs in meeting their enrollment objectives.

We believe that the reason that managed care has been so successful in reducing health care costs in market sectors other than Medicare is that the marketplace has created conditions for effective competition. Highly sophisticated purchasers, such as employers and state governments, drive competition through a bidding process. Consumers, such as employees, are given comparative information and are thus well informed about available options which further drives competition. On both the demand and supply sides, competition works.

In the Medicare program, competitive forces are not working as effectively and costs remain high. On the supply side, health plans do not need to bid for services; instead they are paid automatically, based upon historical data driven by fee-for-service payments. On the demand side are uninformed consumers who don't know which options are available. With the growing number of options and complexity of the Medicare program it is very difficult to make comparisons or even understand the competitive advantages of one option versus another.

The proposed HCFA demonstration will test new methodologies for driving competition. Given the urgency of national budget issues, we recommend that the demonstration go forward with the support of this committee.

Enrollment Broker Benefits for the Medicare Consumer

Service improvements occur in two ways. By providing "one stop shopping" an enrollment contractor is allowing beneficiaries a rational method of learning about which health plan options are available, how the programs work, and how they differ. In addition, an unbiased third party is able to prevent fraud and abuse by offering straightforward information without pressure or inaccurate claims.

There is much evidence that prospective Medicare beneficiaries have a difficult time understanding the Medicare program, how fee-for-service and managed care programs work, and how the health plans offered in any area differ. Consequences of the confusion are low HMO enrollment, misunderstandings about how to use health insurance, and irrational purchasing. Almost all studies of the Medicare program indicate that HCFA should provide more information to beneficiaries and promote an informed choice.

At this time twenty-two states have purchased enrollment contractor services or are in the bidding process to acquire these services for their Medicaid programs. States have found that use of the broker is a cost-effective and efficient method of educating recipients about the health plan choices available to them. Without a broker, states have found, even when managed health plan choice is mandatory, up to 50% of enrollees into state Medicaid programs do not make a choice at all and must be assigned to a health plan. Benova's experience is that with information 90% of state recipients make an informed choice. Enrollment contractors can be equally effective in a voluntary environment where beneficiaries choose between fee-for-service and managed health care. In fact, because without information many beneficiaries are likely to do nothing, the provision of information through a contractor can increase enrollment in managed care just by raising its visibility.

Description of Enrollment Contractor Services

Enrollment contractors operate as many other brokers (travel agents for example) or retail establishments do. They pull together a set of competing products (health plans in this case) into a convenient venue for choice, and they offer a single point of purchase to the consumer.

Typical services include mailing written materials such as brochures, booklets and comparison charts, call centers offering live operators trained to answer questions and walk consumers through the choice process, seminars, one-on-one "choice counseling" and enrollment processing. In many cases, the enrollment contractor can replace services provided by individual health plans and reduce expenditures spent on education and enrollment.

Technical Feasibility/Industry Experience

The enrollment contractor industry is working effectively with private and public employers, with health care purchasing alliances, and is especially well established with state Medicaid programs. At this time, 22 states have purchased enrollment contractor services or are in the bidding process to acquire the services.

There are numerous firms providing enrollment contractor services. With experience in six states, and a 12 year history, Benova is one of the most experienced enrollment contractors. However, several companies offer services to multiple states; a recent bid by Pennsylvania for enrollment contracting attracted bids from eight different firms.

Successful enrollment contractors are technically sophisticated and experienced in both communications and processing of enrollment transactions. They are well equipped to handle enrollment data from multiple plans and transmit the data to the sponsor be it a private employer or a public agency. Enrollment contractors are able to adapt their systems, to the varying demands of each region, and mix of health plans.

Elimination of Biased Selection

One of the key concerns about the managed care program for the Medicare population is that it doesn't appear to save money. This contrasts with the private sector and the Medicaid programs which have seen significant savings through managed care. There is some evidence that a biased (or healthy) population joins managed care plans, while sicker beneficiaries stay in fee-for-service. This can happen naturally, as beneficiaries with extensive provider networks choose to maximize their flexibility by staying in fee-for-service. It is also possible that health plan marketing practices encourage biased selection by targeting the most healthy segment of the population. This targeting could occur by the subtle messages portrayed by the pictures on health plan brochures, by highlighting benefits that attract the most healthy, and by overt sales practices.

Enrollment contractors will have no incentive or interest in biasing selection to or away from managed care. It is a key hypothesis to be tested that the use of a third party can reduce biased selection, and contribute to the use of managed care plans to reduce Medicare health care expenditures.

Cost Effectiveness of Third Party

It is extremely expensive for the insurance and HMO industry to educate and enroll Medicare beneficiaries into their programs. HMO executives tell us that it can cost up to $700.00 per member to enroll a new member. Much of the effort is duplicative as health plans spend millions to take enrollment from one plan to another. Medicare anticipates spending around $10.00 per beneficiary on the enrollment contracting service. This is consistent with enrollment contracting services in the Medicaid program.

One of the key hypothesis to be tested by a demonstration is whether a third party can provide administrative efficiencies. However, some efficiencies are apparent. For example, prudent use of the Medicare beneficiary list will eliminate the need to recreate the list for marketing purposes. Giving the Medicare beneficiary basic information about how the program works will eliminate the need for this to be done by each health plan and sales agent. Third party enrollment can eliminate the duplication of these processes. And beneficiaries who have made an informed choice are more likely to remain with their chosen health plan which will reduce the number of times that beneficiaries will need to be reeducated about their options and, from the perspective of the health plans, this lengthens the revenue stream associated with a new sale.

Working Effectively with the Health Plan Industry

Benova's experience is that an enrollment contractor can work very effectively with participating health plans and assist health plans to meet their goals. A third party can assist health plans by saving them money, by enrolling informed beneficiaries who are more likely to stay in their chosen health plan longer, and by heightening awareness of the managed care industry, increasing HMO enrollment.

Before a demonstration, it is typical for the enrollment contractor and the sponsoring agency to engage in a planning process to work out operational details, and create the type of partnerships needed. Our experience is that these relationships are successful.

Conclusion

The concept of operating an open enrollment with the opportunity for consumers to receive comprehensive and unbiased information is found in many studies outlining how to improve the Medicare program, and in many of the proposed pieces of Medicare legislation. We are pleased to have this opportunity testify to our support for this concept.

Statement of the National Association of Health Underwriters
by
David K. Kehl
Senior Director of Government Affairs

I appreciate having this opportunity to present the views of the National Association of Health Underwriters regarding the Medicare Demonstration Projects.

NAHU represents nearly 13,000 health insurance agents and brokers, serving the insurance needs of over 100 million Americans.

Many of our members handle Medicare supplement policies, and have established a good working relationship with their senior clients. Unfortunately, because of what appears to be an anti-agent bias in the Health Care Financing Administration, the services of agents are not available to seniors under the Medicare HMO program.

We have two concerns which we hope can be addressed as part of the effort to expand the availability of choices and options to our senior citizens.

First, in the implementing instructions governing the current Medicare HMO program, contained in the HMO Manual for the Medicare Select program, **"HCFA strongly discourages the use of Medicare marketing representatives who are not employees of your health plan."** In essence, HCFA is telling the plans that they should not use independent agents.

Last year, in recognition of the important services independent agents can provide to seniors, the Ways and Means Committee included language in the committee report for the Medicare Preservation Act which would basically have overridden the HCFA directive. The language stated:

> "With respect to marketing and enrollment, it is the Committee's intent to allow independent agents acting on behalf of MedicarePlus organizations to explain the plan's benefits and limitations and to accept enrollment forms from individuals electing the product."

Since this legislation never became law, the existing HCFA directive still governs, and in the absence of any directive to the contrary, will evidently be applicable to the Medicare Choice demonstrations. We strongly urge that the directive be lifted overall, and certainly with respect to these demonstrations, so that the plan participants will not be intimidated from utilizing the services of independent agents.

Secondly, HCFA's plan to use third party contractors to conduct all enrollment activities in the competitive pricing demonstration project will effectively preclude a role for agents.

NAHU is strongly opposed to this approach, and urges that enrollment be the responsibility of the plan itself and its representatives, as is currently the case with respect to the Medicare HMO program and the choices demonstration project.

HCFA appears to be concerned that seniors will receive biased information and that only the healthier risks will be recruited if enrollment remains with the plan. This concern can be alleviated by allowing independent agents to participate. Independent agents provide information on the alternatives available. They utilize their hands-on experience to walk customers through the different options available and go over what might be best suited to the customer's own personal needs. They can answer questions based on real world knowledge, not on the basis of an instruction manual, as would likely be the case for employees of third party contractors. Third party employees would not be able to help steer seniors to a particular plan which might best meet the seniors' needs, because these employees are instructed to be "neutral". If they do steer seniors to a particular plan, they could be accused of taking sides, and rightly so.

With regard to risk selection, independent agents do not have any incentive to risk-select. They will receive a commission regardless of whether they sign-up healthy or sickly persons.

We believe it would be extremely shortsighted for the Medicare program not to take advantage of the knowledge and expertise which professional health insurance agents can provide. No one knows more about the contents of an insurance policy and its applicability to the personal needs of a beneficiary than does an insurance agent. An agent's career success depends on such knowledge and understanding. An agent must have this knowledge base in order to successfully go through the state licensing process.

As we move in the direction of providing seniors with more options under the Medicare program, they are going to need help in understanding the different plans. Simply receiving a batch of printed materials is not going to do the job. They are likely to feel overwhelmed. Only the professional insurance agent is going to be able to meet with seniors in the privacy of their own homes and help them pick and choose from among a range of options the plan which would best meet their needs. Seniors often have a familiar agent they have used and relied on over the years, and thus have more confidence in advice from such an individual than from strangers, such as government or company employees.

Health insurance agents will also, as part of their service, act as intermediaries between the beneficiary and the plan, assisting seniors with problems involving claim denial, billing questions, etc. This service will be particularly beneficial to senior citizens, who may not have anyone else to turn to for help in receiving proper payment for their medical needs.

Finally, it should be remembered, from a consumer protection standpoint, that agents must be licensed by the state. They are currently tested by each state for competency, undergo a criminal background check and a fiscal responsibility check, and must take education and continuing education courses prior to becoming licensed or having a license renewed. Will these standards be applied to third party contractors or HMO employees? Many states currently do not require licensing for employees of insurance companies or managed care plans. The result is an unlevel playing field in which employees with little insurance knowledge may give misleading or faulty information.

In conclusion, we believe that independent, licensed, professional insurance agents are best equipped to bridge the gap between Medicare beneficiaries and new Medicare choices. When it comes down to relying on unlicensed company employees or unlicensed employees of government-financed third party contractors, versus licensed, experienced professional agents free of charge to the government, why not allow agents the opportunity to show how they can make the programs work for our senior citizens?

PREMIER

July 26, 1996

Chairman Bill Thomas
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1136 Longworth HOB
Washington, D.C. 20515

Dear Chairman Thomas:

I am writing today in strong support of HCFA's planned competitive pricing demonstration for Medicare risk contracts. The demographic realities that the aging of the Baby Boom generation will ultimately force on the Medicare program demand all reasonable alternatives to reduce expenditures and improve program efficiency be seriously considered. Using competitive pricing, or competitive bidding, to determine Medicare payment rates for capitated contracts, laboratory services, durable medical equipment, and even selected high cost and high volume surgical procedures is a promising cost containment approach that deserves testing and evaluation.

There are many design issues involved in any complex demonstration. HCFA should work cooperatively with existing health plans and emerging provider sponsored networks in resolving specific demonstration design questions as they might arise. Holding hearings on the demonstrations allows for open review of HCFA's procedures. HCFA should carefully review and respond to all concerns raised by the providers before proceeding with the demonstration. But, we should not let the special interests use this process to deter the need to move forward with this demonstration.

Mr. Chairman, my statement of support for the competitive pricing demonstration is made knowing full well how painful a truly competitive health care market place will be. There is enormous excess capacity in all elements of the current health care delivery and financing systems. Although competition, based on price and quality, is the best mechanism to squeeze out this excess it will be painful. The Medicare program provides a statutory entitlement for beneficiaries, not for providers or plans. That fact is too often ignored in policy debates.

Sincerely,

James L. Scott
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Washington, DC

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ISSUES RELATED TO MEDICARE PAYMENT POLICIES FOR HOME HEALTH AGENCY AND SKILLED NURSING FACILITY SERVICES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

JULY 23, 1996

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ISSUES RELATED TO MEDICARE PAYMENT POLICIES FOR HOME HEALTH AGENCY AND SKILLED NURSING FACILITY SERVICES

TUESDAY, JULY 23, 1996

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

The Subcommittee met, pursuant to notice, at 2:08 p.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
July 16, 1996
No. HL-21

CONTACT: (202) 225-3943

Thomas Announces Hearing on Issues Related to Medicare Payment Policies for Home Health Agency and Skilled Nursing Facility Services

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, announced today that the Subcommittee will hold a hearing to examine Medicare's payment structure and current efforts to develop prospective payment systems for services provided to Medicare beneficiaries by home health agencies and skilled nursing facilities. **The hearing will be held on Tuesday, July 23, 1996, in the main Committee hearing room, 1100 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. 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:

Home health and skilled nursing facility (SNF) services are among the fastest growing of Medicare's benefits. This growth results in part from Medicare's payment methodologies (which are in part cost-based), an increasing number of beneficiaries using these services, and from an increasing average volume of services. To illustrate, Medicare's spending for SNF services increased from $2.5 billion in 1990 to $10.3 billion last year, for an average annual rate of growth of 33 percent. Separately, Medicare's spending for home health services has become the program's fastest growing benefit increasing from $2.6 billion in 1989 to $16 billion in 1995, for an average annual growth rate of 35 percent.

Regarding Medicare's SNF benefit, Medicare covers extended care services provided in nursing homes for beneficiaries who require skilled nursing or rehabilitation services following a hospitalization. The SNF benefits are covered under Medicare Part A for up to 100 days per spell of illness. To be eligible, the beneficiary must have received inpatient hospital services for at least three consecutive days and must be transferred to a SNF usually within 30 days of discharge from the hospital. A physician must certify that the beneficiary is in need of such services, which can only be provided on an inpatient basis. Beneficiaries are required to pay a daily coinsurance charge equal to one-eighth of the inpatient hospital deductible for days 21 through 100.

The Balanced Budget Act of 1995, which was vetoed by the President, included a proposal which addressed SNF reimbursement and utilization issues. The proposal established a prospective payment system (PPS) and in the interim, developed policies to address the increased volume and utilization in SNFs with a view toward implementation of the new PPS system.

With respect to the home health benefit, both Medicare Parts A and B cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Persons must also be homebound and under the care of a physician who establishes and periodically reviews a plan of care for the patient. While a beneficiary can not become eligible for home health on the basis of needing only occupational therapy, this can continue eligibility for home health care coverage, even if intermittent skilled nursing care or physical or speech therapy are no longer needed. Home health care agencies

(MORE)

are currently reimbursed on the basis of reasonable costs, up to specified limits. Cost limits are determined separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide), and according to whether an agency is located in an urban or rural area. Costs limits, however, are applied to aggregate agency expenditures; that is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by the agency.

Spending for home health has been growing at a faster rate than other benefits. Consequently, its share of total net Medicare spending has increased from 3 percent in 1989 to 10 percent in 1995. Almost all home health claims are paid out of the Medicare Part A Hospital Insurance Trust Fund, which is estimated to become insolvent in the year 2001. Home health spending as a percent of total Medicare Part A expenditures has increased from approximately 4 percent in 1989 to 13 percent in 1995. The Congressional Budget Office projects that spending for home health services will increase to $31 billion by the year 2002.

Similar to the SNF benefit described above, the Balanced Budget Act of 1995 included provisions to reform payment policies for home health agency services. These provisions, and recent modifications proposed by the Administration, will be the focus of the hearing.

In announcing the hearing, Chairman Thomas stated: "Despite the President's veto, we are committed to curbing the growth in the cost of the SNF and home health benefits and moving forward with a prospective payment system for post-acute care services in order to increase the rate of Medicare spending at a slower rate. We look forward to hearing from these witnesses about their recommendations on proposals put forth by Congress, the Administration, and the industry."

FOCUS OF THE HEARING:

The hearing will focus on Medicare's home health and SNF benefits, in particular, current payment methodology and prospects for implementation of a PPS.

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, August 6, 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 on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/' or over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. The Subcommittee will come to order.

Today's Health Subcommittee hearing is on two of Medicare's post-acute care benefits: Home health and skilled nursing. As this Subcommittee has heard in hearings this year and last, Medicare spending for both home health and skilled nursing services has grown over 30 percent per year over the past several years and is projected to continue to grow at similar levels well into the future. These rising costs, caused primarily by an increased use of services, prompted the Congress to develop new payment policies for both home health and skilled nursing facilities.

Three times, in 1982, 1984, and 1990, Congress has directed the Department of Health and Human Services by statute to develop prospective payment systems for Medicare skilled nursing facilities. Also in 1993 OBRA conferees expressed an expectation that HHS would present such recommendations in time for "implementation no later than October 1, 1995."

Separately, again, on three occasions in statute, in the Orphan Drug Act of 1983 and in reconciliation acts in 1990 and 1993, the Congress charged HHS with developing a prospective payment approach for home health services. Congress is still waiting. That old adage, "if you want something done, do it yourself," applied to this new majority, and that is why we went ahead and did it ourselves. We included in the Balanced Budget Act of 1995 new policies that implemented separate prospective payment systems for both home health and skilled nursing.

We worked closely with the providers of these services and believe we developed proposals which would both address the significant increases in costs and streamline the administration of these benefits. Unfortunately, the President chose to veto the proposals.

Due to the veto, the challenges facing the Medicare home health and skilled nursing benefits remain unresolved. Now it is time for Congress, the administration, and the provider community to work to develop meaningful payment reform for these services, and I would define "meaningful" as payment reform which constrains the growth of Medicare costs while ensuring—"constrains" so no one can say it is cutting—the growth of Medicare costs while ensuring that beneficiaries receive medically appropriate care delivered in cost-effective ways.

Today we will hear from Mr. Vladeck for the administration and the Prospective Payment Commission on issues related to implementation of payment reforms, such as prospective payment, and from representatives of home health and skilled nursing facilities who have also examined these issues in great detail.

Having outlined the history of when Congress asked and the failure of a number of administrations to deliver, obviously these solutions are far more difficult than it might appear to the average viewer.

So, I welcome the distinguished witnesses to this hearing and would recognize the gentleman from California, the Ranking Member from California, Mr. Stark, for any remarks he may have.

Mr. STARK. Thank you, Mr. Chairman.

I think we may be saying the same thing in different ways. I am sure we agree that prospective payment for home health and SNF, skilled nursing facility, services, if not all post-acute care, is needed

and inevitable. And, as we see the change to managed care, the old traditional lines begin to blur. It is getting harder and harder to tell where acute care in a hospital stops and the hospital-owned home health care starts. In some cases, I think the hospitals may be gaming us by double dipping a little bit.

Of all the proposals, the administration proposal, the Republicans, the Blue Dogs, the Yellow Dogs, they all contained provisions for prospective payment in SNF and home health, but they differed in the amount of savings and the implementation dates. And so, I think you are right. I think it is complex, and it has tremendous pressure depending on who ends up getting more or less of the reduced pie, which puts pressure not only on us but on HCFA.

So, I would like to know more about the effect of the proposed changes. I might say relative only to this that the veto may have been a blessing and we may have a chance to look at this in more detail and direct HCFA in the right way. A recent GAO report shows that the growth in home health care is primarily due to the proprietary agencies. They provide more visits and longer episodes than government and nonprofit agencies.

Now, it is not clear whether they are providing better care or not, but there are a lot of issues to look at here, and I thank you for calling this hearing to see if we can figure it out. I, too, would like to get this show on the road.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Any other Members who may have written remarks can certainly place them in the record without objection. I would tell the Administrator that his written remarks will be placed in the record, and he can inform the Committee in any way he sees fit about the success, failure, marginal improvement, movement toward, soon to conclude, any other information that he might provide us on the question of home health and SNF payments.

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

Mr. VLADECK. Thank you very much, Mr. Chairman. I appreciate the opportunity to appear before you today to discuss the growth in skilled nursing facility and home health agency expenditures and the development of prospective payment systems for those services.

When I first got into this business in the seventies, I used to say that part of the basic canon of every Medicare Administrator was that Medicare was not a long-term care benefit; Medicare covered only acute services. Certainly no one envisioned when the benefit structure of Medicare was first created the kind of circumstances in which we would find ourselves today.

In the current fiscal year, we will pay more than $28 billion for SNF and home health agency services and other post-acute services. While our rules still limit these services to beneficiaries who require skilled care, many of those services are furnished to beneficiaries who, by anyone's definition, are long-term care patients. Our projections now suggest that by the year 2002, under current law, expenditures for these services will be almost $55 billion.

The dramatic increase in our expenditures for post-acute services arise from demographic change, from a significant increase in the number of providers, from a decline in acute hospital lengths of stay, from changes in medical practices, and from the financial incentives for providers. We have seen a substantial increase in the number of beneficiaries using multiple post-acute services, and we have evidence that volume and intensity of services per user is also increasing.

But there have also been a number of policy changes that have encouraged the use of post-acute care. Some of these changes had unintended consequences, but almost all of them were undertaken in the belief that they would reduce total costs to the program by shifting resource use from more expensive hospital-based to less expensive post-acute care settings. For the most part, these were piecemeal changes attempted through the years to meet specific needs or to achieve specific objectives. The one thing I think we can say about all of them is that so far none of them has been demonstrated to have saved the program any money.

The Prospective Payment System for hospitals also created incentives for hospitals to establish hospital-based post-acute units in at least two ways: First, hospitals that have such units are better able to discharge patients early, thus doing better under the Prospective Payment System; second, the intersection between the reimbursement rules for acute hospitalization and for long-term care facilities permit hospitals to allocate a portion of their overhead to the long-term care unit and to receive cost-based payment for that part of their total operating costs.

The result of these policy changes and the incentives of the PPS, prospective payment system, has been to provide opportunities for providers to exploit the areas of Medicare where expenditure growth is less constrained, where the current law offers relatively few incentives for cost-conscious behavior, and where professional norms of appropriate quantities of practice are less well established.

There are a range of other outmoded policies associated with our current policies, including the new provider exemptions from cost limits for SNFs, rehabilitation, and long-term care hospitals, and the favorable presumption provision that long applied to SNFs, home health agencies, and hospices. We have closely monitored the growth in utilization of Medicare post-acute benefits. Much of the growth in utilization and expenditures has resulted from the industry responding appropriately to incentives created by the current system. But some of this growth has been the result of directly abusive or even fraudulent behavior. I want to assure the Congress that we have intervened aggressively with the tools we have available to us to stem the growth of this misuse of Medicare.

But of course, comprehensive control of post-acute care expenditure growth, as the GAO itself has reported, cannot be realized without legislation. As both the Chair and the Ranking Member noted, both the administration and the Congress have appropriately made payment reform for SNFs and home health a top priority in Medicare reform. There are areas where our policies diverge, but I, too, would emphasize the opportunity to find common ground on a broad range of issues.

Before I talk about specific legislative proposals, I would like to suggest that they should be viewed as means to an end, not an end in themselves. The real goal should be a post-acute care payment system that provides comparable incentives across delivery sites. While we should accelerate our efforts to develop prospective payment systems for each category of post-acute provider, we should not be permanently wedded to separate payment systems for each of these separate benefits. Rather, we should work to better understand the value of each post-acute care provider type and how to better manage and coordinate care across the continuum.

Our guiding principle in any lasting reform of our post-acute care benefits should be to make the system of services more beneficiary-centered by developing an infrastructure of post-acute and long-term delivery systems that is integrated and flexible in meeting the needs of those with chronic conditions.

In some possible future payment system, we would want to provide payments sufficient to ensure that beneficiaries receive high-quality care in the appropriate settings and that any movement among settings occurs only when medically appropriate and not as part of an effort to generate additional revenues.

Let me touch very briefly on the status of our payment demonstrations for home health and SNFs. We are testing two alternative methods of prospective payments for home health agencies. We have largely completed phase I of the demonstration which tested a per visit prospective payment system and demonstrated very little impact on total expenditures from that system. We began phase II of the demonstration in June 1995, and we are testing a per episode prospective payment system. We will draw on data from phase II and additional research to provide the necessary information to design a payment system that accommodates the full range of home health services covered under the program.

Without this information, for example, we cannot yet determine whether the definition of an episode we chose for the demonstration 120 days, is appropriate for a national payment system. Currently, 120-day episodes only capture about 60 percent of all home health care visits. If 120 days were to be used as the definition of an episode, that would mean that almost 40 percent of all home health visits would fall outside the basic prospective payment mechanism.

Also, last year we began the Multi-State Nursing Home Case-Mix and Quality Demonstration. We are testing a per diem prospective payment system for both routine and therapy services integrated with a quality monitoring system for SNFs. Today we have already learned a lot about how to appropriately design a prospective payment system for SNFs and what we would need in order to implement such a system. Whenever we have the legislative authority to proceed, we will have already done much of the legwork moving down the road toward prospective payment for SNFs.

We have relied on these experiences in formulating the administration's proposals for payment reform. In home health we plan a two-step transition to a per episode prospective payment system in 1999. I think there is broad agreement among representatives of the industry, many Members of Congress, and other experts that

for home health a per episode payment system is a superior way to constrain costs without sacrificing access or quality.

In our legislation, we have sketched out some of the features that are desirable for such a system, but in order to put one into place, we need authority which we do not currently have. We need the authority to request data from home health agencies that will support research and implementation efforts, to develop appropriate case mix adjusters, and to develop an appropriate definition of an episode of care.

While we are in the process of such development, we propose to implement an interim payment system that would allow us to achieve substantial savings.

The conference agreement proposal of last year called for the immediate implementation of a prospective payment system for home health. Agencies would have been paid a per visit prospective rate subject to an annual dollar cap that would be calculated to approximate all covered services delivered to a beneficiary during a period of 120 days, but would be applied up to 165 days' worth of services. Agencies that keep total payments for the year below the annual cap would be allowed to retain half of the savings. Numerous outliers and extended-care exceptions would be paid outside of the cap on a per visit rate.

We oppose this proposal because we do not believe that a payment system that permits as much as 30 percent of visits to be paid without utilization controls can guarantee the appropriate level of savings. We also fear that the use of inadequate case mix adjusters could create an incentive for agencies to avoid caring for heavy-care patients with the greatest needs.

Also, we believe the plan assumed too much about the extent to which the necessary data systems and information were in place in order to facilitate immediate implementation of prospective payment.

I know you are aware of our proposal to shift financing of a portion of the home health benefit from part A to part B. Under the President's proposal, the first 100 home health visits following a 3-day hospital stay would be reimbursed under part A. All other visits, including those not following hospitalization, would be reimbursed under part B, but would not be subject to the part B coinsurance or deductible. Also, this transfer would not affect the part B premium and would not change access to the benefit by beneficiaries.

Clearly, capping part A financing of the home health benefit saves the financially vulnerable Hospital Insurance Trust Fund on the order of $55 billion over 7 years, which I suspect was associated with this Committee's support of such a similar proposal last year. But there are deeper sound policy reasons for advancing this proposal.

The home health benefit, like the SNF benefit, was originally designed to provide short-term recuperative services to beneficiaries immediately following discharge from a hospital. As such, the benefit provided 100 visits under part A and up to another 100 visits under part B. To expand the benefit, Congress in 1980 removed the part A and part B visit limits and eliminated the hospital stay requirement, thus turning home health into an unlimited benefit.

An unintended consequence of OBRA 1980 was to burden the Hospital Insurance Trust Fund with almost all the financing of home health, regardless of whether or not the visits are related to a hospitalization.

The President's proposal to move a portion of the financing of home health back to part B restores the original part A coverage of post-hospital care services and uses part B to finance all other home health services. It maintains the congressional intent for a home health benefit that is available to all beneficiaries regardless of their part A or part B coverage. It also maintains the intent to have a home health benefit that does not require out-of-pocket expenses to be borne by beneficiaries.

Most importantly, it would allow us to focus for the future in two separate sets of coverage policies for two distinctly identifiable groups of home health users: Those who are in the acute recuperative stage following a hospitalization and those who are receiving home health care for chronic conditions.

Let me end this discussion of home health with a note of complete agreement. Both Congress and the administration wisely propose to permanently extend the savings from the OBRA 1993 freeze on home health cost limits by not allowing for the inflation that occurred during the freeze. As with home health, both the administration and the Congress agreed that the savings from the OBRA 1993 cost limit freeze should be permanently extended for SNFs as well.

With respect to SNF reimbursement reform, we are further along with our efforts and could implement a system as soon as we have the legal authority to do so. However, as with home health, we have proposed a two-stage process to allow transition to a fully prospective system.

For the interim system, we would establish an interim prospective rate for routine costs based on facilities' specific costs subject to regional limits. We would at the same time immediately eliminate the new provider exemptions and new exceptions to cost limits. We would require SNFs to bill Medicare for all services their residents received, prohibiting payment to any entity other than the SNF. This would also reduce beneficiary part B copayments for services covered under part A. To ensure that Medicare does not overpay for these services, we would also establish limits on ancillary services based on amounts payable for similar services provided on a fee-for-service basis under part B.

We are committed to moving from that transition stage to a full PPS for SNFs beginning in fiscal year 1998 provided we get the legislative authorization to do so. The prospective rate would be designed to cover all three SNF cost categories: Routine, ancillary, and capital-related costs.

Of course, last year's conference agreement also proposed a two-step movement to a full prospective payment system. One area of difference between the congressional and administration provisions is the unit of payment. The administration's plan does not specify whether PPS payments should be made on a per episode basis, as in the conference agreement, or on a per diem basis. We have decided not to specify a unit of payment until further research and

demonstration results can shed light on the appropriateness of one or the other.

To be honest, prospective payment systems have been in use for nursing home care—first in State Medicaid Programs, then under our demonstration—for more than a decade, and in every single instance, they have relied on the per diem as the unit of payment.

We are testing a per diem approach on a demonstration basis in six States and have no comparable experience with per episode payment systems. But we will have sufficient data from our case-mix demonstration and experiment to develop a per episode payment system for SNFs should we be convinced that that would have better effects on patient outcomes, quality, or access to care.

Now, we also disagree with the conference agreement's provision that places limits on ancillary, non-routine payments separate from the basic prospective payment system. We are concerned that those limits could place patients at risk of inadequate services. We would provide somewhat different control on those expenditures through their incorporation into prospective payment.

In conclusion, I think we all agree that these expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that we need legislation to slow down the growth. I have laid out for you today our vision for the future of post-acute care payment. Because we do not yet have all the tools to implement this vision, we have put forth concrete proposals to modify payment policies for SNFs and HHAs as I have described them.

There are some significant differences between our proposals and those that this Congress enacted, but we think the commonalities outweigh them. It is my hope that we can work together to develop payment policies that provide the right incentives—incentives to provide quality care, promote access to care, and inhibit fraud and abuse. We look forward to the process of working together with you in that enterprise.

I appreciate again the opportunity to appear before you today.

[The prepared statement follows:]

STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR
HEALTHCARE FINANCING ADMINISTRATION

Medicare Payment for Home Health Agency and Skilled Nursing Facility Services

Introduction

Thank you, Mr. Chairman, for the opportunity to testify today. I am pleased to discuss the growth in skilled nursing facility (SNF) and home health agency (HHA) expenditures and our plans for developing prospective payment systems for these services. We are committed to doing payment reform and moving quickly to enact it.

When I first encountered these issues in the late 1970s and early 1980s, Medicare was used primarily as an acute care benefit, and nobody envisioned that it would cover as much long-term care as it does now. However, times have changed. In 1996, Medicare will pay for more than $28 billion in post-acute services -- mostly SNF and HHA services, but also including rehabilitation and long-term hospital care. While Medicare rules still limit these services to beneficiaries who require skilled care, many of these services are furnished to beneficiaries who are long-term care patients. Currently, more than 15 percent of total Medicare program dollars pay for post-acute services, as opposed to about 3.5 percent of program expenditures in 1986. The President's FY 1997 budget projects that, in 2002, expenditures for post-acute care services will be more than $54.7 billion.

Expenditures for post-acute care services are among the fastest growing components of Part A and total Medicare spending. However, these expenditures represent just the tip of the iceberg on spending for long-term care patients. Although the majority of nursing home stays are not covered by Medicare, many of the individual health care services used by nursing home residents are covered -- such as hospital care, physician visits, and therapy services.

The number of Medicare-certified SNFs has grown 38 percent since 1986, from 9066 to 12536 (including a more than a 250 percent increase in hospital-based SNFs). Home health agency growth has been even more dramatic. In 1986, there were 5907 home health agencies, compared to 9200 currently -- a 56 percent increase. The increased supply has permitted more utilization. We have seen a substantial increase in the numbers of beneficiaries using both SNF and HHA care. In 1984, 298,000 Medicare beneficiaries used 9.6 million days of SNF service. In 1994, about 925,000 Medicare beneficiaries used 36.9 million days of SNF care. Similarly, in 1984, 1.2 million Medicare beneficiaries had 31 million covered HHA visits. This increased to 3.2 million beneficiaries receiving 209 million covered visits in 1994. Further, we have seen evidence that the intensity of services per user is also increasing. SNF patients are receiving more therapy and other services during their stays, and HHA patients are using more services, up from 25 visits per user in 1984 to 65 visits per user in 1994.

Reasons for the Growth in Post-Acute Care Utilization/Expenditures

Let me highlight just a few of the reasons why such explosive growth in utilization and expenditures occurred. These include policy changes, incentives created by antiquated cost-based reimbursement systems, changing demographics, medical advances, and increases in demand by beneficiaries and physicians.

Policy Changes

First, a number of policy changes have encouraged the use of post-acute care. While some of these changes had unintended consequences, many of these changes

were undertaken with the belief that they would reduce total costs by shifting resource use from more expensive (hospital) to less expensive (post-acute care) settings. For the most part, these policy changes were not systematic attempts to reform Medicare. Rather, they occurred piecemeal throughout the years to achieve specific objectives. And, we have found, they have not reduced overall program costs.

Example: Home Health Benefit Expansion

Let me discuss the expansion of home health coverage and eligibility as an illustration. As you are aware, OBRA-1980 removed the 100 visit limitations under Part A and Part B and also eliminated the 3-day prior hospital stay requirement. In effect, OBRA-1980 transformed the home health benefit into an unlimited benefit -- one that serves the chronic, long-term needs of patients as well as the needs of those who require recuperative care after a hospital visit. In response to the potential increase in utilization due to the OBRA-1980 expansion of the benefit, HCFA attempted to restrict utilization through administrative measures -- namely, we interpreted, where possible, coverage and eligibility requirements in a more narrow fashion. However, these attempts were thwarted by a 1988 court case, Duggan v. Bowen, the settlement of which resulted in a re-interpretation of the "part-time or intermittent" eligibility criteria in a way that vastly expanded the benefit's coverage. The confluence of the OBRA-1980 changes and the Duggan settlement had a dramatic impact on home health utilization, as noted by the General Accounting Office (GAO) in its March 1996 report on Medicare Home Health Growth (GAO/HEHS-96-16).

In the aggregate, as a result of the OBRA-1980 changes and the Duggan settlement, we have witnessed a steady growth in the number of home health visits per beneficiary per year. Much of the growth in home health outlays is due to patients who receive more than 100 visits per year. The Duggan settlement alone is estimated to have resulted in a 38 percent annual increase in home health expenditures from 1988 to 1992, and a 167 percent increase in visits per beneficiary from 1989 to 1995.

OBRA-1980 also allowed for Medicare certification of for-profit home health agencies. Proprietary agencies -- which now represent 48 percent of all certified agencies -- are the fastest growing segment of Medicare home health expenditures. One analysis suggests that beneficiaries receiving care from proprietary HHAs receive 21 more visits, on average, than those receiving care from non-profit agencies, after controlling for the differences in health and functional status of the beneficiary, as well as age, sex, and living situation.

Incidentally, the OBRA-1980 legislation resulted in the Hospital Insurance Trust Fund financing approximately 99 percent of the financing for the home health benefit, regardless of whether or not visits are related to a hospital stay. As I'll explain later, this is a problem we seek to fix in our legislative proposals.

Example: SNF Coverage Guidelines and the Impact of the Medicare Catastrophic Coverage Act of 1988

SNF utilization and expenditures have also increased as a result of a number of policy changes over the years. In April 1988, we clarified the SNF coverage guidelines based on evidence that the existing guidelines were interpreted inconsistently across fiscal intermediaries, resulting in arbitrary and excessively restrictive claims determinations as well as geographic differences in SNF coverage. In some areas, beneficiaries did not apply, or were not encouraged to apply, for Medicare SNF coverage because of the possibility of retroactive denial of their care. After

implementation of the new coverage guidelines, retroactive denials decreased significantly.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) was designed to change the Medicare benefit structure to cover catastrophic conditions more fully. Several aspects of the SNF benefit were changed under the law, including the elimination of the 3-day prior hospital stay requirement, changes in the copayment, and broadening of coverage (to 150 days in a calendar year). As you know, the MCCA was subsequently repealed in 1989. However, that was not before the industry responded to expand SNF utilization. The elimination of the prior hospital stay requirement and the broadening of coverage led to the potential that Medicare coverage would be substituted for Medicaid coverage of nursing home care. This was especially likely since the OBRA-1987 changes in nursing home certification made Medicare and Medicaid requirements virtually equivalent. In some cases, States actively recruited facilities to obtain Medicare certification so that they could bill Medicare whenever appropriate. The increase in the number of Medicare-certified facilities was dramatic. The increase in capacity that indirectly resulted from MCCA, coupled with the clarification of coverage guidelines, led to explosive growth in SNF utilization in the late 1980s.

Example: Impact of Hospital PPS

Finally, the implementation of the Prospective Payment System (PPS) for inpatient hospitals also resulted in increased utilization of post-acute services. Hospital PPS provides payment to hospitals on the basis of the medical characteristics of the patients they treat, rather than the resources they expend in providing care to patients. Hospitals responded to the incentives in PPS by shortening the lengths of stay. Patients were discharged earlier, with less complete recovery, resulting in increased use of post-acute services. There has been a significant shift in Medicare spending from PPS hospitals to post-acute providers. In 1986, acute care hospitals received more than 91 percent of Medicare Part A payments whereas post-acute care providers received less than 9 percent of Part A payments. In 1993, however, the percentage of Part A payments to hospitals decreased to less than 74 percent in 1993, while payments to post-acute care providers increased to more than 26 percent.

In fact, PPS not only created incentives for hospitals to discharge patients earlier, but also to establish hospital-based units for post-acute services. In 1994, almost 60 percent of hospitals had a post-acute care unit (e.g., a rehabilitation unit, SNF, or hospital-based HHA). These hospital-based units benefit hospitals in two ways: first, hospitals are better able to discharge patients early, thus profiting under the PPS payment system. Second, HCFA's reimbursement rules allow hospitals to allocate a portion of their overhead to the distinct-part unit, and they receive cost-based payment for these services.

Cost-Based Reimbursement Systems Provide Few Incentives for Cost-Conscious Behavior, Invite New Market Niches, and Allow Room for Fraudulent and Abusive Practices

The result of these policy changes and the incentives of PPS has been to provide an opportunity for providers to exploit the areas of Medicare where expenditure growth is less constrained, and where current law offers relatively few incentives for cost-conscious behavior.

Payment for post-acute care services is still based on cost reimbursement subject to limits, and does not incorporate utilization limits. Relative to hospitals, the norms of

professional practice in post-acute care providers are less well established. Thus, utilization limits may be more necessary than in acute care.

These cost-based systems are accompanied by other outmoded policies, such as the new provider exemptions from the cost limits for SNFs, rehabilitation, and long-term care hospitals, and the favorable presumption provision that applied to SNFs, HHAs, and hospices. The favorable presumption was designed as a shorthand means of carrying out the limitation on liability protection that is afforded beneficiaries and providers under the law -- but it was a shortcut that went well beyond the intent of the limitation on liability protection. It forced us to automatically pay for non-covered care. We believe this was harmful to the best interests of Medicare program integrity.

The industry's interest in defining a subacute care benefit is another example of providers pursuing opportunities in less constrained areas of Medicare. Industry proponents have created a subacute care "market" financed primarily by Medicare. Providers market these services to patients who would traditionally have received a longer inpatient hospital stay, and are generally sicker than traditional SNF patients. The major providers of subacute care are SNFs, which receive exemptions and exceptions from the payment limits to provide high level care to Medicare patients, although long-term care and rehabilitation hospitals are also providing subacute care.

The Department of Health and Human Services, under the auspices of the Offices of the Assistant Secretary for Policy and Evaluation (ASPE), has just completed a two-part study of subacute care. The study included a synthesis of the literature and research on subacute care, and a market area analysis of subacute care in four markets. The study found that there is no agreement on a specific definition of subacute care, although there is increasing consensus about the characteristics of subacute care patients and the key elements of an "ideal" subacute care program. While many providers incorporate some of these elements into care, few providers incorporate most of these elements. Thus, much of what is called subacute care is "old wine in new bottles" and marketing is ahead of the product.

There is scant information about the costs and potential public savings associated with subacute care apart from industry estimates. In general, these industry studies significantly overestimate the potential for public savings associated with subacute care. Although a sub-acute benefit may have the potential to decrease hospital lengths of stay, Medicare could end up paying for care twice -- once for the initial hospitalization and again for the subacute care stay -- for patients who would have ordinarily remained in the hospital.

The current payment systems have created a climate that, if not actually encouraging abuse, does not do nearly enough to prevent abusive practices. Under current program policies, providers and suppliers' billing practices are fragmented and uncoordinated, resulting in inappropriate and excessive Medicare charges and payments. For example, a therapy provider may bill Medicare for therapy services provided to nursing home residents. Certain supplies can also be billed directly by a supplier. These polices also encourage abusive billing practices where Medicare is billed for services and supplies that residents do not receive or services that are not medically appropriate or effective (e.g., do not improve patients' functioning). Further, these policies put beneficiaries at risk of out-of-pocket liability for Part B coinsurance for services that could have been furnished under Part A. In an effort to ensure quality oversight consistent with the OBRA-1987 reforms, we are seeking to change these policies. Our desire is to ensure that nursing homes coordinate the provision of, and consolidate the billing for, all services that are provided to residents. But an important secondary effect of these

changes would be to signal an intolerance of abusive practices.

Other Factors

I do not want to leave you with the impression that it was policy changes alone that created the explosive growth in post-acute utilization and expenditures. Changing demographics, medical advances, and increases in demand by beneficiaries and physicians have all contributed to this phenomenon. Medical advances, for example, have expanded the range of patients who can benefit from certain therapies, and have made it possible to provide interventions (such as intravenous drug therapy) in less intensive settings. Certainly, shifts in demographics have had an immense impact on the use of post-acute and long-term care services. For example, the over 85 age group is the most likely to use nursing home services, and this age cohort has increased by 34 percent in the last 10 years. Studies also show that home health care is serving many more of the older elderly population who require longer term care. Physicians and beneficiaries are increasingly showing a preference for home health care over other modalities. Finally, there has been a growth in marketing efforts toward physicians by HHAs to stimulate demand.

HCFA Administrative Efforts to Stem the Growth of Inappropriate Utilization and Costs

HCFA has closely monitored the growth in utilization of the Medicare post acute care benefits. Much of the growth in utilization and expenditures has resulted from the industry responding to incentives created by the policy changes I've described. However, some of this growth has been the result of inappropriate utilization of the Medicare post-acute benefits. I want to reassure the Congress that we have intervened where possible to stem the growth of inappropriate utilization. The following are some of the efforts we have undertaken, or are undertaking, to address this concern.

Home Health Care

Three years ago, I commissioned the Medicare Home Health Initiative, an agency-wide, comprehensive assessment of the home health care benefit. The Initiative involved consultation with representatives from consumer groups, the home health industry, professional organizations, fiscal intermediaries, and State agencies. The Initiative has spawned various efforts to make a number of improvements to the benefit and, where possible, assert greater control over its utilization.

We are in the process of revising the home health Conditions of Participation (CoPs) in order to hold agencies accountable for better, more accurate patient assessment, care planning, coordination of service delivery, and quality assessment and performance improvement. We hope to publish a notice of the proposed changes to the CoPs shortly. We also recently overhauled our provider manual to provide better guidance to agencies on the complex home health eligibility and coverage rules; we would expect this greater clarification to reduce the amount of inappropriately furnished services that are billed to Medicare.

We have also worked to increase physician involvement in the monitoring of home care services. Physician involvement in care plan oversight is critical to ensure that the appropriate level of care is being provided. We need to avoid situations in which physician certification is merely a rubber stamp of a plan of care that has been completed by a home health agency. To achieve this goal, HCFA is now reimbursing physicians for complex care plan oversight, and we hope that recent increases to the

reimbursement amount will further engage physicians in the careful planning of home care services. We are also involved in a number of efforts to educate physicians about the home care benefit.

We are trying to better educate beneficiaries about the home health benefit in an effort to help them recognize instances of inappropriate care or fraud and abuse. We have published a new home health brochure and have produced a video to be shown in hospital and office settings. Beginning early next year, we will be sending a Notice of Utilization statement to inform beneficiaries of the services being billed on their behalf so that they can detect any aberrancies. Finally, HCFA is testing the impact of increased sharing of information between State survey agencies and regional home health intermediaries on ensuring that HCFA pays only for services that meet home health coverage requirements.

The December 31, 1995 sunset of the favorable presumption provision gives us an opportunity to reduce the number of inappropriate claims that had previously been automatically paid. We support continued limitation on liability protection for a provider where it can, on a post-denial basis, demonstrate that it and the beneficiary did not know, or could not have known, that the service furnished was not covered by Medicare. However, we believe that the limitation on liability protection should not be broadened once again to shield excessive and, in some cases, abusive billing practices.

We will continue our diligence in attempting to stem the tide of inappropriate home health utilization. As the GAO noted in its March 1996 report on Medicare Home Health Growth, HCFA is working to gain greater control over the use of the home health benefit. We appreciate the GAO recommendation that the Congress consider providing additional resources to HCFA so that controls against abuse of the home health benefit can be better enforced. As you are aware, we have engaged in numerous efforts to deter and detect fraudulent and abusive practices in the home health industry through our Operation Restore Trust (ORT) demonstration and the Medicare Home Health Initiative. We also note that the GAO suggested that Congress may wish to consider whether the home health benefit should continue to become more of a long-term care benefit or if it should be limited primarily to a post-hospital acute care benefit.

SNF Care

For SNFs, we are in the process of establishing, by regulation, guidelines for payment of therapy services. Medicare has long had guidelines limiting the reasonable cost of the physical and respiratory therapy services provided by outside suppliers for clinics, rehabilitation agencies, public health agencies, or other providers of services. Under these guidelines, the reasonable cost for such services cannot exceed an amount equivalent to the salary and other costs that would have been incurred in an employment relationship, plus an allowance for costs, such as travel, that an individual not working as an employee might incur. HCFA has been working to revise the existing salary equivalency guidelines for physical and respiratory therapy, and to develop such guidelines for occupational therapy and speech language pathology. The GAO has concluded that these guidelines are necessary to prevent abusive billing practices. We hope to publish proposed salary equivalency guidelines soon.

We have also enlisted the aid of physicians in curtailing the inappropriate practice of targeting a facility's entire patient population for the indiscriminate provision of therapy assessments and treatments en masse, without regard to whether each individual within the group has an actual medical need for the services. We have encouraged physicians

to resist pressure to order or approve any therapy services that are not, in fact, medically necessary to improve or maintain the individual resident's functional status.

We are also using the some of the funding provided through our Operation Restore Trust demonstration to compare all bills submitted for nursing home residents and to identify services billed under both Part A and Part B.

Payment Reform Legislative Proposals

Of course, control of post-acute care expenditure growth cannot be fully realized without legislation, and both the Administration and the Congress have appropriately made payment reform of the SNF and HHA benefits a top priority in Medicare reform. I will describe our payment reform proposals and will then compare them with the proposals that appeared in the Conference Agreement, where appropriate. There are important areas of common agreement and areas where our policies diverge. But I believe that we have an opportunity to strike common ground on a number of issues, and I assume that when the Administration and Congressional leaders get back to the budget negotiating table, the areas of common agreement will be critical to a successful budget compromise.

The Broader Context for Payment Reform: A Beneficiary-Centered Delivery System and, Perhaps, an Integrated Payment System

Before I delve into specific legislative proposals, I'd like to suggest that these proposals should be viewed as means to an end, not an end in themselves. Many argue that the post-acute care payment system of the future must be one that provides comparable incentives across delivery sites. While we should not stop our efforts to develop prospective payment systems for post-acute providers, we should not be permanently wedded to separate payment systems for each of the self-contained benefits. Rather, we should strive to better understand the value of each post-acute care provider type and how to better manage and coordinate care across the health care continuum.

I would suggest that payment reform should support an infrastructure of post-acute and long-term care delivery systems that is better integrated and more flexible in meeting the needs of those with chronic conditions and disabilities. That is, a guiding principle in any lasting reform of the Medicare post-acute care benefits should be to make the system of services "beneficiary-centered." To be beneficiary-centered, an integrated delivery system needs a reliable and predictable stream of financing. But, it also requires a system of maintaining information on clients that is consistent and available to all service providers. This kind of information is essential as we work to target funds and determine how we go about fairly and accurately assessing what kind of care someone needs. Beneficiary-centered services also rely on inter-disciplinary case management that involves formal and informal caregivers and supports and encourages, where appropriate, beneficiaries to direct their own care. Finally, a beneficiary-centered system needs relatively standardized service packages typically provided by various health care professionals.

There is considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the post-acute settings. These distinctions are becoming increasingly blurred with advancing technology. For example, physical therapy and other rehabilitation services can be provided in each of the settings. A recent HCFA analysis shows that 53 percent of beneficiaries treated in the hospital for hip fracture use SNF services, 14 percent use home health services, and 14 percent use

rehabilitation hospital services. Similarly, 25 percent of patients treated in the hospital for stroke use SNF services, 26 percent use home health services, and 16 percent use rehabilitation hospital services. While there may be some clinical differences in the patients who go to each of these settings and in the outcomes as a result of care provided in each of these settings, it is also likely that patient and physician preferences influence which type of post-acute service is used.

Despite the considerable overlap, Medicare's payment and coverage rules vary by setting. While I don't wish to discount the importance of beneficiary preference in making these decisions, I would like to ensure that Medicare payment is not the primary reason for care setting decisions. Medicare payment methods and amounts for similar services provided in each of the post-acute settings differ. And more expensive stays do not always imply more services or better outcomes. For example, some provocative early research findings suggest that, for some conditions, outcomes may be no better for beneficiaries treated in one setting than another, even though Medicare payment may be substantially different. I am hopeful that further research into the characteristics of patients that use care in each of the post-acute settings, and an analysis of outcomes, can provide information about the most appropriate setting for different types of patients.

As I've suggested, any effort to control the utilization of post-acute care services and ensure equity and appropriateness of payment must involve a mechanism to track outcomes and services that address patient care needs. Such a mechanism ideally begins with a valid and reliable assessment screening instrument that would provide a preliminary assessment of the patient's needs and the types of services that would best meet desired health outcomes at the lowest possible cost. This type of instrument could also be used to assess the individual's values and preferences for continuing care, so that if two or more types of care would typically provide the desired outcomes at comparable costs, the individual could choose the type of care he or she would receive under Medicare. Such an assessment instrument should also be made up of core data elements (e.g., functional status, available care supports, etc.) that would be relevant across the care continuum and that would support case-mix payment systems.

As you may be aware, HCFA has been developing assessment instruments -- the Uniform Needs Assessment Instrument (UNAI), the long-term care facility minimum data set (MDS), and the Outcomes and Assessment Information Set (OASIS), which is a core standard assessment data set for home care. The next challenge is to identify common elements among the instruments to support an integrated payment system.

Additionally, HCFA is evaluating case-mix systems to support prospective payment reforms. The Multi-State Case-Mix and Quality demonstration for SNFs has used the MDS to classify long-term care patients according to the intensity of resource use. Additionally, we are embarking on research toward the development of a case-mix classification system for HHAs which utilizes selected OASIS items. Other work is being conducted to evaluate the feasibility of a case-mix payment system for rehabilitation hospitals.

Under a possible future payment scenario, we would want to provide payments sufficient to ensure that beneficiaries receive high quality care in the appropriate settings, and that any transfers among settings occur only when medically appropriate and not in an effort to generate additional revenues.

In an effort to make payment systems "site-neutral," we might also consider splitting apart payment of the "medical" services from the room and board services.

That way, payment for the "medical" services can be the same for similar patients regardless of whether they are delivered in the home or in a nursing facility. This would help address problems related to the institutional bias as well as clarify the allocation of responsibilities between Medicare and Medicaid.

This discussion addressed our general direction regarding the future of post-acute care payments. The message I mean to convey is that we are thinking more broadly about an integrated reimbursement system for post-acute care services even as we focus our attention on the reform proposals that are currently on the table. In the meantime, we are committed to developing prospective payment systems for SNF and HHA providers.

The prospective payment systems for SNFs and HHAs form the heart of our payment reform proposals in the President's Medicare balanced budget package. The development of PPS systems for SNFs and HHAs is proceeding well, despite delays. The delays have been largely due to the complexity in developing case-mix systems.

Status of PPS Demonstrations and Studies -- What We've Learned to Date

Home Health

The National Home Health Agency Prospective Payment Demonstration is testing two alternative methods of prospective payment. Phase I of the demonstration tested a per-visit prospective payment. Phase II of the demonstration, which began in June 1995, is testing a per-episode prospective payment, and will last for two more years.

In Phase I, we tested a per-visit payment method that established a separate payment rate for each of six types of home health visits (i.e., skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services). Although we found that agencies being reimbursed through prospective rates were more likely than other agencies to keep their cost increases below inflation, the differences were fairly small. The demonstration had no significant effect on the number of visits provided, quality of care, access to care, and other Medicare costs. Thus, we learned that a per visit payment methodology is not effective in controlling expenditure growth.

In Phase II, participating HHAs are receiving an agency-specific episode payment based on 120 days of care and outlier payments for episodes that extend beyond 120 days. Outlier visits are reimbursed at per-visit prospective rates. A new episode of care does not begin until there has been a gap in home health services for 45 or more days after the initial 120 days. Agencies receiving per-episode payments are subject to stop-loss and profit sharing provisions.

The episode rates are based on an agency's cost experience during a base year -- the year prior to the agency entering the demonstration. Thus, the per-episode rates used during the demonstration reflect an agency's case-mix during the base year period. In recognition that an agency's case-mix may change during the demonstration relative to the base year period, the demonstration includes a case-mix adjuster as one of its payment adjustments. If an agency serves patients requiring relatively few services during the base year period and then serves patients requiring more resources during a demonstration year, the per-episode payment rate may not be sufficient. The case-mix adjuster adjusts payments for differences in patient characteristics. It is designed only to refine payments to reflect case-mix change within an agency, not to differentiate case-mix among HHAs.

We do not yet have results from this phase of the demonstration. Thus, we do not yet know whether the definition of an episode chosen for the demonstration (120 days) is an appropriate definition for a national payment system. This is because 120 days captures only about 60 percent of all home health visits. If 120 days were to be used as an episode in a national payment system, that would mean that almost 40 percent of all home health visits would fall outside the episode as outliers.

SNFs

In July of 1995 we began our Multi-State Nursing Home Case Mix and Quality Demonstration. This three-year demonstration is testing a per diem prospective payment system and a quality monitoring system for SNFs. The payment system utilizes resident assessment data (the MDS 2.0) applied to resource utilization groupings (RUGs III) to determine case-mix adjusted payments. In the first year, only routine costs were paid prospectively. Recently, we have begun incorporating payment for therapy services furnished to Medicare beneficiaries into the prospective payment. Over 500 nursing homes are participating in the demonstration.

To date, the demonstration has provided valuable insight into the proper design of a PPS system for SNFs and informed us about how best to implement such a system. We're in the process of working out many of the operational issues to make a full scale implementation easier. We've also learned that subtleties in the elements that make up the case-mix adjustor can send strong signals to providers -- that making payment contingent on patients requiring services means that many more patients will receive those services. We've learned that it is appropriate to use the same assessment instrument for both Medicare and Medicaid. We've also learned that interrupted SNF stays may be more common than previously thought (for example, one-third of stroke patients are readmitted to the hospital under a different DRG); this greatly complicates the design of a per episode PPS.

Description of Administration's Proposals for Payment Reform

The information we have gained from the demonstrations thus far laid the foundation for the payment proposals that were included in the Presidents FY 1997 budget submission.

Home Health Payment Reform Proposals

We proposed a number of home health payment reforms designed to achieve needed cost control, improve financial management, and control fraud and abuse. The focus is our plan to transition into a per-episode PPS in 1999. There is broad agreement among industry representatives, and many members of Congress, that a per-episode payment system is the superior way to constrain costs without sacrificing access or quality. We have sketched out in our legislation some of the features that are desirable for such a system. For example, we would anticipate that all services currently covered and paid on a reasonable costs basis under the Medicare home health benefit, including medical supplies, would be covered under the payment. The per episode payment amount would be based on the most current audited cost report data available. We would employ an appropriate case-mix adjuster that explains a significant amount of the variation in cost. The episode payment amount would be adjusted annually by the HHA market basket index. The labor portion of the episode amount would be adjusted for geographic differences in labor-related costs based on the most current hospital wage index. The Secretary would have the authority to designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the

type or amount of medically necessary care. Finally, if a beneficiary elects to transfer to, or receive services from, another HHA within an episode period, the episode payment would be pro-rated between the HHAs.

We are committed to implementing a PPS system for home health as soon as possible. There is, however, some work remaining to be done before we can implement such a system -- namely, the development of a case-mix adjuster that can explain a significant amount of variation in costs per case and the development of an appropriate definition of an episode of care. Our legislation seeks authority to request data from HHAs to support our research and development efforts.

While we continue to develop these essential features of an episodic PPS system, we propose to implement an interim payment system that would allow us to achieve some cost control. The Administration's interim payment system would rely on proven techniques of current law in an effort to achieve guaranteed, up-front savings without disrupting the industry with a host of new payment methods.

The interim system would superimpose a new cost limit onto the existing cost-based reimbursement scheme. This new cost limit would build on agencies' actual experience (in a base year) in resource use per beneficiary. It would give agencies the flexibility to provide the appropriate amount of care (duration of visits, number of visits, and skill level of caregiver) within this limit, and to share in savings if agency costs fall below this limit.

To be more specific, payment to an HHA would be the lesser of: (1) the agency's actual costs, or (2) a per visit cost limit set at 105 percent of the median national cost for free-standing HHAs, or (3) this new agency-specific per beneficiary annual limit. As soon as feasible, we would modify the agency-specific per beneficiary limit to reflect regional or national variations in utilization. This proposal can be implemented immediately, with few administrative changes at negligible cost, and allow for a sensible phase-in to a prospective payment system.

We also proposed to eliminate periodic interim payments (PIP) for home health agencies simultaneous with PPS implementation in 1999. PIP was established to encourage new providers to participate in Medicare by improving cash flow by paying a set amount on a bi-weekly basis. However, with about 100 new HHAs joining Medicare each month, access to home health is no longer a problem. Further, the Office of the Inspector General has found that Medicare tends to overpay providers who receive PIP, and has validated our contention that it is sometimes difficult to recover these overpayments.

We also proposed to base the visit payment limitation on the location where services are rendered, not where services are billed. Many HHAs are established with a parent office in an urban area and branches in rural areas. When HHAs bill Medicare, the payment limitation is based on the higher wage rate for the urban area even though the service delivery occurred in a rural area.

In comparison, the Conference Agreement proposal called for the immediate implementation of a prospective payment system for home health. Agencies would be paid a per visit prospective rate subject to an annual dollar cap that would be calculated to approximate all covered service delivered to a beneficiary during a period of 120 days. However, the payment cap would be implemented such that HHAs would be paid for providing 165 days worth of services with 120 days worth of dollars. Agencies that keep total payments for the year below the annual cap would be allowed

to retain 50 percent of the savings. Numerous outliers and extended care exceptions would be paid outside of the cap on a per visit rate.

The Administration opposes the Conference Agreement proposal for the following reasons. First, we believe that savings cannot be guaranteed since the proposal relies wholly on an untested, unreliable new payment methodology that uses an inappropriate case-mix adjuster and that would allow about 30 percent of visits -- outliers -- to be paid a prospective rate subject to no utilization control. To the extent that savings do not reach the savings target, the Republican failsafe hammer would have come down hard on agencies.

Second, we fear that the proposal to pay 165 days of service with 120 days worth of dollars creates an incentive for agencies to avoid caring for heavy care and long-term care patients and thus would hurt access to, and continuity of care for, the sickest patients with the greatest needs.

Third, the plan is built upon the false assumption that data and systems are in place to facilitate immediate implementation. In fact, we are certain that it would take 2-3 years to develop the systems and gather the data necessary to implement the payment scheme.

Fourth, the Conference Agreement prescribes "policing" of the industry by HCFA to ensure that agencies do not circumvent the system. This policing would add significant additional administrative expense to HCFA and be very burdensome to the industry.

Finally, the Conference Agreement does not provide for an eventual transition to a comprehensive PPS that covers all HHA visits.

We understand that the home health industry has put forth a new proposal that may have gained some attention by lawmakers. This proposal would impose two interim reimbursement systems upon the industry until an episodic PPS can be introduced. The second phase is similar to the Conference Agreement and the concerns we had about that proposal are comparable. The first phase would entail a per visit PPS. Frankly, we have to do some more study on this new variant, but we continue to believe that our proposal is superior to the other proposals.

I know you are aware of our proposal to shift financing of a portion of the home health benefit from Part A to Part B. Under our proposal, the first 100 home health visits following a three-day hospital stay would be reimbursed under Medicare Part A. All other visits, including those not following a hospitalization, would be reimbursed under Part B. Part B visits would not be subject to the Part B coinsurance or deductible. The transfer would not affect the Part B premium. The proposal would not alter general coverage or eligibility rules and thus would have no change on access to the benefit by beneficiaries.

Clearly, by capping Part A financing of the home health benefit, we would be saving the financially vulnerable HI Trust Fund about 55 billion dollars over 7 years. This is an important motive, and I note that Republican members once intended to achieve the same goal with a similar technique. But there are other sound reasons for this policy and, to explain them, I need to put this proposal into some historical context.

As I've already discussed, the home health benefit, like the SNF benefit, was

originally designed to provide short-term, recuperative, post-acute care services to beneficiaries after discharge from a hospital. The benefit was only available to those beneficiaries who were discharged from a hospital following a minimum 3-day stay. The benefit provided up to 200 home health visits during a calendar year. The first 100 visits were financed under Part A of Medicare. There was no beneficiary cost-sharing during these visits. If beneficiaries exhausted all of these Part A visits and carried Part B insurance, they were then eligible to receive additional visits financed under Part B, up to a maximum of 100 visits. For these visits, beneficiaries bore some of the costs through a $60 deductible. (Until 1973, beneficiaries also paid coinsurance for Part B visits).

In Congress' view, the pre-OBRA-1980 home health benefit was too limited, resulting in some beneficiaries using too much expensive institutional care. For this reason, in OBRA-1980, Congress removed the Part A and Part B visit limits and eliminated the hospital stay requirement. Home health thus became an unlimited benefit.

An unintended consequence of the OBRA-1980 change was to burden the Part A Trust Fund with approximately 99 percent of the financing for the home health benefit, regardless of whether or not visits are related to a hospital stay. The huge shift in financing to Part A clearly was not consistent with the original intent of Part A, the Hospital Insurance Trust Fund, which was designed to only finance services that centered around a hospitalization.

The President's proposal to move a portion of the financing of home health back to Part B restores the original Part A coverage of post-hospital services and allows Part B to finance all other home health services. It maintains Congressional intent for a home health benefit that is available to all beneficiaries regardless of their Part A and Part B coverage. And it maintains Congressional intent to have a home health benefit that does not require out-of-pocket expenses borne by beneficiaries. Finally, it will allow us to better focus coverage policies for the two groups of home health users -- post-hospital and chronic care users.

Let me end the home health discussion with a note of agreement. Both the Congress and the Administration wisely proposed to permanently extend the savings from the OBRA-1993 freeze on home health cost limits by not allowing for the inflation that occurred during the freeze. In the absence of this legislation, spending reverts to pre-freeze levels. Also, both the Congress and the Administration agreed that the home health re-certification survey frequency should be lessened in certain cases in order to allow the Secretary greater flexibility in targeting resources toward poor performing HHAs and to give relief to the current backlog of initial certification surveys. This change became law when Congress passed our FY 1996 appropriations and we thank you for the relief it provides.

SNF Payment Reform Proposals

As with home health, both the Administration and the Congress agree that the savings of the OBRA-1993 cost limit freeze should be permanently extended for SNFs.

With respect to SNF reimbursement reform, we are further along with our research and demonstration efforts on SNF PPS and thus could implement a system more quickly than in the case of home health. However, as with home health, we have a two-stage proposal to allow us to transition to a fully prospective PPS for SNFs.

We have a multi-part proposal for our interim system. First, we would establish an interim prospective rate for routine costs. This rate would be based on facility-specific costs, subject to regional limits. The regional limits would be based on data from freestanding SNFs only. Under current law, hospital-based SNFs are allowed a higher cost limit to reflect the higher costs in these SNFs. However, research has not substantiated a difference in the characteristics of patients treated in hospital-based and free-standing SNFs.

Second, we propose to eliminate immediately the new provider exemptions and new exceptions to the cost limits. The 3-4 year cost limit exemption for new providers under current law allows SNFs to be reimbursed for inflated costs for several years. Meanwhile, the exceptions for atypical care or extraordinary circumstances effectively allow SNFs to bill Medicare fully for more costly "sub-acute" care services which Medicare reimbursement would not otherwise completely cover. Under our proposal, SNFs that had exceptions in the base year would be protected under a hold harmless provision.

Third, we would require SNFs to bill Medicare for all services their residents receive (except the services of physicians, certified nurse midwives, psychologists, hospice services, and nurse anesthetists), prohibiting payment to any entity other than the SNF for services or supplies furnished to Medicare-covered SNF patients. This consolidated billing proposal is offered, in part, in response to Inspector General reports that some Part B suppliers bill Medicare for supplies that were never delivered to nursing home residents. It would also reduce beneficiary Part B copayments for services covered under Part A. To ensure that Medicare doesn't overpay for these services, we would also establish limits on ancillary services based on amounts payable for similar services provided on a fee-for-service basis under Part B. In order to implement this, we would require SNFs to include HCFA Common Procedure Codes on their bills. This would also provide the data necessary to construct a SNF PPS rate that covers ancillary services.

As an additional control on ancillary expenditure growth, we also propose to update the therapy guidelines for physical therapy (PT) and respiratory therapy (RT), and establish similar therapy guidelines for occupational therapy (OT) and speech-language pathology. As part of their SNF care, Medicare beneficiaries are eligible for therapy services. While some SNFs employ their own therapists, many use contractors to provide these services. Salary equivalency guidelines determine the maximum Medicare payment for the service, based upon an estimate of the costs of providing the service via a salaried employee. We discussed this effort under our administrative efforts to control costs. Because of the time consuming process we must go through to accomplish this administratively, we are also proposing legislation to accomplish this more quickly.

We are committed to implementing a full PPS beginning in FY 1998, and our proposed legislation reflects this commitment. The prospective rate would be designed to cover all three SNF cost categories -- routine, ancillary, and capital-related costs.

The Conference Agreement also proposed an interim and full prospective payment systems. The interim payment system would remain cost-based. Routine costs would be subject to the current limits which are separately computed for hospital-based and freestanding SNFs. However, the definition of routine costs would be expanded to include additional services. Ancillary services would be subject to a per episode limit. Capital payments would be reduced by 15 percent.

One area of difference between the Congressional and Administration provisions is the unit of payment for the prospective payment systems. The Administration's plan does not specify whether PPS payments should be made on a per episode basis, as in the Republican plan, or on a per diem basis. We have decided not to specify a unit of payment until further research and demonstration results can shed light on the appropriateness of one or the other. We are concerned that the Conference Agreement provision is based on a system that has not been appropriately informed by research. HCFA has been testing a per diem prospective payment on a demonstration basis in six States, and States have been implementing per diem prospective payment systems for years. There is no comparable information for per episode payment system. Not only do we not have sufficient information to determine the appropriate level of payment, no research has been conducted on the effects of a per-episode payment system on patient outcomes, quality, or access to care.

The incentive under a per episode prospective payment system could be for facilities to discharge patients as quickly as possible as facilities receive the same payment irrespective of how many days the beneficiary remains in the SNF. Earlier discharge may result in poor quality care and increased overall program costs as beneficiaries still needing services may return to the hospital or initiate home health visits. Furthermore, in the absence of an accurate case-mix adjuster (which currently does not exist to predict per-episode costs), SNFs would have an incentive to avoid more resource intensive patients and access to SNF care for the beneficiaries that need it the most would be reduced.

Another area of significant disagreement is the Conference Agreement's provision to place limits on ancillary (non-routine) payments. We are concerned that these limits could place patients at risk of receiving inadequate services. Facilities would have the incentive to ensure that the cost of services their patients receive does not exceed the limit, since they would receive no additional reimbursement for any additional services. The Administration's proposal would provide controls on expenditures for ancillary services by requiring facilities to bill for the services its patients receive, establishing therapy guidelines, and limiting payment of other ancillary services to the Part B fee schedule, without placing beneficiaries at risk of receiving inadequate services.

Finally, the Conference Agreement would also fail to eliminate the differential in payments between freestanding and hospital-based SNFs. Research has revealed no significant differences between patients in freestanding versus hospital-based SNFs and provided no justification for the payment differential. The Administration's plan recognizes that this distinction is no longer justified and would apply the same cost limits to hospital-based and freestanding SNFs.

Conclusion

There is widespread agreement that SNF and HHA expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that legislative efforts are needed to slow down this growth. I have laid out for you today our vision for the future of post-acute care payment. Because we do not yet have all the tools to implement this vision, this Administration has put forth concrete proposals to modify payment policies for SNFs and HHAs, and I have described these for you today. There are significant differences between the payment proposals put forth by the Administration and by Congress. However, there are many commonalities. It is my hope that we can work together to develop payment policies that provide the right incentives -- incentives to provide quality care, promote access to care, and inhibit fraud and abuse. Thank you for the opportunity to testify today.

Chairman THOMAS. Thank you, Bruce. This is becoming a weekly scenario. I know that it is difficult for you to do all your other work that you are charged with doing, and we appreciate the willingness not only to come and testify but to spend some time answering questions and interacting in a way that we better understand what you are doing. It is an imposition on your time, and we know that.

I want to visit a couple of points. I have a whole bunch of questions. I will probably have to submit a number of them in writing rather than taking all afternoon, as we have done before. You do mention in your testimony the administration's proposal in transferring, following a certain profile, home health care costs from part A to part B. It has usually been described as a $55 billion savings to the HI Trust Fund. Is that your number or CBO's number?

Mr. VLADECK. I believe that is the OMB/President's budget estimate number.

Chairman THOMAS. You believe it is the OMB number? I believe——

Mr. VLADECK. I am sorry. That is the CBO number.

Chairman THOMAS. I believe it is the CBO number.

Mr. VLADECK. OK. Yes.

Chairman THOMAS. Do you have a number that was generated by OMB that either agreed with or differed from the CBO? My assumption is, if it was higher, you took the CBO one.

Mr. VLADECK. We did have a number, Mr. Chairman. I honestly do not remember what it was. I would be happy to give that to the Committee as soon as I——

[The following was subsequently received:]

The estimate generated by OMB for the proposal to transfer certain home health costs from part A to part B was $69.55 billion through 2002, using the fiscal year 1997 budget baseline. This amounted to approximately 54 percent of home health costs and was based on the most recent data available at that time. This estimate is higher than the CBO estimate because CBO, we believe, transferred 40 percent of home health costs to part B. (This was based on the latest available to CBO on the proportion of home health visits above 100.)

Chairman THOMAS. Here is my reason for asking that question; because I recall when the trustees presented the Trustees' Report, there was a major press conference, and Secretary Shalala indicated that one of the reasons they were in support of this was that we were returning to the pre-1980 structure. I took some objection to that because it was not returning to the pre-1980, and we had testimony to indicate that. In fact, you folks agreed, because it did not include the deductibles that were available back then, so it was—arguably, the concept was the same, but the mechanics and the payment structure were different.

What I do not think everybody has appreciated—and I want to make sure I understand the trigger mechanism that you have, because I think CBO may have misunderstood the trigger mechanism as well. You say that the part A costs for home health will remain in part A if it follows a hospital visit and the number of visits is less than 100.

Mr. VLADECK. That is correct.

Chairman THOMAS. Is there any time consideration from the time the beneficiary was in the hospital and the first of the 100 visits was triggered?

Mr. VLADECK. We used the Medicare term of art of a spell of illness, so it would need to be associated with the same illness for which the hospitalization occurred.

Chairman THOMAS. And the spell of illness is defined by time or condition?

Mr. VLADECK. It is defined by condition and the receipt of services. In other words, if one has a spell of illness for pneumonia with a set of pneumonia-related services and then goes 30 days without the receipt of any services associated with that illness, that defines the end of the spell of illness.

Chairman THOMAS. So, it has a time as well as a condition definition. My understanding is the 3-day hospital is the minimum trigger for the benefit, and 100 is the maximum number of visits under part A. But you have introduced another factor, which I do not think CBO fully appreciated, and that is the 30-day trigger.

Mr. VLADECK. I would have to make inquiry, but I would be happy to.

[The following was subsequently received:]

The Medicare statute defines a "spell of illness" as beginning on the first day a beneficiary receives inpatient hospital services, inpatient rural primary care hospital services, or extended care facility services and ending on the first period of 60 days in which the beneficiary is not an inpatient of a hospital, rural primary care hospital, or SNF. Under the administration's home health transfer proposal, Medicare part A would cover up to 100 home health visits during any spell of illness if the services were furnished in accordance with a treatment plan developed during a stay of no less than 3 days in a hospital or rural primary care hospital and home health services began within 30 days of discharge. There is no "condition" definition, as you have described it. Also, Medicare part A would cover home health services furnished to a beneficiary who has part A coverage only.

All other home health visits, including those not following hospitalization, would be reimbursed under part B and not be subject to the normal part B coinsurance or deductible. Furthermore, this proposal would not affect the part B premium.

Chairman THOMAS. So, how do you get to part B under your plan? The shift from part A to part B, regardless of whether it is generally defined as chronic or acute, would occur after 100 visits or the first visit after 30 days.

Mr. VLADECK. Or, the first visit for a patient who has not been hospitalized for the condition for which the home health services are provided within the preceding 3 days.

Chairman THOMAS. And if the patient has been hospitalized, meets the 3-day minimum, but does not start that first visit until more than 30 days after discharge, that goes to part B?

Mr. VLADECK. I believe we would define that as a separate spell of illness, yes.

Chairman THOMAS. My belief is that OMB did not compute that. They computed it on a weighted average from the 100 and more than 100 normal shift. You will find that if OMB computed the actual dollar shift based upon our understanding of the President's policy, it would be significantly higher than $55 billion. And, I am going to request OMB to rethink the way in which they designated the costs, because it is, again, far higher than the $55 billion. If you have any information or data that OMB or others did—I keep saying OMB. I mean CBO, obviously.

The Congressional Budget Office, I believe, in computing their numbers did not fully appreciate the time factor. If you folks did in your policy and you came up with different numbers, or you did

and you believe you can substantiate what CBO did with its numbers, the Chair would very much appreciate the clarification on that, because I do think we are going to get a discrepancy in the numbers.

Mr. VLADECK. We will look into it, sir.

[The following was subsequently received:]

I believe you are correct. It is our understanding that the CBO assumed that Medicare part B would cover all home health visits over 100 without regard to whether or not there was a hospital stay.

Chairman THOMAS. In dealing with home health, you talked about areas that you are trying to deal with in terms of case mix adjuster and the variation in costs per case and the development of an appropriate definition of an episode of care. Obviously, this has been going on for some time.

Do you want to go out on that limb? When can we get some kind of a yardstick, or are we probably pursuing the wrong approach to trying to measure? Where are we?

Mr. VLADECK. We believe, Mr. Chairman, we can begin field testing new classification systems or measurement systems for home care case mix during 1997. To have a full year of data on the case-mix experience of home care agencies applying these new techniques would take us into calendar 1998. We will be in active testing of such classifications within months from now, not years from now.

Chairman THOMAS. And, you indicated that perhaps you may be seeking some legislative authority to get some data that you cannot now utilize to help those research efforts. What is it that you do not think you can do? What do you need from us, and why?

Mr. VLADECK. Well, let me tell you what is perhaps the most significant part of that, and it has to do with some issues in the definition of eligibility for home care services. But we have found in development of nursing home case-mix measures and in much of our other long-term care activity that the functional status of the patient—their ability to perform activities of daily living—is often a more powerful predictor of how much service they will need than a medical diagnosis.

We do not routinely collect systematic data from home health agencies on activities of daily living. The data we get from home health agencies at the moment is very much tied to a so-called classical medical model. It identifies particular problems for which skilled services are required but does not give us a complete enough picture of the characteristics of the patient to develop the information we need on case-mix characteristics.

Chairman THOMAS. Finally, for this round, you indicated that you agreed with us in terms of not building into an updated cost limit freeze period. But my belief is that you did build in an increase for that period by including an inflation factor. Is that correct? Notwithstanding the fact that they were frozen, you provided for an inflator. Can I go back to early math where they kept telling me that one times zero is zero, two times zero is zero, three times zero is zero, and so forth? So, I do not understand how you can include an inflating factor when the base was zero.

So, one, is it true that you included an inflation factor for those years that we had the freeze, notwithstanding the fact that you included the freeze?

Mr. VLADECK. My understanding is that the proposals and the associated pricing in both this year's President's budget proposal and last year's took the freeze through the end of 1996 as a given. We began inflation from the expiration of the OBRA 1993 freeze and rolled that forward into the prospective payment systems, but did not go back into the freeze period and reinflate.

Chairman THOMAS. So, you believe you did not include inflation for the period that we had the freeze.

Mr. VLADECK. That is correct. I believe that was what we intended to do. I qualify that only because I think we kept the proposals in separate parts of the legislation, and I believe the scoring reflects that. I will double-check that, but I am pretty sure that is what——

[The following was subsequently received:]

OBRA 1993 mandated a freeze on Skilled Nursing Facility (SNF) routine cost limits and Home Health Agency (HHA) cost limits for 2 years. The freeze on SNF routine cost limits expired on September 30, 1995; the freeze on HHA cost limits expired on June 30, 1996. the Medicare statute requires that both SNF and HHA cost limits be updated, in a prescribed manner, for the postfreeze periods.

The SNF routine cost limits effective for cost reporting periods prior to the OBRA 1993 freeze were extended through the freeze. The inflation that would have been added in each of those two years was not paid, and this resulted in savings to the Medicare Program. However, by law, HCFA must recognize the inflation for the 2 freeze years (fiscal years 1994 and 1995) in determining the fiscal year 1996 limits. As authorized by section 1888(a) of the statute, we updated the limits by inflating the previously issued schedule of cost limits, rather than by rebasing the cost limits using the most recent available cost report data.

For the most recently published HHA cost limits, we updated for the freeze years through a rebasing of the cost limits using the most recently available cost report data. This manner of inflation adjustment is prescribed by section 1861(v)(1)(L)(iii) of the Medicare statute.

As you are aware, both the Congress and the administration had proposed to permanently capture the savings generated by the OBRA 1993 freeze on SNF and HHA cost limits. Our proposal would not have extended the freeze, but instead would have permanently extended the savings realized from setting future cost limits in a manner that would not allow for the inflation that occurred during the freeze. Now that the OBRA 1993 freeze has expired for both SNFs and HHAs, and HCFA has had to accommodate inflationary increases in the latest schedules of cost limits, the Congress and administration may want to consider other mechanisms by which we can permanently capture the savings generated by the freeze.

Chairman THOMAS. You believe it was your intention to do that, notwithstanding the fact it may not have been done; or it was done, and it was your intention?

Mr. VLADECK. Well, it was done, I believe, in the legislation. The problem is that we have since been required by law to update the cost limits for both SNF and home health agencies, effective this past July 1, because the OBRA 1993 limits expired without intervening legislation.

Chairman THOMAS. That may be an interpretation of the law. We may interpret it differently.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

Just a couple things. Your Inspector General last year, I think, found that there was a higher reimbursement in home health agencies that are proprietary and recommended that we not grandfather in the utilization patterns of higher reimbursing agencies. Is

this something that you plan to do, or do you think that the proprietaries are providing better care since they do more visits?

Mr. VLADECK. Well, one of the concerns we had about the conference agreement proposal was the notion of moving to an interim prospective payment for home health agencies based on individual agencies' experience in terms of case-mix adjustment. And, we do not think we should use a case-mix-based system for home health agencies until we have one that does not depend on agency-specific data and accurately explains variations in costs across different kinds of agencies in different parts of the country.

So, with the development of the right kind of case-mix classification for home health we are seeking one that would not be affected by either differences in prior practices among agencies or by different modes of operation prospectively for the agency.

Mr. STARK. I am not sure we are talking about the same thing. I am just talking about the higher costs due to higher utilization patterns. I do not know whether that has anything to do with case mix. Your inspector general found that you just had utilization patterns that were higher in the for-profit agencies. Is that——

Mr. VLADECK. The question is, as always——

Mr. STARK. Nothing with regard to case mix. I am just talking about patterns across a group. In fact, is that something you want to grandfather in?

Mr. VLADECK. No, it is not, which is why I think we need an agency-neutral measure of case mix eventually.

Mr. STARK. Let's hop to the end. Can we have one PPS for all post-acute services?

Mr. VLADECK. We would like eventually to move in that direction.

Mr. STARK. All the way to bundling?

Mr. VLADECK. I am not sure about that. Let me distinguish between the two, if I could.

Mr. STARK. OK.

Mr. VLADECK. We have stumbled into a recognition that we have invested a lot of time and energy in the development of separate patient assessment systems and forms and processes for nursing home patients, for home health agency patients, for patients in hospitals awaiting discharge, and in many Medicaid Programs, for recipients of home- and community-based long-term care systems.

All of these forms or assessment devices have enormous amounts of overlap across the different kinds of services. We have also known for a very long time that there is an enormous amount of substitutability between the kinds of services people who receive home care get, those in nursing homes get, those in hospital-based long-term care facilities get, and so forth. We also know that the actual service a person receives is as much a function of what is available in the community, what the physician is familiar with, and what the individual's preference may be, as any clinical or scientific determination.

Mr. STARK. You did not factor in one other thing. What leads to the highest gross payment if, in fact, the hospital owns the home health agency, shortens the DRG, diagnosis related group, stay, collects the full DRG, and then collects out of the home health

care? It is getting more per patient, right, than when it is separated?

Mr. VLADECK. That may also be a consideration.

Mr. STARK. You think that might be a factor.

Mr. VLADECK. The point is if a patient needs 2 hours a day of skilled nursing services and some housekeeping and some physical therapy three times a week, whether they receive it in a SNF or a subacute unit of a general hospital or a rehab hospital, for the great bulk of patients it may very well be the same identifiable bundles of service.

If we can really predict the appropriate bundles of service based on patient characteristics and put a price on those, then that should not vary by site of service. And the payment system should be the same for all like services, regardless of where the patient receives them.

Then the question becomes, how do you distinguish payment for residential facilities where there are hotel costs or room and board costs from services delivered in the home? That also gets to some very interesting Medicare/Medicaid interactions. But in the long term, if we want a system that is driven by patient characteristics connecting to a set of services the patient ought to get, the exact place where this patient receives those services may not matter. We are a little ways from being able to demonstrate that.

Mr. STARK. Thank you.

Chairman THOMAS. I thank the gentleman.

The gentleman from Nevada has a time problem, and if he would like to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

Mr. Vladeck, I just have a couple of questions. I know this is a little bit off the subject, but I think our office was in contact with yours this morning, and I just wanted to discuss the S/HMO 2s.

You were here on April 18, and we talked about it. I know you are a big fan of the S/HMO 2s and the demonstration projects that we have. We talked about the July 1 waiver date, and I personally talked to your office back in June, and I guess there were some problems held up. The problem was not with your office at that point. It was with OMB.

The company Sierra Health Services has now put in about $1.2 million to develop this program. They are very excited about it, and they have had to recently lay off 11 employees because of the delays. But your office talked to me at that time, which I relayed back to them, that August 1 still looked very good.

I guess what I want to find out is: Is August 1 going to happen? If not, what are the problems? And, how can we get it resolved?

Mr. VLADECK. August 1 is getting closer every day. It is a week from Thursday. I think that is still possible. We have talked to OMB about this within the last week. They are trying to move it as quickly as they can in the midst of their other work. If it is not then, I am confident it will be very, very soon thereafter. And we are doing everything we can to——

Mr. ENSIGN. The problem is your office told me that if it is like August 2, that puts everything off until September 1. In other words, if it is not by the 1st of the month, it puts everything off 30 days.

Mr. VLADECK. Yes, we have done the pricing and other work on a monthly basis, but we will, if we do not hit August 1, revisit that and see if, at the worst, we can make it the 10th or the 15th or some appropriately round number.

Mr. ENSIGN. Can I just get you on record to say you will personally do everything you can——

Mr. VLADECK. I will personally do everything I can, first, to see that we can hit August 1, or if the approval comes through shortly after August 1, to find a way not to require that they wait until September 1, to get up and running.

Mr. ENSIGN. Thank you very much, and thank you, Mr. Chairman.

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

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Vladeck, let me just raise one point. I noticed in your testimony that you indicate you need legislative authority to request data from the home health agencies to support the research and development efforts in order to complete the necessary work to implement the new system. It is highly unlikely we are going to get a Medicare bill enacted into law this year. There are only a few weeks left of legislative calendar in order to get a bill passed.

I am wondering whether the administration would support a separate bill on this issue, and perhaps the leadership in Congress would also make arrangements that this type of legislation could be considered, so that we at least remove that obstacle in moving forward in this area.

Mr. VLADECK. We would be happy to work with the members to do such a piece of targeted legislation.

Mr. CARDIN. I would hope the Chairman would take note of that. If we are not able to get a major Medicare bill passed this year, we should at least try to pull out issues that are not controversial so that HCFA can at least get the type of information it needs from the provider groups in order to move forward. We might want to take a look at that to see whether we can at least get that aspect——

Chairman THOMAS. I would tell the gentleman that all the changes we made we thought were noncontroversial. Once we sit down and begin discussing what is and what is not noncontroversial, I hope there is something left on——

Mr. CARDIN. Well, it seems to me that getting information from the industry in order to implement the plan would be considered noncontroversial by everybody on this Committee, not just one side of the Committee. But anyway, I think it is worth it for us to try to isolate those areas just in the unlikely event we are not able to pass a comprehensive Medicare reform bill this year. But at least be able to move forward so that next year we are not in the same position in an area where there really is no controversy. Just a friendly suggestion from one Member of the Committee.

Chairman THOMAS. The Chairman is always open to friendly suggestions and thanks the gentleman. By the way, how are you coming with HCFA in Baltimore——

Mr. CARDIN. Oh, we are making——

Chairman THOMAS. Excuse me. I did not want——

Mr. CARDIN. We are making great progress, depending upon how you look at it.

Mr. Vladeck, on the waiver of liability issue that expired on December 31, 1995, I am curious as to what impact that has had on the number of denials and appeals. Some of us have looked at that waiver of liability issue with the SNFs and with the home health care industry as a way of reducing administrative costs for HCFA and unnecessary expenses by the provider groups, and I am curious as to whether you have seen an increase in the number of denials and appeals since the expiration of the waiver of liability provision.

Mr. VLADECK. Frankly, Mr. Cardin, I have not looked systematically at the data. It is a little early, but I should have and have not yet. We will report that to you in the next week or so.

My perception is that in the home health area we have focused so much of our review activities on a relatively small fraction of agencies which have anomalous billing patterns that the number of denials for most agencies has probably remained at the very low level. But, I do not want to say much more about that in the absence of actual data. We will supply it to the Committee and to you as soon as we can.

Mr. CARDIN. If you could get that information to me, I would appreciate it.

[The following was subsequently received:]

The limitation on liability protection for providers, suppliers, and beneficiaries (established under section 1879 of the Medicare statute) has not expired. Only the time-limited favorable presumption—in which HHAs, SNFs, and hospices were automatically reimbursed for noncovered services—expired on December 31, 1995. Therefore, under current law, providers may seek Medicare reimbursement on a post-denial basis if they experienced a denial that could not have been anticipated.

HCFA's inventory of claim denial statistics include both denied claims that are nevertheless paid under the limitation on liability protection and denied claims not paid under this waiver. We do not expect, and have not yet witnessed, any significant change in the overall denial rate resulting from the December 31, 1995, sunset of the favorable presumption provision, there has been a decrease in the percentage of claims, subject to the provision, that are ultimately paid.

Did HCFA undertake any cost/benefit analysis when you decided not to support the extension of the waiver authority?

Mr. VLADECK. I do not believe we formally had it scored. We did have some concerns expressed by the folks we work with on program integrity, both within HCFA and in the inspector general, around the issue. And there is always some concern about how you appropriately evaluate the savings associated with averted expenditures of that kind, most of our problems with home health agencies that are receiving periodic interim payments involve recovery of overpayments. If we had an agency where there was a waiver of liability, we paid them, then we found a pattern that justified removal of the waiver, we would be seeking to go after money that had already been paid. Even if we said we paid you $1 million too much, we might never recoup $1 million.

So, the cost/benefit on those issues is a fuzzy analysis. It was not formally scored.

Mr. CARDIN. Well, good. It has been almost a year since the expiration of the authority.

What I would also like, if you can get back to me, is whether it has had any chilling effect on the provider taking a marginal patient whose condition may not be fully known because they are

worried about the liability issues; whereas, under the former provisions, as long as they stayed in the comfort level, they did not have to worry about that. I am curious as to whether you have had any concern as to whether certain types of patients are perhaps being denied the ability to find adequate providers under the current situation.

Mr. VLADECK. We have heard that expressed prospectively as a concern on the part of some of the agencies. We have heard a very occasional anecdote about that. It will be a while before we can say anything systematically, but I would also suggest that some of the folks who are directly in the business could probably respond more directly to that. We will massage what data we can and see what we can provide you with at this stage in the process.

[The following was subsequently received:]

In our view, there is currently an oversupply of home health agencies and we do not believe that the current market conditions would preclude any beneficiary who meets our coverage requirements from receiving the providers' services. This is particularly so since there are long-standing administrative procedures which permit a home health agency that may have strong doubts to share the risk with the beneficiary.

In those few instances where an agency may have a strong doubt about Medicare coverage, there are billing instructions that permit the agency to inform the patient that it doubts Medicare will pay and then, if the patient chooses to receive the services, to bill Medicare and receive an official claims determination. In such situations, either Medicare ultimately covers the services or, if the services are not covered, the home health agency may bill the patient. In our view, these advance notice procedures protect the HHA from liability in situations where there is genuine doubt.

Mr. CARDIN. Thank you very much.

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

Mr. MCCRERY. Thank you, Mr. Chairman.

I have a couple of questions. Before I ask those, though, I want to refer to your conclusion in your testimony, Mr. Vladeck, in which you say, "There is widespread agreement that SNF and HHA expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that legislative efforts are needed to slow down this growth."

I notice you did not say it is time to cut Medicare. It is time to slow down the rate of growth in expenditures in Medicare. I point that out simply to point up the fact that that is what we are all endeavoring to do, is slow the growth in expenditures in Medicare. It is not helpful to the effort, which we all have admitted on numerous occasions, that it is very difficult for certain parties—individuals, not political—to use this issue and say that one side or the other is trying to cut Medicare, when, in fact, we have all, from the First Lady to the Administrator of HCFA, said we are trying to restrain the growth, we are trying to slow down the rate of growth. So, I am glad you used that terminology in your testimony. I think it is accurate and it is helpful for us all to use that terminology and not stoop to the low political trick of saying that we are trying to cut Medicare when it would be better if we would all work together to try to slow the rate of growth.

Now, to my questions. There has been a growth in ancillary services related to SNFs, and I am just wondering, has there been a

study of whether there has been enhanced patient outcomes due to the growth of these ancillary services?

Mr. VLADECK. I do not know of any systematic study we could point to. I would acknowledge, implicit with your question, that much of the growth in ancillary services came after changes in the law in 1987. These changes were meant to encourage the provision of more extensive services, particularly the part A covered services, through arrangements between facilities and independent providers of therapies or other kinds of care.

So, to the extent that the growth has been in response to that desire, there probably has been an improvement in quality. However, we are concerned and we have some limited empirical evidence that the separate billing of ancillary services does not represent an increase in the number of services provided to patients. It just represents the unbundling of a billing process in which in the past we or the family or Medicaid paid an all-inclusive rate that included certain supplies, that may have included x rays, that included therapeutic services, for which we are now being billed separately. So, we do not have historical data from which we can tell the extent to which the increased billing is actually the result of the increased provision of services.

Mr. MCCRERY. Well, related to that, have you studied managed care's experience with post-acute services, either as it relates to Medicare HMOs or private HMOs?

Mr. VLADECK. We have one relatively good but small-scale study of managed care utilization of home health services in the Medicare Program. We do not have comparable data on skilled nursing facility care.

I must say the study of home care was rather discouraging in the sense that it suggested that some managed care firms might be under-supplying needed home health services to Medicare beneficiaries, counter to the probable over supply of certain of those services on the fee-for-service side. But it is a one-shot, one-time kind of study, the most systematic data we have, and we do not have comparable data for SNF services.

Mr. MCCRERY. Any plans to expand our knowledge on that?

Mr. VLADECK. Well, we believe the the case-mix demonstration, which we are currently conducting in six states should give us data on a number of clients who are managed care enrollees as well as the full array of services they are receiving in those facilities.

Mr. MCCRERY. Thank you.

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

Mr. MCDERMOTT. Thank you, Mr. Chairman.

When the Medicare legislation was written, a fatal error was made when they included the usual and customary fee language for physicians. I am looking for the same kind of mistake in the way the language was written with respect to the home health care benefit. Do you think there is specific discrete language that needs to be changed? I understand that obviously there are many factors that have gone into the increase in home health care spending. The increase is partly moving people out of hospital beds more quickly into ambulatory settings and so forth. But once having done that, said that, and factored that part out of the increased spending, I

would be interested in hearing your suggestions about the kinds of things that you would do if you had a free hand and could redesign the program now knowing what we know.

Also, I have the feeling that from some of the managed care operations—I know from Group Health of Washington that they obviously are doing this as a part of their whole managed care approach, but most managed care operations do not collect data in a way that HCFA can access it and decide how much spending is from overutilization and how much is not. And so, I do not know where you can get the data to make a judgment about the bundling of services.

I am really giving you kind of a blue book question because I really do not have a clear idea how to go with this issue.

Mr. VLADECK. My own focus of effort in the basic statute would be the definition of coverage for Medicare home care services. There are defined as services that are provided to a beneficiary who is home-bound, which increasingly is a questionable term, that must be skilled and provided on an intermittent basis. Both skilled and intermitted have created definitional problems for us for the last 20 years, since they are statutory terms that are only partially related to expectations about professional practice or what we know about the needs of beneficiaries.

Our current definitions of skilled and intermittent, in fact, are defined by a consent decree we entered into after the district court found us in violation of the law because of a previously overrigid interpretation of those terms. This overrigid interpretation, in turn, was a response to the opening of the gates created by OBRA 1980.

We have not proposed changes because we do not know enough to prepare a substitute definition. Eventually we need to have a much better statutory definition of what we are supposed to be covering when we cover Medicare home care services or, for that matter, any Medicare post-acute services.

I must say, we do not have a better definition, of hospital services, but when the program was first enacted, we had a much higher degree of professional medical consensus about what hospitals were for, what kinds of patients ought and ought not to be in hospitals. The boundaries on long-term care have been unclear and the lack of clearity of the statutory language does not help us put those types of boundaries around the program.

Mr. MCDERMOTT. I ask the question because my father, who is almost 91, had an episode of heart failure last year, and while he was in the hospital, we went down with my mother to see if we could get some kind of home health care for him after he left the hospital. He did not meet the home health care qualifications because they were using the activities of daily living as the standard by which he was judged; whether he could climb the stairs to the second floor, the bathroom was on the second floor—we were quizzed on a whole series of issues. I wonder if there is any way to be more precise about it, given the database that you now have access to.

Mr. VLADECK. Well, I think we are getting there, Mr. McDermott. I think it is an embarrassment that, as Mr. Thomas suggested, I can share with a lot of my predecessors, on how little we know about the characteristics or outcomes of home care services for the

Medicare population. But eventually, we ought to be able to come to some degree of consensus that a patient in congestive heart failure with the following treatments and the following needs, needs the following kinds of services, this is one of the hard issues that we have not addressed yet but we will need to. Which will be very different if the beneficiary has a competent caretaker at home, a spouse who is still competent and physically mobile for example, as opposed to living alone.

I think we know enough from our experience, frankly, in the Medicaid Programs and other community-based programs to begin defining the issues around which we need to get the information to put some better shape to this benefit.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Vladeck, in your answer to Mr. Stark earlier, you mentioned that HCFA was willing to take a look at another way of approaching post-acute care, maybe looking at the more holistic approach, more of a systematic, consistent type of approach.

If you were to look at that area, how would you treat some of the data collection materials, the compatibility of that data in terms of per diem, per cost, and per visit? How would that compare? Also, what would be some of your goals in looking at that data and moving to a more holistic approach?

Mr. VLADECK. Mr. Christensen, our major goal would be to identify payments associated with particular services which were associated in turn with particular patient characteristics, and then, in the overlapping circles, in the broad range, in the middle, to try to not have the payment system in and of itself push folks in one direction or another in terms of kind of facilities. You would need separate payments for residential services or hotel services. Some patients, who need very intensive rehabilitation, ought to be outside those overlapping circles in a separate category from those who need 2 hours of physical therapy a day.

Mr. CHRISTENSEN. So, you would not advocate having, say, a neutral cost as far as going to the respective site differences? Or would you go with the same type of cost on site——

Mr. VLADECK. I would say that to the extent that the clinical services are the same, we ought to be neutral across sites.

Mr. CHRISTENSEN. As far as ensuring that the development of different prospective payment systems for SNFs or home health care type agencies, would there be any incompatibility in terms of the two different types of systems?

Mr. VLADECK. Well, I think the chairman has appropriately noted that the specific payment systems for SNF, for home health, and for rehabilitation services have been awfully long in the making. And, it is imperative to get them ready to go as quickly as possible. But we are looking very closely at areas of overlap in definitions of patient characteristics, of services, and so forth, so that we do not get too far away from a track that would permit us to move toward a unified payment system.

We have to do this as a first step because it has been so long in coming, but we want to make sure it does not eliminate the pos-

sibility of moving from there to a more integrated system across service type.

Mr. CHRISTENSEN. What type of timeframe are you looking at in this type of approach?

Mr. VLADECK. We are ready to implement a SNF perspective payment system for 1998. We think a true case-mix-based system for home care will probably take until 1999. We probably ought to watch those for a couple of years before we move into the development of a more integrated kind of system. I think we are talking about 5 years, plus/minus, to be able to go to a unit of payment that is associated with post-acute needs but not associated with a particular category of provider.

Mr. CHRISTENSEN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Bruce, in the State of Wisconsin for years they have had a Community Options Program, COPs, which has resulted in the State saving dollars on skilled nursing care, and we are talking apples and oranges because there the State savings naturally would come out of the Medicaid Program. But my question to you is, since we see rapid growth in this provided coverage, do we not see any offsets in other portions of the Medicare Program with the home health benefits?

Mr. VLADECK. No, we have not seen other offsets, and, in part, this is because of the way we pay for hospital care. We have clearly seen a very dramatic reduction in hospital length of stay for a whole variety of reasons since the Prospective Payment System was put into place. But since we are paying the same amount for a hospitalization, whether it is 6 or 10 days, if the hospital stay is shortened because a patient moves into community-based care or home care in the 7th day rather than the 11th day, that is an increase in total costs in the Medicare Program.

Part of the issue is some of the long-term care providers have suggested maybe that the only way to save money over time from the expansion of long-term care services is by appropriately offsetting reduction on the hospital side, which also would require, of course, statutory change, and we are beginning to look at some of the specifics of what that might require.

Mr. KLECZKA. Your office has reported, and I think GAO has also reported, on fraud and abuse in the home health program and the skilled nursing program. What is being done about that from your agency standpoint? And what can Congress do to help in that regard?

Mr. VLADECK. Well, home health agencies in particular have been the focus of Operation Restore Trust, which is the President's initiative to bring together HCFA, the Inspector General, the FBI, the Department of Justice, State Medicaid fraud agencies to combat fraud and abuse in our health care programs. In particular, we are doing three things with home health agencies.

First, in the five Operation Restore Trust States, we are cross-matching Medicare and Medicaid claims data for individual clients to make certain that we are not being billed twice for the same

service or not being billed for incompatible services. We are also cross-catching SNF patients claims in these states.

Second, the inspector general has undertaken an expanded program of audit of home health agencies, both of their cost reports and of the appropriateness of the services for which they are billing.

And, third, what is——

Mr. KLECZKA. If I can interrupt, that would also include overutilization?

Mr. VLADECK. That is absolutely correct, yes.

Mr. KLECZKA. OK.

Mr. VLADECK. Our third effort may have the greatest long term payoff. In three of the five Operation Restore Trust States—and we are going to be adding the other two very soon—we have, for the first time, connected the licensure and inspections work of the State survey and certification agencies with the operations of the program integrity people. We are having the Medicare home health intermediaries identify for surveyors particular agencies and patients about whose billing patterns they are concerned with. So, when the surveyors do their regular inspection of the home health agencies, they know to look at the necessity and appropriateness of services provided in those agencies to those patients. This is proving to be a very cost-effective way of looking in much more detail at what is going on in those providers.

Mr. KLECZKA. Fine. Thank you very much.

Mrs. JOHNSON [Presiding]. Thank you. I am going to try to finish quickly so that you can leave and not wait through these votes.

First of all, I am really appalled at what I hear from my home health agencies, which is that they get paid $80 for a 1-hour visit but their home health aide gets paid $8. Why can't you look at that margin?

Mr. VLADECK. Well, we have a——

Mrs. JOHNSON. I just hear that over and over. The numbers may not be exact agency to agency, but the difference between what the home health aide gets paid and what the agency gets paid is odd.

Mr. VLADECK. Mrs. Johnson, I could not agree with you more. We are on a cost-based system that permits the allocation of a whole variety of agency costs on top of the hourly wages of the aide. The limits we have are nationally determined per visit limits that do not get very well to the question of how those dollars are allocated between the agency and the actual worker.

Mrs. JOHNSON. Are you doing any analysis, and are you doing any work to deal with that?

Mr. VLADECK. Well, we think the answer is to move away from a cost-based system altogether.

Mrs. JOHNSON. Even in an episode-based reimbursement system, you really have to know costs.

Mr. VLADECK. There have been efforts in home health in California and in other parts of the long-term care service system to adjust payment mechanisms to improve the allocation of the revenue between the actual employees and the overhead functions of the provider so that more payment reaches the employee who is actually delivering the care. Apart from the policy questions about that

kind of micromanagement, such efforts have always turned out to be pretty much unenforceable.

Mrs. JOHNSON. Does HCFA have the authority to reinstate the waiver of liability for claims paid in error that expired?

Mr. VLADECK. I do not believe so. I think that was statutory. We certainly——

Mrs. JOHNSON. Could you get back to me with a clear answer on that?

Mr. VLADECK. Pardon?

Mrs. JOHNSON. Would you get back to me?

Mr. VLADECK. I would have to check. Yes, I certainly will.

[The following was subsequently received:]

Our statutory authority to make "favorable presumptions" expired on December 31, 1995, and it is unclear to us whether we could reinstate this policy administratively. Even if we could, it has been HCFA policy since 1986 to oppose further use of favorable presumptions because favorable presumptions permit automatic payment for noncovered care. Reinstatement of the favorable presumption for HHAs, SNFs, and hospices would add about $100 million in annual costs to the Hospital Insurance (HI) trust fund, as estimated by HCFA actuaries.

Mrs. JOHNSON. OK. Thank you. And then you mentioned in your testimony that you expect to implement a PPS for home care soon. How soon?

Mr. VLADECK. As I said, I expect to begin testing a system of case-mix measurement for PPS. We are testing——

Mrs. JOHNSON. The problem with that is that costs are rising so rapidly.

Mr. VLADECK. Yes.

Mrs. JOHNSON. We really do not have 3 years, and that has been your prediction.

Mr. VLADECK. Both the conference agreement proposal and the administration's proposal seek to achieve significant savings in the interim before we go to a fully prospective payment system for home health. It is not something we want to live with long term because of some of the potential negative impacts of putting such tight cost limits without appropriate case-mix adjustments. We quite agree, and I think that is one of the areas of common ground where we need to do something very quickly on the cost side. Then, as soon as the technology is available, we can move to a truly case-mix basis.

Mrs. JOHNSON. I think we may have to be more aggressive than that. What I heard you say in answer to a preceding question is that the DRG system is now preventing us from realizing the reduction in hospital costs that would help pay for the increase in home health costs?

Mr. VLADECK. Well, I would refine that a little bit by saying the combination of the DRG system and the congressionally mandated update amounts has limited our ability to take those savings.

Mr. MCCRERY [Presiding]. Mr. Vladeck, I think Mr. McDermott has one more question he wants to ask you before we can let you go.

Mr. McDermott.

Mr. MCDERMOTT. In your thinking about this whole issue, what has been your experience recently? Some say that the whole debate we have had in the Congress has moderated health care costs; at

least it seems like health care costs are coming down. Is that the experience in home health care since 1993?

Mr. VLADECK. No. The growth in Medicare home health expenditures varies from region to region and is fueled, at least in part, by the extraordinary continuing growth in the number of agencies participating in the program. And that is one of the things that I referred to in my written testimony is rewriting our basic requirements for home care agencies to raise the bar and the quality expectations about agencies in a way that we think will begin to address some of those issues.

But we do not see any significant sign of deceleration in the growth of home health expenditures. SNF has also grown very rapidly, I think in part Because of some policy decisions we made to make it easier for facilities to qualify for exceptions on the basis of their case mix. Because of our failure to get a case-mix-based prospective system in time, that has turned out to be quite expensive.

Other areas the growth has moderated more. Certainly in durable medical equipment we have seen some considerable moderation. In other parts of the program, we have seen some moderation. But home health and SNF have continued to grow very rapidly. Since we and Medicaid are essentially the only payers for most of the nursing home and home health services, and they are the fastest growing components of national health expenditures. It is one of the reasons why, after years of the pattern being different in the last couple years, Medicare costs have diverged so significantly from private sector costs.

Mr. MCDERMOTT. Thank you.

Mr. MCCRERY. Thank you, Mr. Vladeck, very much.

Mr. VLADECK. Thank you, sir.

Mr. MCCRERY. Our next panel is Mr. Newhouse and Dr. Young. If they would come forward and take seats, we will begin your testimony.

Mr. Newhouse and Dr. Young, your prepared testimonies will be entered into the record in their entirety, and if you would, summarize those for us. We will begin with Mr. Newhouse.

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. NEWHOUSE. Thank you very much. Good afternoon, Mr. Chairman. I am Joseph Newhouse, the Chairman of the Prospective Payment Assessment Commission, accompanied by Donald Young, M.D., the Commission's Executive Director. We are pleased to be here today to discuss the development of prospective payment systems for post-acute care. I am going to refer to a number of charts that are appended to my written testimony.

As has been noted, Medicare payments for post-acute care are the fastest growing part of the Medicare Program. These increases in spending are driven primarily by increases in volume. Medicare has modified its policies over the years to contain the payment per unit of service, but its ability to control volume has been more

problematic. I am going to try to describe deficiencies in current payment and coverage policies that I think are responsible for this.

Let me first talk about SNF payments. Part of the growth in SNF spending has been due to increases in the number of beneficiaries receiving care and the total days of care provided. Between 1990 and 1995, as you see on chart 3, both the number of beneficiaries and the total days of care grew about 9 percent a year. But the largest contributor to SNF spending increases has been the growth of ancillary services provided during the stay.

Unlike the routine costs, the room and board costs, which are subject to payment limits, the payment for ancillary services is virtually unconstrained.

A third factor, in addition to the increases in beneficiaries and the role of ancillary services that has played a role in increasing SNF spending, has been new providers. New providers are exempt from the routine spending limits for up to their first 3 years of operation. Between 1990 and 1995, the number of new providers has increased by 4,000, which is a 40-percent increase.

Now, one might expect more post-acute care as hospital inpatient length of stay declined, but the ProPAC analyses of these changes since the beginning of PPS do not indicate any strong association between changes in the length of stay and increases in SNF service use. So, we are skeptical that the increased use in the nineties is much related to changed patterns of inpatient use.

Let me now turn to home health. That has also increased by an average of 33 percent a year since 1990. That has not been due primarily to per visit payment increases. They have been growing at just 3 percent a year, as shown in chart 5. The principal reason for the escalation of home health spending has been an unchecked growth in the number of visits. Between 1990 and 1995, the number of visits more than tripled. That is due to an increase in the number of beneficiaries using home health services, which doubled from about 5 percent to 10 percent of the Medicare population, and it has also been an increase in the number of visits per user, which has also doubled. In 1990, the average number of home health visits per user was 35, and by 1995, it was 70, as shown in chart 6.

The nature of the home health benefit is also changing. In 1993, nearly half of the visits were for AIDS services, which include the personal care services such as bathing, dressing, and grooming, while in 1988, 5 years earlier, those services comprised only a quarter of the visits.

Now, unlike the SNF benefit, Medicare beneficiaries do not need a prior hospital stay to receive home health services, and, in fact, only 60 percent of the home health episodes in 1994 were preceded by a stay. Also, unlike most other Medicare benefits, home health has no cost sharing.

There has also been a large number of new entrants into home health between 1991 and 1995. The number of agencies grew by 50 percent, primarily proprietary agencies, provide more aide visits and more total visits than other agency types.

There has been wide agreement that we need a system to control this spending growth. Both the Subcommittee and the administration have proposed prospective payment systems to do so. The

Commission strongly supports prospective payment for these services and other providers as well. But this is not an easy task.

As has been alluded to, there are ill-defined coverage policies and very inconsistent policies across sites.

Two of the most important issues in designing a prospective payment system relate to defining the unit of payment and developing a case-mix measure. The most extreme form of aggregation, of course, is an annual capitation payment. Less extreme would be bundling with the hospital admission or an episode payment for just the post-hospital stay.

Those have all a variety of implementation issues, and we believe that a first step would be to move toward an episode of care payment for a particular service such as a SNF admission.

The development of the case-mix measure is critical. The reliable case-mix measures to adjust SNF or home health payments do not now exist, and without that, there will be an incentive to avoid complex patients.

Let me with that, Mr. Chairman, stop and try to answer your questions.

[The prepared statement and attachments follow:]

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good afternoon, Mr. Chairman. I am Joseph Newhouse, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., the Commission's Executive Director. We are pleased to be here today to discuss the development of prospective payment systems for post-acute care, including skilled nursing and home health services. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

Payments to post-acute care providers, including rehabilitation facilities, long-term care hospitals, skilled nursing facilities (SNFs) and home health agencies, are the fastest growing portion of the Medicare program. SNFs and home health agencies account for the vast majority of these payments. Between 1990 and 1995, Part A payments to these two providers more than quadrupled, from $6 billion to $26 billion (see Chart 1). By contrast, the rest of Medicare Part A payments grew only 50 percent over this period. As a result, the share of overall Part A spending represented by SNFs and home health agencies has grown from 10 percent to 22 percent (see Chart 2). This payment growth is becoming an ever larger contributor to the approaching insolvency of the Part A Trust Fund.

The increase in skilled nursing facility and home health expenditures is driven primarily by increases in the volume of services provided. While Medicare has modified its polices over the years to slow the rise in the payment per unit of service, its ability to control the number of services furnished remains elusive. As I will describe shortly, this is due to deficiencies in current payment and coverage policies.

This afternoon I would like to discuss several factors responsible for the growth in spending for skilled nursing facilities and home health agencies. These factors clearly illustrate the need to develop and implement prospective payment systems for post-acute care. Developing such systems is not an easy task, however, and I will discuss some of the problems that must be overcome to develop policies that will slow spending growth, while maintaining access to needed care for Medicare beneficiaries.

SNF Payments

Over the past five years, Medicare SNF payments have grown, on average, 33 percent a year. Medicare pays for up to 100 days of SNF care per spell of illness for beneficiaries who recently have completed a minimum three-day hospital stay and are in need of skilled nursing or rehabilitative services on a daily basis. A beneficiary copayment that is equal to one-eighth of the hospital inpatient deductible begins on the 21st day. In 1996, this copayment amount is $92.

Medicare pays facilities separate amounts for routine services, ancillary services, and capital. Payments for routine services, which include room, board, and skilled nursing services, are based on facility-specific costs subject to national limits based on average per diem costs. Capital costs and those for ancillary services, such as physical therapy, occupational therapy, speech therapy, laboratory tests, and radiology procedures, are reimbursed on a facility-specific cost basis without limits.

Part of the growth in SNF expenditures has been due to increases in the number of Medicare beneficiaries receiving care and the total days of care provided. Between 1990 and 1995, the number of beneficiaries and the total days of care grew at the same rate, about 9 percent a year (see Chart 3). The average Medicare-covered SNF stay was about 27 days in 1994, which appears to have remained relatively constant over this period. This stability may be related to Medicare's SNF copayment requirement, which begins after 20 days of care.

The largest contributor to the SNF expenditure spiral has been the growth in the volume of ancillary services provided during a stay. Unlike routine costs, which are subject to payment limits, payments for ancillary services are virtually unconstrained. For the most part, SNFs are paid their costs for these services subject only to Medicare's "reasonableness" criterion and certain salary limitations for therapists. High ancillary costs also can boost payments indirectly because above-average ancillary service use can be a justification for an exception from Medicare's routine cost limits.

Medicare beneficiaries are receiving more ancillary services during their SNF stays than ever before. It is difficult to precisely quantify the volume of ancillary services that are being provided because facilities are required to report only their charges to Medicare. But between 1990 and 1994, charges for ancillary services grew from 15 to 30 percent of total Part A skilled nursing facility charges.

New providers also have contributed to growing SNF expenditures because many of these facilities are exempt from the routine per diem limits for up to their first three years of operation. This policy was implemented to recognize the start-up costs of new providers. Between 1990 and 1995, there were 4,000 new SNF providers, including both hospital-based and free-standing facilities, raising the total number of SNFs to over 14,000.

Mr. Chairman, routine cost growth has been constrained somewhat through cost limits; for example, these limits were frozen in 1994 and 1995. As a result of these constraints, SNF per diem cost limits rose only 13 percent between 1990 and 1995, from $91 to $103. But, average SNF payments per day more than doubled over this period, from $100 to $265. This was due to increased ancillary service use and the higher routine payments to new providers, as well as capital reimbursement and exception payments above the routine cost limits. As a result, there is a growing divergence between Medicare's routine cost limits and what the program actually pays for each SNF day (see Chart 4).

While one might expect to provide more post-acute care as hospital inpatient lengths of stay decline, ProPAC analyses of these changes since the beginning of PPS do not indicate a strong association between changes in length of stay and increases in SNF service use. Thus, we do not believe the increased use in the 1990s is much related to changed patterns in inpatient use.

Home Health Payments

Medicare home health expenditures also have increased by an average of 33 percent each year since 1990. To qualify for the home health benefit, beneficiaries must be homebound and require skilled nursing services, or physical or speech therapy on a part-time or intermittent basis. If these conditions are met, beneficiaries may also receive occupational therapy, home health aide, or medical social services. Agencies are paid their costs for home health services, subject to limits based on national average per visit costs.

Home health expenditure growth has not been due primarily to per visit payment increases--these payments have been growing at less than 3 percent per year, on average (see Chart 5). The principal reason for the escalation has been an unchecked growth in the number of home health visits.

Between 1990 and 1995, the number of home health visits more than tripled, from 69 million visits to over 252 million visits. This is due to increases in both the number of beneficiaries using home health services and the number of visits each of these beneficiaries received. In 1995, about one-tenth of all Medicare beneficiaries received home health services, nearly double the number of recipients in 1990.

Even more striking is the fact that the number of visits per user also doubled. In 1990, home health users averaged 35 visits per year. By 1995, this had risen to 70 visits (see Chart 6). A growing percentage of home health recipients are receiving more services over longer periods of time. In 1993, 16 percent of home health recipients received 100 or more visits, accounting for 62 percent of all visits in that year. ProPAC analyses also indicate that home health episodes of care are lasting much longer than previously. Between 1990 and 1993, home health episodes of care lasting longer than three months increased from 19 percent to 25 percent of all episodes.

The nature of the home health benefit also is changing. In 1993, nearly half of all home visits were for aide services, which include personal care services--such as bathing, dressing, and grooming--simple wound dressing changes, and assistance with medications. In 1988, these services comprised only a quarter of all home health visits. ProPAC's work shows that very long home health episodes (166 days or more)

are dominated by aide visits, while shorter episodes and those following a hospitalization have proportionately higher skilled nursing and therapy visits.

The recent increases in home health use result from a relaxation of Medicare coverage requirements in 1989, largely in response to a court decision. These revisions enabled more beneficiaries to qualify for the benefit and expanded the number of services each could receive. Unlike other Medicare facility services, there are no limits on the number of days of care that may be furnished, as long as a physician periodically certifies a need for skilled nursing services or physical or speech therapy.

In addition, unlike the SNF benefit, Medicare beneficiaries do not need to have a prior hospitalization in order to receive home health services. In fact, only 60 percent of home health episodes in 1994 were preceded by a hospital stay. Finally, unlike most other Medicare benefits, home health care has no beneficiary cost-sharing requirements.

Access to home health services also is growing as the number of home health agencies increases. These agencies may be hospital-based or freestanding facilities. Between 1991 and 1995, the number of agencies grew by 50 percent, driven by increases in proprietary agencies. Proprietary agencies generally provide more home health aide visits and more total visits than other agency types.

Controlling Post-Acute Care Expenditures

As you can see, Mr. Chairman, there is a pressing need to control post-acute care spending growth. Over the past year there have been proposals put forth by this Subcommittee and the Administration to institute prospective payment systems for both skilled nursing facilities and home health agencies to control Medicare expenditures. The Commission strongly supports prospective payment for these, and all, providers. Payment methods that move away from cost-based reimbursement can slow expenditure growth while encouraging providers to deliver care in the most efficient manner.

As you know, however, controlling expenditures is not an easy task. This is particularly true in the post-acute care arena because, as I have described, much of the growth in post-acute expenditures is related to the number of beneficiaries receiving these benefits as well as the number of services provided. These factors are related to ill-defined coverage policies, especially for home health benefits, that resulted largely from court decisions in the late 1980s. While many of the services provided are presumably reasonable, necessary, and medically appropriate, it is nearly impossible to identify those which are or which are not. In addition certain covered services, such as home health aide visits, provide important supportive services, but generally extend beyond Medicare's traditional coverage of acute care medical benefits. While many, if not most, of these services may be of value to Medicare beneficiaries, it is not clear their value is commensurate with their additional cost to the Medicare program.

Further, coverage and payment policies must be considered in the context of all the settings where post-acute care may be delivered. There is a large overlap in the types of services that SNFs and home health agencies deliver. Other facilities, such as rehabilitation facilities, long-term care hospitals, and ambulatory facilities, also provide many of these services. A recent ProPAC analysis examined the use of post-acute providers by individuals hospitalized with the same diagnosis-related group (DRG). For those DRGs in which a significant share of the patients used post-acute care, utilization was spread across provider types. One-quarter of beneficiaries hospitalized with a hip fracture (DRG 209), for example, used only home health care, while almost 20 percent went to a SNF (see Chart 7). An additional 20 percent of beneficiaries used two or more post-acute care providers.

The choice of a post-acute provider is affected by several factors, including patient needs and provider supply. It is very likely that Medicare payment polices also affect these choices. To the extent that payments are constrained in one setting, care may be shifted to other settings thereby increasing overall Medicare spending. Actions by providers faced with payment limits also could result in beneficiaries

receiving additional services. For example, a prospective, episode-based payment system for post-acute care only could increase the incentives for a patient to be discharged from a hospital to a skilled nursing facility for period of time, then subsequently be referred for home health services.

The Commission believes that payment methods and incentives should be consistent and coordinated across all delivery sites. For several years, HCFA has been sponsoring research and demonstration projects to develop prospective payment systems for post-acute services. 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.

Prospective Payment Systems

Two of the most critical issues in designing a prospective payment system relate to defining the unit of payment and developing a case-mix measure.

Establishing an appropriate unit of payment is critical to controlling the volume of services provided. Ideally, this unit should include all of the services associated with a full episode of care. In the hospital inpatient setting, for example, hospitals receive a payment for each admission to cover all of the services provided during that admission.

An annual capitation amount that covers all medical care for a person, such as used to pay managed care plans, is the most comprehensive unit of payment. Evidence indicates that such an all-inclusive payment is associated with different patterns of post-acute care use. A ProPAC analysis of state per capita Medicare spending showed that in states with high managed care penetration, skilled nursing facility services were used slightly more than the national average and home health services were used much less. Less extreme than a per capita amount for all services would be an episode-based payment that would cover all post-acute services or all services associated with a hospital admission. Given the difficulties in implementing this type of approach quickly, however, separate episode payment mechanisms for each type of post-acute facility is a more feasible alternative at the present time.

Currently, SNF and home health agency payments are subject to per day or per visit limits. Simply moving to a prospective per diem or per unit payment system, however, would do little to control the increase in the volume of services. In fact, it could encourage providers to increase the number of SNF days of care or home health visits unless related policies were implemented to control volume.

As a first step, the Commission believes that prospective payment should cover all of the services furnished over an appropriate episode of care, such as a SNF admission. For example, a prospective payment for SNFs should include routine and ancillary services, as well as capital. In general, the more services that are covered under a prospective rate, the stronger the incentives for providers to appropriately manage the mix of services a patient receives. Defining an appropriate episode for home health is more difficult because it is harder to establish when treatment begins and ends. As I have described, for some beneficiaries, home health care involves primarily supportive services furnished over many months or even years.

Eventually, Medicare could consider bundling the payment for post-acute care with the payment for inpatient hospital care. While this approach raises the problem of which entity should receive the payment, it could provide Medicare with greater control over total expenditures for an episode of care and might ensure that beneficiaries receive a continuum of care in the most appropriate settings. This solution would be most effective in controlling SNF expenditures because beneficiaries must have been hospitalized prior to receiving SNF services. By contrast, this solution alone would not affect spending for the substantial number of home health users who do not have a prior hospitalization.

While possibly the best course of action, prospective payment for an episode of care, with or without a link to hospital payment, is not without its shortcomings. While

fee-for-service payment methods provide incentives to increase the number of services furnished, episode-based systems contain incentives for providers to reduce care. Without an appropriate measure of resource costs for each episode that reflects an individuals' needs, such a system also could also encourage providers to seek out the least complex patients. A case-mix measure is frequently used to match the relationship between resource costs and patient needs.

A case-mix measure is necessary to ensure that the per episode payment reflects the resources necessary to provide care appropriately while, at the same time, encouraging efficiency. Payment rates that do not accurately reflect appropriate resource use have the potential to either increase expenditures if they are too high or reduce access to care if they are too low. In the hospital inpatient setting, hospitals receive a payment for each admission that varies depending upon the diagnosis-related group (DRG) to which the patient is assigned. The DRG payment rates are based on individual patient characteristics and estimated resource use.

Currently, a reliable case-mix measure that could be used to adjust SNF or home health payments does not exist, although HCFA has been actively conducting research in this area. In the hospital setting, a patient's diagnosis is used to predict resource use. It is not as useful in the post-acute care area, however, because patient needs vary widely, even for those who share the same diagnosis. A case-mix system that differentiates patients based on their functional needs, cognitive limitations, and social situation may better predict resource need.

Certain research initiatives categorize patients according to the intensity of services they receive in a post-acute setting, such that patients who used more services would be presumed to have needed more resources. A payment system that relies on this type of case-mix adjustment, however, contains incentives for providers to increase the volume of services they provide to receive higher payments regardless of the needs of the patient. Nonetheless, as I will discuss in a moment, such a payment system may serve us well in the interim as we develop appropriate measures. Such measures correlate resource use with functional needs, such as the ability to perform certain activities associated with daily living. In this way, the complexity of the patient, and coordinated payment rate, would be based on objective criteria that are not associated with service use.

The need to develop a robust case-mix measure for post-acute care services as soon as possible cannot be overemphasized, Mr. Chairman. In the meantime, however, other mechanisms must be implemented to help constrain service use. For SNFs, these payment constraints should focus particularly on ancillary service use, which is a significant contributor to current growth. One approach that I find attractive is to transition from today's policies to a full episode-based system. For example, during the transition, payments could be based on a mix of per diem payments or per visit payments and a portion of a full episode payment. Over time the proportion of the payment that is episode-based could be progressively increased. A transition would allow time to collect data and to improve the case mix measure, as well as to modify other policies if the need arises.

Other Policy Considerations

While PPS may help constrain post-acute expenditures, alone it may not overcome increased expenditure growth associated with increases in volume, particularly the rise in the number of beneficiaries using these benefits. The lack of clear and enforceable coverage requirements opens the door to continued increases in SNF admissions, particularly where PPS payment policy encourages hospitals to discharge patients as early as possible.

The Medicare program has even less control over the appropriate use of the home health benefit. The lack of a prior hospitalization requirement, the rise in the number of home health agencies, and the ease of receiving services at home could substantially increase the number of beneficiaries receiving this benefit from the current level of 10 percent.

While the Commission supports episode-based payment systems, I personally continue to be concerned, especially with regard to home health, that an episode

system provides very strong incentives for agencies to admit new individuals that require only a small amount of care. Without proper controls or adjustments, agencies could reap windfall payments. Although I don't have a good solution for this problem at the moment, I believe it must be addressed, and ProPAC would be happy to continue to work with you and your staff on it.

The Commission also believes that implementing a cost sharing policy for home health services, just as there is for virtually all other Medicare benefits, would help to constrain service use that is marginal medical value. The Commission has recommended that any copayment policy, however, should be subject to annual limits such that access would not be restricted inappropriately.

Mr. Chairman, I am aware that the issue of Medicare's presumptive waiver of liability policy has been brought to the attention of the Committee. In general, Medicare does not pay providers for claims they submit for services that are not covered by the Medicare program. Medicare, however, has paid for some of these denied claims if they were denied because they were determined to be not medically reasonable and necessary and the provider could show that it did not know or could not have known that the services were not covered.

For a number of years, both home health agencies and SNFs automatically received payments for denied claims if the number of these claims were below a certain threshold, 5 percent for SNFs and 2.5 percent for home health agencies. Agencies that have claims below this threshold were presumed to not have known that the claims were not reimbursable. This presumptive waiver of liability expired in 1995, but some would like this policy reinstated.

The continued need for this policy is questionable. It was introduced during a period when implementation of coverage rules was stringent but inconsistent, and facilities faced uncertainty. The rules that were in place at that time are no longer in force, and as I noted there are now few limits on coverage. This policy also relieved providers of the responsibility to ensure that all the services they provide are appropriate and reimbursable under Medicare. Given the dramatic increases in the use of post-acute services, the need to reinstate the presumptive waive of liability should be considered carefully.

Conclusion

Mr. Chairman, payments for post-acute care services, particularly for skilled nursing facilities and home health providers, are growing at an unsustainable rate. Completing necessary research and implementing well-designed, case-mix adjusted, prospective payment systems for all post-acute providers must be given a high priority. ProPAC is continuing work in this area, and we look forwarding to working with the Subcommittee as you seek to improve and preserve the Medicare program.

This completes my formal testimony, Mr. Chairman. I would be pleased to answer any questions from you or other members of the Subcommittee.

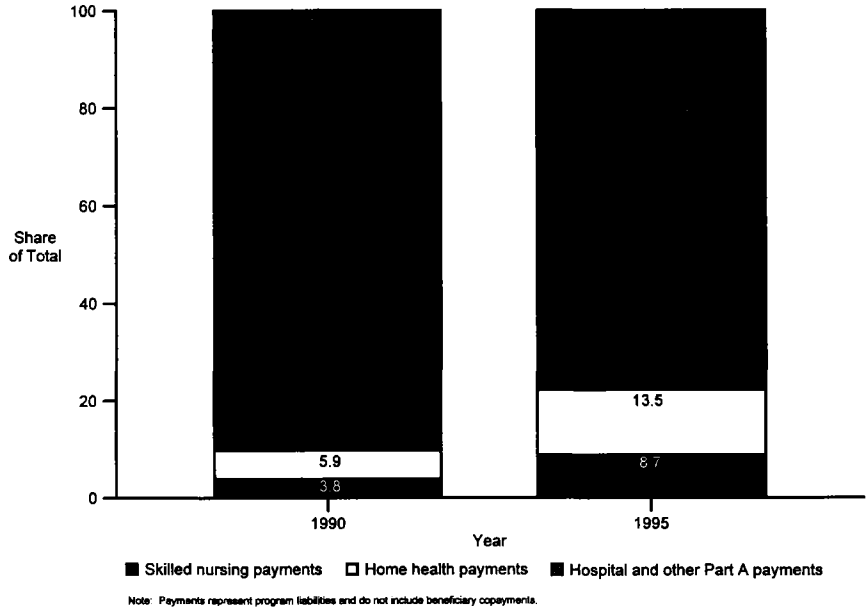
Chart 1. Medicare Skilled Nursing Facility and Home Health Agency Payments, 1990-1995 (In Billions)

Year	Skilled Nursing Facility	Home Health Agency
1990	$ 2.5	$ 3.9
1991	2.9	5.7
1992	4.5	8.0
1993	6.4	10.4
1994	8.3	13.6
1995*	10.3	16.2
Average Annual Increase	33%	33%

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 2. Medicare Skilled Nursing Facility and Home Health Agency Payments as a Share of Total Part A Payments



Note: Payments represent program liabilities and do not include beneficiary copayments.

Chart 3. Medicare Skilled Nursing Facility Payments and Use, 1990-1995

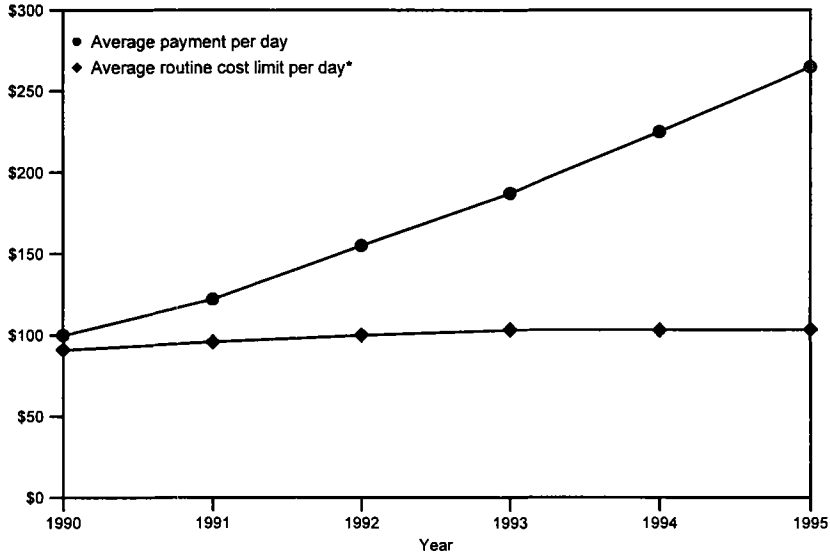
Year	People Served	Days (In Millions)	Payments Per Day
1990	638,000	25.1	$100
1991	671,000	23.7	122
1992	785,000	29.0	155
1993	908,000	34.3	187
1994	945,000	36.9	225
1995*	990,000	38.8	265
Average Annual Increase	9%	9%	22%

Note: Payments are incurred Part A expenditures rather than outlays and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 4. Medicare Average Payment Per Day and Routine Cost Limits, 1990-1995



* Estimates based on rates effective on the first day of each fiscal year.

Chart 5. Medicare Home Health Agency Payments and Use, 1990-1995

Year	People Served	Visits (In Millions)	Payments Per Visit
1990	1,940,000	69.5	$56
1991	2,223,000	100.2	56
1992	2,523,000	135.6	58
1993	2,868,000	169.4	61
1994	3,325,000	221.9	60
1995*	3,615,000	252.3	63
Average Annual Increase	13%	29%	3%

Note: Payments are incurred expenditures rather than outlays and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 6. Medicare Home Health Visits Per Person Served, 1990-1995

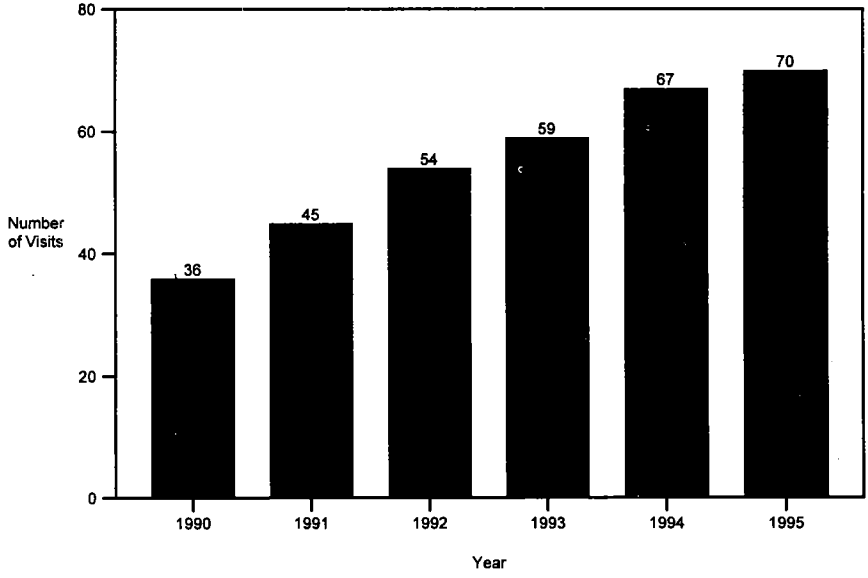


Chart 7. Post-Acute Care Provider Use Within 30 Days of PPS Hospital Discharge, Selected DRGs, 1994

Provider	Beneficiaries (In Percent)		
	DRG 209[a]	DRG 14[b]	DRG 471[c]
Skilled nursing facility only	18.8%	19.8%	12.3%
Home health agency only	25.5	12.3	23.1
Rehabilitation facility only	8.6	9.5	14.7
Long-term care hospital only	0.3	0.5	0.4
More than one	20.4	9.2	29.9
None	26.4	48.7	19.7

Note: DRGs were assigned during PPS hospital stay. PPS = prospective payment system. DRG = diagnosis-related group.

[a] Major joint and limb reattachment procedure of lower extremity.

[b] Specific cerebrovascular disorders except transient ischemic attack

[c] Bilateral or multiple major joint procedures of lower extremity.

Mr. MCCRERY. Thank you, Mr. Newhouse.

Dr. Young, did you want to add anything before we go on to questions?

Dr. YOUNG. No.

Mr. MCCRERY. Well, as you pointed out in your testimony, there are probably more questions than answers, at least right now. However, we all acknowledge that we have very little time to come forward with some solution to try to constrain the growth of cost.

I wonder if you might give us some idea of the difficulty, though, that we face by going through for us a common example of someone seeking post-acute services and the various alternatives that they have, say somebody that gets a hip replacement and then he wants to choose some form of post-acute services. Just go through for us the different options that that person has and describe the various reimbursement options.

Mr. NEWHOUSE. I am glad you picked that example, Mr. Chairman, because if you look at chart 7, we have the data on exactly how Medicare beneficiaries with hip fracture sort themselves out across alternative settings. You will see that just under a fifth use a skilled nursing facility; about a quarter use a home health agency; a little under 10 percent use a rehabilitation facility. Those percentages are people that use only those facilities. A fifth use more than one, and a quarter use none of the above. So, this really makes the point very nicely that people who need these services may get them in a variety of settings and the need to try to keep payment policy neutral toward what setting is used.

As I said in my written testimony, if we do something for just one service, we run the danger that we will artificially push people toward another site of care for these services.

Mr. MCCRERY. Given that wide range of choices, as we go through this exercise of trying to develop a prospective payment system, what should our goals be? And what do we want to accomplish?

Mr. NEWHOUSE. Well, in the larger sense, of course, we want to deliver an appropriate set of services in an efficient way. One of the problems in this area is that there is little agreement on what constitutes appropriate services, as Bruce Vladeck said.

There is also disagreement on who is eligible for those services or some ambiguity about who is eligible.

An episode payment gives an incentive to be efficient in delivery of care. Unfortunately, it also gives some incentives to offer care to beneficiaries that might not have been receiving it before. For example, if we take the home health visit rate of 70 visits per person and we say that is what we will base an average episode payment on, and I now have a person that could use a relatively small number of visits following some relatively short stay, maybe now that person is not getting any, but now I have a strong incentive to offer that person a few visits and collect a fairly large episode fee.

It is for that reason that I suggested in the testimony that we consider a mixture, at least during the transition, of a partly episode-based payment and a partly visit-based payment, or at least a payment that moved partly with the number of units of service. This is now me speaking personally rather than for the Commission.

Mr. MCCRERY. OK. Thank you.

The gentleman from California.

Mr. STARK. I am looking at a couple of instances, Mr. Newhouse. We hear today that hospital-based SNFs cost more than freestanding SNFs. There is, however, a State of Florida study that shows that Florida hospitals send sicker and older patients, and presumably less profitable, out to the freestanding SNFs and keep the healthier patients for themselves.

Do you think problems like this are just occasional and anecdotal at best? Or do you think that as we have different payment systems for all these different entities, that a certain amount of—I hate to use the word "gaming" because people like to maximize their returns, but there is a certain amount of learning that the people who manage care can figure out and use to maximize their returns. Is this a problem that we ought to look at, or is it just an occasional result of local custom?

Mr. NEWHOUSE. I do not have an answer for that question. I do believe, Don may be able to correct me, that the length of stay-in hospital-based SNFs, if we go back and we look at the preceding stay, was shorter than in the freestanding SNFs. Is that correct?

Dr. YOUNG. That is right.

Mr. NEWHOUSE. The problem is trying to disentangle whether the hospital-based SNFs have shorter preceeding hospital stays because they are substituting days in the hospital for days in the SNF or whether there really is a different case mix that is coming out. At least as I read the existing data, we do not know how to disentangle that. It goes back to the issue of trying to develop some kind of case mix adjusters for any kind of episode-based system.

Mr. STARK. Well, I think that is where—Dr. Young, is not—the closer we get to a universal bundled payment, in my opinion, the sooner we will get to a fairer payment structure. Is that possible, in your opinion?

Either one, both. Is it possible to take an appendectomy or a hip replacement and say, we'll bundle the whole thing—surgery, anesthesiology, hospital, SNF, rehabilitation, the whole ball of wax—and then let the providers duke it out as to who's going to be the manager, the physician, the hospital, the insurance company? I mean——

Mr. NEWHOUSE. In one sense we have the extreme of bundling now in the at-risk side of Medicare and that bundles it all. As for bundling hospital admission in traditional Medicare, a very important question is, what that would do, within DRG variation in payments or dispersion. As you know, one of the goals of the DRG system is to try to minimize variation and have a fixed payment for a relatively homogeneous person.

I have not seen the recent data showing how that would be affected. I hope that we can do that as a part of our analysis this year.

Now, one safety valve on the existing system would also have to be modified which is the outlier system. At least I think it would have to be rethought a bit if we were going to bundle in post-acute.

Finally, on the home health side, 40 percent of the episodes come without any qualifying hospital stay. So, we can not bundle that part of it.

Mr. STARK. But do they come with the recommendation of a physician?

Mr. NEWHOUSE. Yes. That's required.

Mr. STARK. That must be a result of some diagnosis, some CPTD coding. The physician is not doing that for free. They are coding an office visit, a phone visit, or a nursing visit, some visit that leads to the recommendation of the home health care, right?

Mr. NEWHOUSE. Yes.

Mr. STARK. And, if you put the physician at some risk financially in that decision, they might pay a little more attention to how many home visits are made. Does that seem logical?

Mr. NEWHOUSE. Yes, or put somebody at risk, yes.

Mr. STARK. Besides the taxpayer or the patient.

Thank you.

Mr. MCCRERY. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Newhouse, you made a comment that I wanted to explore. You said that no data shows length of stays at hospitals being reduced, even though the increased use of SNFs has gone up significantly, as well as the cost.

It is my general understanding that the increased use of SNFs and home health care had reduced the stays at hospitals and I wanted to have you elaborate on that.

Mr. NEWHOUSE. The issue here is, you are certainly right that length of stay in hospitals has trended down over time and, as I have said, use of post-acute care has trended up.

What I meant to say was if you looked at the year-to-year changes over the last 12 years or so, there's not much association. In other words, in the years when length of stay falls more, it's not that post-acute increases more.

Mr. CHRISTENSEN. OK, well, just so I am clear where you stand. Because you said earlier that there was no data that showed the length of stay had gone now, and now you just said that it has trended down.

Mr. NEWHOUSE. No. I am sorry, if I said that, I misspoke. The length of stay has certainly gone down, there's no question about that. The only issue is when you try to correlate the timing and the decreases in length of stay which vary from year to year.

Mr. CHRISTENSEN. That's a major difference in statement. I appreciate your clarifying that for the record.

Thank you.

Mr. MCCRERY. The gentlelady from Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman.

In estimating the effect of PPS proposals for home care, CBO assigned a two-thirds discount against potential savings because of the potential for providers to give the intended savings. In other words, they discounted by two-thirds on the theory that the industry would be able to give away two-thirds of the savings advantage.

What's your opinion of such a budget estimating policy? This is just their policy. They do not tell us what facts it's based on but CBO just uses that two-thirds knockdown discount against potential savings. In my experience and in talking with my home health care providers, there's simply no justification for that. What is your opinion of that?

Mr. NEWHOUSE. Well, I think any estimate would be very uncertain but I am not sure what CBO had in mind. But if I were interpreting it, I would guess they were worried about the same thing that I was pointing to which is the possibility that you would introduce a number of new episodes that you're now not seeing with relatively small use.

Some people worried, at the time we introduced the hospital prospective payment system, that admissions would increase a lot from people that were only marginally necessary to be in the hospital. That did not really happen. And it might not happen here either. Probably the controls over the admission to the hospital were better than they would be over who would get home health services.

Mrs. JOHNSON. Have you done no study at all? It seems to me that when we redefined acute care and purposely shortened the stay in hospitals that you would have had in place some ability to oversee whether the home health care services being provided were appropriate.

Mr. NEWHOUSE. Well, part of the problem here is the definition of what is regarded as appropriate. There is much less medical consensus about that then there was, in the hospital stay. But you know, again, 10 percent of the beneficiaries are now getting home health care services or another way of saying that, obviously, is 90 percent are not and I think the issue in the CBO discounting, as I understand it, it is how many, if any, of those 90 percent would start to receive home health care services.

Mrs. JOHNSON. So, you do not have any data on appropriateness?

Mr. NEWHOUSE. No. And, it would be very hard to get any data because we have not paid on this basis before. I just do not know where data would come from. That's why there's a lot of uncertainty in the estimates. CBO presumably has some basis for their estimates, I do not know what it is.

Mrs. JOHNSON. Well, if you were discounting for a volume increase, can you give me some rough idea of what you might discount?

Mr. NEWHOUSE. To be frank with you, I have not thought about it very much and when I have, I have just decided it's too hard. I do not have any real data to do it with.

Mrs. JOHNSON. Well, it is being done and if you give it some thought and give me an idea of what you would think about and what you think the percentage might be. We are really stuck because we have this arbitrary situation and it means that the proposals that come from the industry are simply, in a sense, not reviewed carefully. That is not reasonable because we have agencies that have done some remarkable things to control volume and cost and, have some hard evidence. It means that that hard evidence is not considered.

I do want to ask you one other larger question. What are your thoughts on the feasibility and desirability of taking an integrated or a site-neutral approach, a more comprehensive approach to designing Medicare payment policies for post-acute care?

What I mean is, we are finding that if you merge Medicare and Medicaid long-term care payments and presumably if we begin to see home care payments differently, what we really ought to be de-

signing is a far more flexible post-acute care capability that has built into it both quality assurance and appropriateness of care indicators.

It is going to be increasingly hard for the government to decide which is cheaper, home care, long-term care, or going into a hospital for a few days. We have a very hard time allowing the most appropriate setting to be deciding what is reimbursed. And, have you given any thought to a far more integrated system?

Mr. NEWHOUSE. I think that's the direction we ought to be headed in, but it ultimately raises the issue of integrating with the Medicaid benefit, which, obviously raises a whole host of issues.

Mrs. JOHNSON. But you ought to be looking at those, too. Just because you work for us, they're all integral and they serve the same population. So, we really need help on a more integrated approach.

Thank you.

Chairman THOMAS [Presiding]. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I would like to revisit this issue, Mr. Newhouse. I was looking over your written statement and then I also saw in here similar statements to what you said earlier. I also want to ask, though, should we consider rebasing the DRG payment, in light of reduced lengths of stay at hospitals? Would that show an effect with the SNFs in terms of looking at this data?

Mr. NEWHOUSE. I am not sure it would, that simply rebasing would do very much to the SNF payment.

Mr. CHRISTENSEN. But in light of the increased use of SNFs should we look at, and the reduced——

Mr. NEWHOUSE. I understand what you're asking. I think the issue is more or less rebasing than it is just the amount of the update factor every year. That is as length of stay falls—now it becomes rebasing if it falls differentially by DRG—but as it falls more, kind of across DRGs, are we updating the payment rates in an appropriate way to take account of that fall.

We have made recommendations, over the years, for update factors that are based on such things as the productivity increase and the amount of case-mix index that is thought to be coding changes and so on and so forth.

By and large, the Congress has enacted update factors that, while not always identical with our recommendations, have been very close to them. And, so, my answer is that I think the updates have been about on target and that we have probably have taken down or raised them at a rate that was appropriate. And, therefore, in effect, this substitution has been taken into account.

Now, it's possible that that has not been done quite right, DRG by DRG. But we do adjust periodically the DRGs, so, in the relative rates, that should be picked up over time as well.

Mr. CHRISTENSEN. What kind of new data would you need to reexamine this issue?

Mr. NEWHOUSE. Well, there are some things that are very hard to adjust because they are very uncertain, such as, the amount of technological advance. The only factor I can point to that we could have better data on, on the hospital side, would be the amount of

coding change. Where we should redo some of the studies that were done about 10 years ago.

Mr. CHRISTENSEN. OK. I would like to get Dr. Young's answer on this question.

In your testimony it states that the ProPAC analysis of these changes since the beginning of PPS do not indicate a strong association between the changes in length of stay and increases in SNF service use. Thus, we do not believe that the increased use in the nineties is much related to change patterns in in-patient use.

Would you continue to stand by that statement or do you believe that the SNFs increased in use has reduced some of the hospital stays?

Dr. YOUNG. The first thing we did was to ask the question, is there a relationship at any period of time? So, we looked at length of stay changes from the beginning of PPS, 1984 through the current time.

The second thing we did was to look at the growth in SNF spending and home health spending. Since 1984, the beginning of PPS length of stay started declining rapidly at that time, until 1988 or 1989 there was no substantial change in either SNF or home health spending with dramatic declines in length of stay. So, simply looking at it temporally, over time, there was no relationship.

The growth in home health and SNF started in 1989/1990 in association with the class-action lawsuits that Mr. Vladeck talked about and changes in HCFA's coverage policies. Thereafter, spending grew very rapidly while length of stay continued to decline.

So, looking at it timewise, there was no association. The second thing that we have done over time is provide you with recommendations for annual update factors. The recommendations you have enacted have been close to our recommendations, overall slightly lower then our recommendations. In those recommendations, and implicit in your annual update factor has been a productivity adjustment. The productivity adjustment accounts for changes in how hospitals operate including changes in length of stay.

In our early years, in fact, our update included what we call the site-of-care substitution to account for these kinds of factors.

The bottom line is, therefore, I personally believe that, while you can argue around the margin, what you're paying hospitals is what you believe is an appropriate amount that incorporates the declines in length of stay that we have all observed. And that, the spending growth that's going on for SNF and home health is, indeed, related to those changes in length of stay but that the extra money, if you would, has already been taken out of the hospital through the annual updating process and you would gain nothing further by rebasing the rates.

Mr. CHRISTENSEN. Thank you, Dr. Young.

I am anxious to hear the following witnesses and their take on that same area. So, thank you Mr. Chairman

Mr. MCCRERY. They may have a different view.

Chairman THOMAS. Thank you.

I am not going to go through a series of questions because the other panel members, I understand, have done a good job in inquiring of you and getting the kind of information that we are looking

for. I do not mean to pursue something that's going to get a lot of people worried but we've been having these lunches with CRS and going into background information for staff and members because, frankly, some of this is quite complicated and has a specific history and if you do not understand that, it's hard to understand where we are now.

I have been blessed with that ignorance to a certain extent, so, I do not have to assume the obvious. I can actually ask questions. We were looking at home health care and SNF financing and the history of it several weeks ago with a number of experts.

One of the things I think that is somewhat self-evident but that there is evidence to show it clearly is that, to a very great extent and almost in its entirety, these two industries have been created by the government payment structure. I think evidence for this is that we had a researcher on loan and she said, on a different contract unrelated to what we were talking about, they had occasion to examine the skilled nursing facility area and found out that in the highest percentage of private pay, in any of the structures they were looking at, it was something like 5 percent or less.

So, clearly, we're looking at a 95 percent-plus government payment structure. And, obviously on the home health care, not only is it related to the DRGs but growth areas and, with very creative and talented people, not that the number of visits does not provide better quality and certainly quantity, but the fact that you pay for it might also have some connection to what they do and that's why we are here.

All that being said, what I am saying is to a very great extent, as far as I am concerned, these two industries were created by the government's willingness to pay in the way in which they paid. And, to the degree that HCFA and you folks look at ways of modifying the way that we're paying, you're not changing the game.

And that, I am wondering to what extent—going back to those original questions of a prospective payment system or doing away with some of the differences that are becoming more and more artificial on the basis of pay—as systems change, focusing on the beneficiary and creating a continuum of care drawn on, the basis of the needs of the patient rather than the payment structure from HHS, would give you a far better cost return than the current system or some of the suggested modifications of the payment system.

Now, I know that we have had hearings on the PACE and the others. Where are we in terms of fundamentally rethinking what we have created by virtue of the payment structure, that will not go away if we modify the payment structure, but rather fundamentally rethinking the way in which we approach beneficiaries and their needs?

Mr. NEWHOUSE. Well, I think your comments are right on target.

Chairman THOMAS. Except it's going to take 10 years to——

Mr. NEWHOUSE. That's the problem. I heard Congresswoman Johnson say we need a comprehensive system and I agree with that. And then, I heard her say, we need it now and I agreed with that but I can not really get there from here.

We just do not have the kind of case mix adjusters that we would like for this system.

Chairman THOMAS. Now, just stop right there, Mr. Newhouse.

Mr. NEWHOUSE. OK.

Chairman THOMAS. Because I want to pursue this for just a minute.

Mr. Cardin said and Mr. Vladeck agreed we ought to go ahead with changes in the areas that we can reach an agreement. Is the fact that we do not have a risk analysis model, that we do not have case-mix models, is that because it's simply not possible to do or is it because we've never, ever stressed the basics? The collection of data, with full protection in terms of individual's privacy, allows us to get a far broader look at what's going on, and as part of the receiving of payments from the government, a willingness to share data from any kind of a structured model out there, whether it be the fee-for-service or managed care or whatever—it seems to me if we had the ability, had committed ourselves to that fundamental agreement, to collect the data and begin to profile sooner, we would be closer to where we need to go.

Until and unless we do that, we still have significant holes in any kind of a structure that we create, including demonstration projects that are based upon that incomplete data. So, wouldn't the first step be as fundamental a collection of as broad a base data as we can get?

Mr. NEWHOUSE. Absolutely. And, you see that there's a strong recommendation to that effect in my testimony. The problem is that still does not help with the immediate future.

Chairman THOMAS. I understand.

Mr. NEWHOUSE. It's actually for that reason that I suggested a blend, where we kind of put a toe in the water, as it were, with an episode system that was not very well risk-adjusted, because it could not be, and a blend of that with some measure that also took account of use.

As we learned more, we could up the amount of weight in this blend on the episode-based payment.

Chairman THOMAS. I guess if you never begin, you never begin and the downside is if you think things can get worse, they can.

Mr. NEWHOUSE. Sometimes they can get worse even without your thinking they're going to get worse.

Chairman THOMAS. I think that's what happened over the last year.

I want to thank both of you for your continued commitment to try to provide us with the best tools available and I think we may need a couple of private sessions just to keep us up to speed as to where we might make the most meaningful changes, notwithstanding the climate, in which change is trying to be made.

Mr. NEWHOUSE. We're hoping to be of use to you as we go down the future path.

Chairman THOMAS. You have been and we appreciate that. Thank you very much.

Mr. NEWHOUSE. Thank you, Mr. Chairman.

Chairman THOMAS. I ask the next panel to come forward.

The panel consists of Stephen Holt, president and chief executive officer, Visiting Nurses Association of Greater Philadelphia; Margaret J. Cushman, president, VNA Health Care, Incorporated, from Hartford-Plainville, Connecticut; and Phillip I. Hoffman, chief financial officer, Outreach Health Services, Austin, Texas.

Mrs. JOHNSON. Mr. Chairman.

Chairman THOMAS. The gentlewoman from Connecticut.

Mrs. JOHNSON. While the panel is assembling, I would like to welcome Peg Cushman here. She has been one of the bright minds in home care services in our area and runs an outfit that has been very creative in both controlling costs and assuring quality and she still provides services to areas in which security is a very big issue and one of the few agencies in all of Connecticut that does that. She has been a real leader both in Connecticut and nationally and I am very pleased to have her with us today.

Chairman THOMAS. I want to thank all of the panelists for being with us. Any written testimony that you may have will be made a part of the record and you can inform us in the time that you have in any way that you see fit, beginning with Mr. Holt and then we'll move across the panel.

STATEMENT OF STEPHEN W. HOLT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSES ASSOCIATION OF GREATER PHILADELPHIA, ON BEHALF OF THE HOME HEALTH PPS WORK GROUP

Mr. HOLT. Thank you, Mr. Chairman.

My name is Stephen W. Holt and I am the president of the Visiting Nurses Association of Greater Philadelphia, which is one of the largest and oldest, not-for-profit providers of home health services in the country. In fact, we provided home health care services to patients in Philadelphia for 79 years prior to the inception of the Medicare Program. We are celebrating our 110th anniversary this year.

Thank you for the opportunity to speak to you today. I am also providing this testimony on behalf of the Home Health Prospective Payment System Work Group which is a coalition of 20 State and national home health associations dedicated to the prompt implementation of a prospective payment system for home health services under the Medicare Program, and one which provides incentives for high-quality services to be furnished in a cost-effective manner.

The Prospective Payment System Work Group includes representatives of all types of home health providers—nonprofit, proprietary, hospital-based, and free standing—from every region in the country and we have been working for over 18 months with Members of Congress and the administration on the development of prospective payment system as a substitute for copayments and bundling.

The Work Group is united with the National Association for Home Care on the following issues. We support prompt enactment and implementation of "The Revised Unified Home Health PSB Plan." We oppose copayments and bundling and we oppose the shift of home health coverage to part B of the Medicare Program.

The Prospective Payment System Work Group came together at the end of 1994 in response to a challenge issued by Members of Congress that if we did not believe copayments were sound public policy then the home health industry should come up with a better alternative. We accepted that challenge and began to work together with State associations to do so.

We consulted with and received encouragement from HCFA and we worked on a concentrated and continuous basis with both Republican and Democratic Members of Congress and the Subcommittee. We briefed White House staff and kept them apprised of the status of the plan's development. We also worked with the National Association of Home Care to make modification to the plan which would permit unified industry support.

The joint efforts of the Prospective Payment System Work Group and the National Association resulted in the unified industry PPS plan which served as the model for the Home Health Prospective Payment System which was passed by both houses of Congress as a part of H.R. 2491. Unfortunately that plan contained several flaws which were inserted in response to last-minute changes in scoring, among them the 45-day gap in service.

In addition, the HCFA raised concerns that the congressionally passed plan was too complex to be implemented by the effective date contained in the legislation. Accordingly, the prospective payment work group has worked intensively with NAHC over the past 7 months to develop the Revised Unified Prospective Payment System Plan which eliminates the flaws of the early legislation and addresses HCFA's implementation concerns.

We believe that the PPS plan that we have here is far better public policy than copayments for the following reasons. One, the PPS plan provides the mechanism for reducing the rate of growth in Medicare expenditures for home health services while preserving the opportunity for clinical decisions to be made by patients, physicians and providers based on medical necessity.

Two, the PPS plan creates incentives for home health agencies to become more cost-effective and efficient and rewards those that do.

Three, the PPS plan achieves true savings to the health care system.

Four, the PPS plan will reduce administrative costs, both for providers and the government, thereby, helping to preserve home health care as a low-cost treatment option.

Five, the PPS plan significantly reduces the opportunities and incentives for fraud, waste and abuse.

And six, the PPS plan has broad industry support. Never have I seen in my years in home care such collaboration among so many different groups and associations of the industry and never before have I seen them sign onto a plan which will affect every single home health agency in the United States.

By contrast, copayments curtail access to services regardless of medical necessity. They create no incentive for cost-effectiveness or efficiency. They shift a portion of the current inefficient system to patients and they increase administrative costs due to more complex billing.

They will not reduce and could increase the opportunities in the centers for fraud and abuse. And copays, too, are uniformly opposed by the industry and consumer groups.

We also believe the administration proposal to impose a prior hospitalization requirement on part A coverage and shift the bulk of the home health benefit to part B is seriously flawed for the following reasons.

It will add cost and confusion to the benefit because parts A and B have different billing, administrative, and appeals processes. It will reduce the value of the part A health benefit without any corresponding reduction in FICA taxes, which are earmarked for that benefit.

It will require Medicare beneficiaries, who have already paid for that coverage through FICA contributions, to pay for it again through taxes on fixed incomes, and we believe it is an accounting gimmick that does not result in true savings for the Medicare budget or the budget as a whole.

The industry is concerned it will leave the benefit vulnerable to a 20-percent copayment which applies to most part B services. Rather than further considering solutions such as copayments or the part B shift, we believe it is time to get on with implementing PPS for home health care.

This Subcommittee expressed its intent in OBRA 1987 and 1990 that home health reimbursement should be switched to PPS. After nearly 10 years with no progress, it is clear that we will never have a prospective payment system for home health unless it is especially mandated by Congress.

The Revised Unified Prospective Payment System Plan achieves significant savings, provides incentives for appropriate utilization and efficiency, and avoids curtailing access to medically necessary services. It also has extremely broad industry support.

We believe the home health industry has answered what you have challenged us to do and have answered the challenge and developed a better alternative to copayments and we ask that you and the president now do your part and enact and sign into law the Revised Unified Home Health Prospective Payment System Plan.

I would just like to add one thing. Mr. Vladeck did mention that he would like more information from the home care providers than he is currently receiving in order to move forward with PPS and we would certainly be willing to meet with he or his staff to determine what this additional information is.

Thank you very much for your attention.

[The prepared statement and attachments follow:]

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to the Prompt Implementation of Medicare Prospective Payment for Home Care

HEARING BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH

1100 Longworth House Office Building
Tuesday, July 23, 1996

Medicare Payment Policies for Home Health Agency and Skilled Nursing Facility Services

TESTIMONY OF STEPHEN W. HOLT

Mr. Chairman, my name is Stephen W. Holt. I am President and Chief Executive Officer of the Visiting Nurse Association of Greater Philadelphia, which is one of the largest and oldest not-for-profit providers of home health services in the country. We have been providing a comprehensive range of high quality home health services to citizens in the Greater Philadelphia area for more than 100 years.

I am also providing this testimony today on behalf of the Home Health PPS Work Group, which is a coalition of 20 state and national home health associations dedicated to the prompt implementation of a prospective payment system for home health services under Medicare that provides incentives for high quality services to be furnished in a cost effective manner. The PPS Work Group includes representatives of all types of home health providers (nonprofit, proprietary, hospital-based, and free-standing) from every region of the country who have been working intensively over the past 18 months with members of Congress and the Administration on the development of a prospective payment system for home health services as a substitute for copayments and bundling.

The PPS Work Group is united with the National Association for Home Care on the following issues:

1. we support prompt enactment and implementation of the **Revised Unified Home Health PPS Plan** (copy attached);

2. we oppose copayments and bundling; and

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3. we oppose the shift of home health coverage to Part B of the Medicare program.

The PPS Work Group came together at the end of 1994 in response to a challenge issued by members of Congress that, if the home health industry did not believe copayments were sound public policy, it should propose a better alternative. We accepted that challenge and began to design a prospective payment system which had a broad base of support among the state home health associations. We consulted with, and received strong encouragement from, the Health Care Financing Administration. We worked on a concentrated and continuous basis with both Republican and Democratic members of Congress and this Subcommittee. We repeatedly briefed White House staff and kept them apprised of the status of the plan's development. We also worked with the National Association for Home Care to make modifications to the plan which would permit unified industry support.

The joint effort by the PPS Work Group and NAHC resulted in a unified industry PPS plan which served as the model for the home health prospective payment system which was passed by both houses of Congress as part of H.R. 2491. Unfortunately, that plan contained several flaws which were inserted in response to last minute changes in scoring. In addition, the Health Care Financing Administration raised concerns that the Congressionally-passed plan was too complex to be implemented by the effective date contained in the legislation.

Accordingly, the PPS Work Group has worked intensively with the National Association for Home Care over the past seven months to develop the **Revised Unified PPS Plan,** which eliminates the flaws of the earlier legislation and addresses HCFA's implementation concerns by phasing in the plan over 24 months and by simplifying the first implementation phase.

We believe that the **Revised Unified PPS Plan** is far better public policy than copayments for the following reasons.

1. **The PPS plan** provides a mechanism for reducing the rate of growth in Medicare expenditures for home health services while preserving the opportunity for clinical decisions to be made by patients, physicians, and providers based on medical necessity.

2. **The PPS plan** creates incentives for home health agencies to become more cost effective and efficient and rewards those that do.

3. **The PPS plan** achieves true savings to the health care system.

4. **The PPS plan** will reduce administrative costs both for providers and the government, thereby helping to preserve home health as a low cost treatment option.

5. **The PPS plan** significantly reduces the opportunities and incentives for fraud, waste, and abuse.

6. **The PPS plan** has broad industry support, while there is unified opposition to copayments among both providers and consumers.

By contrast, copayments:

- curtail access to services **regardless** of medical necessity and have a particularly harsh effect on the frail elderly with low and fixed incomes (by declining home health services because of copayments, patients will deteriorate and land back in the hospital or nursing home);

- create no incentive for cost effectiveness or efficiency but, rather, create an incentive for higher utilization to offset increased bad debt;

- shift a portion of the current inefficient system to patients, the Medicaid programs, or other health insurance programs;

- increase administrative costs due to more complex billing requirements and bad debt; and

- will not reduce, and could increase, the opportunities and incentives for fraud and abuse.

We also believe that the Administration's proposal to impose a prior hospitalization requirement on Part A coverage and shift the bulk of the home health benefit to Part B is seriously flawed for the following reasons:

- it will add cost and confusion to the home health benefit, because Parts A and B have different billing, administrative, and appeals processes and procedures;

- it will create an incentive for unnecessary hospitalizations;

- it will reduce the value of the Part A health benefit without any corresponding reduction in the FICA taxes which are earmarked for that benefit;

- it will require Medicare beneficiaries who have already paid for that coverage through FICA contributions to pay for it again through taxes on fixed incomes;

- it is an accounting gimmick that does not result in true savings nor does it provide incentives for more cost effective home health services; and

- it will leave the home health benefit vulnerable to the 20% copayment which applies to most Part B services.

Rather than further considering false solutions such as copayments or the "Part B shift," we believe it is time to get on with implementing prospective payment for home health care. This Subcommittee expressed its intent in OBRA '87 and '90 that home health reimbursement should be switched to prospective payment.[1/] After nearly ten years with no progress, it is clear that we will never have a prospective payment system for home health unless it is expressly mandated by Congress.

The **Revised Unified PPS Plan** achieves significant savings, provides incentives for appropriate utilization and efficiency, and avoids curtailing access to medically necessary services. It also has extremely broad industry support.

The home health industry has done what you asked us to do -- we have developed a better alternative to copayments. We ask you and the President to now do your part -- enact and sign into law the **Revised Unified Home Health PPS Plan.**

I would be glad to answer any questions.

1/ See § 4027(c) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) and § 4207(c) of the Omnibus Reconciliation Act of 1990 (Public Law 101-508).

Revised Unified Proposal for a Prospective Payment System for Medicare Home Health Services

Legislative Language

Approved by the Joint Policy Committee of
The National Association for Home Care
and
The PPS Work Group

July 12, 1996

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Revised Unified Proposal for PPS for Medicare Home Health Services
Proposed Legislative Language
7-12-96

CHAPTER 1–PAYMENTS FOR HOME HEALTH SERVICES

SEC. 8601. PAYMENT FOR HOME HEALTH SERVICES.

IN GENERAL- Title XVIII (42 U.S.C. 1395x et seq.), as amended by section 8102, is amended by adding at the end the following new section:

'PAYMENT FOR HOME HEALTH SERVICES

'SEC. 1894. (a) IN GENERAL- Notwithstanding section 1861(v) the Secretary shall provide for payments for home health services in accordance with a prospective payment system as follows.

'(1) PER VISIT PAYMENTS- Subject to subsection (c), the Secretary shall make per visit payments beginning within six months after the date of enactment and on a uniform implementation date to a home health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, under any other contracting or consulting arrangement, or otherwise).

'(2) TYPES OF SERVICES- The types of home health services described in this paragraph are the following:

'(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

'(B) Physical therapy.

'(C) Occupational therapy.

'(D) Speech-language pathology services.

'(E) Medical social services under the direction of a physician.

'(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary.

'(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF SERVICE-

'(1) IN GENERAL- The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) for each type of home health service described in subsection (a)(2).

Such rate shall be equal to the national per visit payment rate determined under paragraph (2) for each such type, 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 (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).

'(2) NATIONAL PER VISIT PAYMENT RATE- The national per visit payment rate for each type of service described in subsection (a)(2)–

'(A) for fiscal year 1997, is an amount equal to the national average amount reimbursed per visit under this title to home health agencies for such type of service including medical supplies during the most recent 12-month cost reporting period ending on or before December 31, 1994, updated by the home health market basket percentage increase for each year prior to implementation; and

'(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year.

'(3) PAYMENTS ABOVE PER VISIT RATES-

'(A) A home health agency may elect to receive per visit payments in excess of the per visit payment rate under paragraph (1) up to the per visit payment limit if such provider can demonstrate that it can reasonably expect to incur such costs and that total payments will not exceed the agency's aggregate limit under subsection (c). The Secretary shall further provide for exemptions, exceptions and adjustments to the per visit payment limit of this section on the same basis as are provided under subsection (c)(3) with respect to the limitations on final payment.

'(B) For fiscal year 1997, the per visit payment limit is calculated as established by section 1861(v)(1)(L). For each subsequent year, the payment limit is equal to the limit for the preceding year increased by the home health market basket index.

'(4) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE- For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the types of home health services described in subsection (a)(2) in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for the fiscal year.

'(c) AGGREGATE LIMITS-

'(1) PHASE I AGGREGATE LIMIT-

'(A) IN GENERAL- Beginning _____ and ending no later than 24 months after implementation, except as provided in paragraph (4), a home health agency may not receive aggregate per visit payments under subsection (a) for a year in excess of an amount equal to the following product:

'(i) The number of unduplicated patients during the year; multiplied by

'(ii) the per patient limit determined for such year.

'(B) ESTABLISHMENT OF PER PATIENT LIMITS-

'(i) For the initial year, the annual per patient limit shall be established through a blend of 75 percent of the agency-specific per patient base year reasonable cost with 25 percent of the census region for the area in which a home health agency is located per patient annual base year reasonable cost, calculated from the fiscal year 1994 cost per visit updated by the home health market basket percentage increase to the year for which the limit applies multiplied by fiscal year 1995 per unduplicated Medicare patient visit utilization.

'(ii) Beginning 12 months after application of the limitation required under subsection (i), the limitation shall be calculated through a blend of 50% agency specific and 50% of the census region per beneficiary annual base year reasonable cost updated by the home health market basket index to the year for which the limit applies, multiplied by the FY95 per unduplicated Medicare patient visit utilization.

'(iii) For new providers and those without agency-specific base year data necessary for the calculation under subparagraphs (i) and (ii), the per patient limit shall be equal to the mean of these limits applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or name may not be considered new providers for payment purposes.

'(2) PHASE II AGGREGATE LIMITS-

'(A) IN GENERAL- Beginning _____ and ending no later than implementation of episodic prospective payment under paragraph (h), except as provided in paragraph (3), a home health agency may not receive aggregate per visit payments under subsection (a) for a year in excess of an amount equal to the sum of the following:

'(i) The sum of: the number of episodes for each case-mix category for which the agency receives payments during the payment year, as described

in subsection (2)(B) and (C), multiplied by the per episode limit determined for each such case-mix category for such payment year; and

(ii) the number of unduplicated patients receiving services beyond 120 days during the year multiplied by the per patient limit for services provided after 120 days as provided under subsection (2)(E).

'(B) ESTABLISHMENT OF PER EPISODE LIMITS FOR FIRST 120 DAYS-

'(i) IN GENERAL- The per episode limit for a payment year for any case-mix category for the area in which a home health agency is located (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) is equal to–

'(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1995, adjusted by the case-mix adjustment factor determined by clause (ii) for the fiscal year involved; multiplied by

'(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

'(ii) DETERMINATION OF AREA- In the case of an area which the Secretary determines has an insufficient number of home health agencies to establish an appropriate per episode limit, the Secretary may establish an area other than the area used to determine the area wage under section 1886(d)(3)(E)) for purposes of establishing and appropriate per episode limit.

'(C) CASE-MIX CATEGORY- For purposes of this paragraph, the term "case-mix category" means each of the 18 case-mix categories established under the Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop and apply a more accurate methodology for determining case-mix categories subject to prior public notice and comment under 5 U.S.C. § 553.

'(D) EPISODE-

'(i) IN GENERAL- For purposes of this paragraph, the term "episode" means the continuous 120-day period that–

'(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

'(II) is immediately preceded by a 45-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

'(ii) PRORATION OF EPISODE LIMIT SPANNING PAYMENT YEARS-The Secretary shall provide for such rules as appropriate to prorate episode limits under this paragraph which begin during a payment year and end in a subsequent payment year.

'(E) ESTABLISHMENT OF A PER PATIENT ANNUAL LIMIT FOR SERVICES PROVIDED AFTER 120 DAYS-

'(i) The per patient limit for services provided after 120 days shall be calculated through a blend of 50% of the agency-specific per patient reasonable cost with 50% of the census region per patient reasonable cost, calculated from the fiscal year 1994 cost per visit updated by the home health market basket percentage increase multiplied by fiscal year 1995 per unduplicated Medicare patient visit utilization of services after 120 days.

'(ii) The limitation shall represent fiscal year 1994 costs per visit updated by the home health market basket index multiplied by fiscal year 1995 annual per unduplicated Medicare patient visit utilization.

'(iii) For new providers and those without agency-specific base year data necessary for the calculation under subparagraphs (i) and (ii), the per patient limit shall be equal to the mean of these limits applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or name may not be considered new providers for payment purposes.

'(3) EXEMPTIONS AND EXCEPTIONS- The Secretary shall provide for an exemption from, or an exception and adjustment to, at the request of the home health agency, the methods under this section for determining payment limits where events beyond the home health agency's control or extraordinary circumstances, including the case mix of such home health agency, create reasonable costs for a payment reporting period which exceed the payment limits. The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such methods, as the Secretary deems appropriate, as determined by the Secretary. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 120 days after receiving a completed application from the home health agency for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied. The total expenditures for exemptions and exceptions shall not exceed the cumulative share of overall program savings achieved for the Secretary which represent 50% of the difference between aggregate per visit payments and the aggregate limits.

'(4) RECONCILIATION OF AMOUNTS-

'(A) PAYMENTS IN EXCESS OF LIMITS- If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

'(B) SHARE OF SAVINGS-

'(i) COMPUTATION- If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in an amount less than the amount determined under paragraphs (1) and (2) with respect to such home health agency for such fiscal year and, with respect only to sections (c)(1) and (c)(2)(E), the home health agency has an average payment per unduplicated Medicare patient at or below 125% of the census region rate (as defined in section (c)(1)(B) and (c)(2)(E), whichever is applicable), the Secretary shall pay such home health agency a payment equal to 50 percent of the difference between such amounts except that the payment may not exceed 10 percent of the aggregate per visit payments up to the aggregate limit made to the agency for the year.

'(ii) INSTALLMENT PAYMENTS- The Secretary may make installment payments during a fiscal year to a home health agency based on the estimated payment that the agency would be eligible to receive with respect to such fiscal year.

'(d) MEDICAL REVIEW PROCESS- The Secretary shall implement a medical review process for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which payments are made under this section to ensure that such individuals receive appropriate home health services.

'(e) ADJUSTMENTS-

'(1) IN GENERAL- The Secretary shall provide for appropriate adjustments to payments to a home health agency under this section to ensure that the agency does not engage in the following for the purposes of circumventing the limits:

'(A) discharging patients to another home health agency or similar provider;

'(B) altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title.

'(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES-

'(A) DEVELOPMENT OF SYSTEM- The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than one home health agency.

'(B) ADJUSTMENT OF PAYMENTS- The Secretary shall adjust payments under this section to each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

'(3) MONITORING LOW COST CASES-

'(A) IN GENERAL- The Secretary shall develop and implement a system designed to monitor significant changes in the percentage distribution of low-cost and high cost patients for which home health services are furnished by the agency over such percentage distribution determined for the agency under subparagraph (B).

'(B) DISTRIBUTION- The Secretary shall profile home health service to determine the distribution of all episodes by length of stay for the purpose of determining regional and national trends.

'(C) LOW-COST AND HIGH-COST PATIENTS- For purposes of this paragraph, the Secretary shall define a low-cost and high-cost patient in a manner that provides that a home health agency has an incentive to be cost efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

'(D) The Secretary shall report to Congress on an annual basis findings and recommendations for ensuring access to appropriate home health services.

'(f) SPECIAL RULE FOR CHRISTIAN SCIENCE PROVIDERS-

'(1) PAYMENT PERMITTED FOR SERVICES- Notwithstanding any other provision of this title, payment shall be made under this title for home health services furnished by Christian Science providers who meet applicable requirements of the First Church of Christ, Scientist, Boston, Massachusetts, and are certified for purposes of this title under criteria established by the Secretary, in accordance with a payment methodology established by the Secretary.

'(2) EFFECTIVE DATE- Paragraph (1) shall apply to services furnished during cost reporting periods which begin after the date on which the Secretary establishes the payment methodology and the certification criteria described in paragraph (1)

'(g) REPORT BY MEDICARE PROSPECTIVE PAYMENT REVIEW COMMISSION- During the first 3 years in which payments are made under this section, the Medicare Prospective Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

'(1) Case-mix and volume increases.

'(2) Quality monitoring of home health agency practices.

'(3) Whether providers of service are adequately reimbursed.

'(4) On the adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

'(5) The appropriateness of the methods provided under this section to adjust the aggregate limits and annual payment updates to reflect changes in the mix of

services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

'(6) The geographic areas used to determine the per episode and per patient limits.'

(h) 'EPISODIC PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES-

'(1) The Secretary shall provide for payments for home health services in accordance with an episodic prospective payment system, in accordance with subparagraphs (2) through (9).

'(2) The Secretary shall develop an episodic prospective payment system taking into consideration, first, the data and processes from section 1894(c)(2) that have proven valid and reliable; and second, the degree of disruption resulting from changing the payment system.

'(3) The per episode amount under such a system shall include all services covered and paid under the Medicare home health benefit as of the date of the enactment of Sec. 1894, including medical supplies. In defining an episode of care, the Secretary shall consider an appropriate length of time for an episode the use of services and the number of visits provided within an episode, potential changes in the mix of services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current data available to the Secretary and shall include consideration of the cost of new regulatory requirements, changes in technology and new care practices.

'(4) The Secretary shall employ an appropriate case mix adjuster that explains a significant amount of the variation in cost.

'(5) The episode payment amount shall be adjusted annually by the home health market basket index. The labor portion of the episode amount shall be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.

'(6) The Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

'(7) A home health agency shall be responsible for coordinating all care for a beneficiary.

'(8) Such a system shall be developed with input from and coordination with representatives from the home health services industry and consumers of home health services.

'(9) The Secretary shall submit a proposal for a prospective payment system consistent with subsections (1) through (8) to Congress within four years of enactment and implementation of the amendments to section 1894 of the Social Security Act. Implementation of an episodic prospective payment system shall be effective no earlier than one year and no later than 18 months subsequent to enactment of such a system.

'(i) Within 60 days of enactment of amendments made by sections (a) through (h), the Secretary shall initiate the development of a data base upon which a fair and accurate case mix adjustor, as required by sections (c)(2)(C) and (h)(3), can be developed and implemented. The data base must:

'(1) be capable of linking case mix data with cost and utilization data;

'(2) contain data from HCFA Form 485 and UB-92;

'(3) contain additional data elements sufficient to support the case mix categories in section (c)(2)(C);

'(4) contain any additional data elements determined necessary by the Secretary in consultation with representatives of the home health industry.

'(j) APPEALS- Section 1878(a) of the Social Security Act is amended to add at the end of "in accordance with subsection (h)" the following:

"any home health agency which has received payment pursuant to section 1894 may obtain a hearing by the Board, with respect to such payment,"

SEC. 8602. Section 1154 of the Social Security Act is amended to add the following new subsections (g) and (h):

'(g) each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of the level of care and quality of services provided individuals receiving home health services pursuant to section 1812(a)(3) and 1832(a)(2)(A)(i).

'(1) If -

'(A) a home health agency has determined that a patient does not meet the conditions for payment of home health services under section 1814 or section 1833, or

'(B) the home health agency has determined that a patient no longer requires home health services, or

'(C) the home health agency has determined that a patient requires a level of care which is inconsistent with the care prescribed by the patient's attending physician, or

'(D) the patient has been authorized by the home health agency to receive a level of care less than that considered by the patient as appropriate to meet the patient's needs, then the home health agency shall provide the patient (or the patient's representative) with a notice (meeting the conditions of prescribed by the Secretary under section 1879) of the determination.

'(2) If-

'(A) the patient (or patient's representative) -

'(i) has received a notice under paragraph (1), and

'(ii) requests the appropriate peer review organization to review the determination,

'then, the organization shall conduct review under subsection (a) of the validity of the home health agency's determination and shall provide notice (by telephone and in writing) to the patient or representative and the home health agency and attending physician involved of the results of the review. Such review shall be conducted regardless of whether the home health agency will charge for continued home health services or whether the patient will be liable for payment for such continued care.

'(B) If a patient (or a patient's representative) requests review under subparagraph (a) while the patient is still a patient of the home health agency and not later than noon of the first working day after the date the patient receives the notice under paragraph (1) then -

'(i) the home health agency shall provide to the appropriate peer review organization the records required to review the determination by the close of business such first working day, and

'(ii) the peer review organization must provide the notice under subparagraph (a) by not later than one full working day after the date the organization has received the request and such records.

'(3) If -

'(A) a request is made under paragraph 2(A) not later than noon of the first working day after the date that the patient (or patient's representative receives the notice under paragraph (1), and (b) the conditions described in section 1879(a)(2) with respect to the patient or representative are met, the home health agency shall not charge the patient for home health services furnished before noon of the day after the date the patient or representative receive notice of the peer review organization's decision.

'(4) In any review conducted under paragraph (1) or (2), the organization shall solicit the views of the patient involved (or the patient's representative).

'(h) The utilization and quality control peer review organization shall monitor the delivery of home health services in a manner which includes, but is not limited to, a review of home health agencies that present significant variation in utilization.'

SEC. 8603. Section 1155 of the Social Security Act is amended to add the following at the end:

'"Notwithstanding the foregoing, any beneficiary receiving home health services subject to review under section 1154(g), and the provider, who is dissatisfied with a determination, shall be

entitled to a hearing by the Secretary and to judicial review of any final determination to the same extent as provided under Section 1869 of the Social Security Act.

SEC. 8604. Section 1816(j) of the Social Security Act is amended to remove the following:

"home health services,"

SEC. 8605. RETROACTIVE REINSTATEMENT OF PRESUMPTIVE WAIVER OF LIABILITY.

'(a) Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "December 31, 1995" and inserting "upon implementation of a prospective payment system for home health care services, under section 1894(h).'

'(b) The second sentence of Section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking "December 31, 1995" and inserting "upon implementation of a prospective payment system for home health care services under section 1894(h).'

Chairman THOMAS. Thank you, Mr. Holt.
Ms. Cushman.

STATEMENT OF MARGARET J. CUSHMAN, PRESIDENT, VNA HEALTH CARE, INC., HARTFORD-PLAINVILLE, CONNECTICUT; ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. CUSHMAN. Thank you, Mr. Chairman for the opportunity to present testimony today on the important subject of prospective payment. I will just give the highlights of my written testimony and ask that it be submitted for the record.

I am Peg Cushman. I am the president of VNA Health Care in Hartford-Plainville, Connecticut, which incidentally is 95 years old this year. It has been around for a while.

I also chair the government affairs committee for the National Association for Home Care and serve on the Prospective Payment Task Force.

The National Association for Home Care is deeply appreciative of the support of this Committee and its members and the attention home care prospective payment has received in this Congress. We thank you for your leadership, as well, in helping to defeat proposals to bundle home care payments into other provider payments and to shift home care from part A to part B of Medicare.

I wish to place NAHC on record as adamantly opposed to the administration's proposal to transfer a portion of Medicare's home health benefit from part A to part B. This transfer proposal would have very serious consequences for Medicare home health recipients.

We also want to thank you, Mr. Chairman, and Members of the Committee for your support on the extension of the presumptive waiver in the budget reconciliation package that was reported out of this Committee and a number of Members of this Committee, including Representatives Johnson, Kennelly, Jacobs, Cardin, Portman, English, and McNulty have written the administration or introduced legislation on its behalf.

Congress has before it a unique opportunity to improve the Medicare home health benefit in a way that the unified home care industry supports and will stand behind. Our goal is to develop a prospective payment plan that would provide cost-effective quality care to beneficiaries, use the best that both Republican and Democratic prospective payment plans have to offer, address concerns raised about previous plans meet deficit reduction requirements, substitute for home care copays and bundling, and finally, address HCFA's concerns about implementation issues.

The revised unified prospective payment plan represents the most advanced thinking in this field that's been done in developing a prospective payment system and it's a substantial improvement over the Medicare current cost-based reimbursement system.

Let me be very direct in the context in which we raise this PPS proposal. Last year, Congress proposed sizable savings from the Medicare home care program, a portion of which was from home care. And since we found copayments and bundling offensive to us, we were challenged to develop a more acceptable way of achieving the required savings. We propose this prospective payment system

in that spirit and as an alternative to the copays, bundling, and other methods for deficit reduction.

Our goal in the home care community in proposing prospective payment is to manage the growth of the Medicare home health expenditures in a method that produces efficiency and preserves access and quality of care for beneficiaries through the development of an implementation of an episodic prospective payment system.

PPS offers many advantages over the current cost-based reimbursement system. The current system is complex. It is costly to administer and the amounts paid are subject to disallowance recoupment long after services are provided. It offers no incentives for providers to have efficiency in their provision of services.

By contrast, prospective payment provides market-like incentives that encourage the efficient provision of services and provides financial incentives for home care agencies to reduce both visit and episodic costs, resulting in Medicare savings without restricting beneficiary access to high-quality home care services. It properly places the burden of efficiency on providers, not beneficiaries.

Our unified proposal calls for a three-phase approach to achieving episodic prospective payment starting with an interim plan that uses existing data to put in place prospectively set per visit payment rates subject to caps, and moves within 5 years to an episodic prospective payment system with a case mix adjuster that distinguishes the cost of providing services to different types of patients.

This plan would give home care providers incentives to reduce costs and increase efficiency by allowing them to keep a portion of the difference between the total per visit payments in the agencies' annual aggregate caps. This provision differs from hospital prospective payment system in that it only would offer a portion of the savings to the agency as opposed to the entire thing.

We believe through our work with Price Waterhouse, that this proposal will present savings roughly equivalent to those offered under the administration's proposal and have built in to the proposal a number of components that can be adjusted to achieve necessary savings.

We are deeply concerned about the assumption CBO has employed in scoring past PPS proposals, as earlier referenced by Representative Johnson. Under the CBO's offsets in the past, a PPS proposal scored at $14.2 billion in savings over 7 years, as was the proposal in the BBA, would actually reduce Medicare home health expenditures by $42.6 billion over 7 years, three times the amount scored.

Never, to our knowledge, has such a high scoring been employed for dramatic assumptions of gaming. An offset of this magnitude would make it almost impossible for home care to offer savings without inflicting great harm in the services available to beneficiaries.

We greatly appreciate the interest that Mrs. Johnson and others on the Committee have demonstrated in this issue. We appeal to the Committee for help in encouraging CBO to employ realistic assumptions that do not penalize providers and patients.

Thank you, again, Mr. Chairman, for the opportunity to testify.

[The prepared statement follows:]

**STATEMENT OF MARGARET J. CUSHMAN, PRESIDENT,
VNA HEALTH CARE, INC.
ON BEHALF OF
THE NATIONAL ASSOCIATION FOR HOME CARE**

Mr. Chairman,

Thank you for the opportunity to present testimony today on the important subject of prospective payment for home care. My name is Margaret J. Cushman. I am the President of VNA Health Care in Hartford-Plainville, Connecticut. I also chair the Government Affairs Committee of the National Association for Home Care (NAHC), as well as serve on the NAHC Prospective Payment System (PPS) Task Force.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's members are every type of home care agency, including nonprofit agencies, like the Visiting Nurse Associations, for-profit chains, hospital-based agencies and freestanding agencies.

The National Association for Home Care thanks you, Mr. Chairman, and Members of the Committee for the support you have expressed for PPS for home care, as well as your leadership in helping to defeat proposals to bundle home care payments into other provider payments and to shift home care from Part A to Part B of Medicare.

NAHC is deeply appreciative of the support and attention PPS for home care has received from this Committee and in this Congress. We have been advocating such a system for more than a decade. Congress, too, has been pushing the Administration for development of a PPS for home care for many years. We were very pleased that proposals to implement such a system were included in the balanced budget plans offered by both parties, and a PPS plan was passed by the full Congress as a part of HR2491, the Seven Year Balanced Budget Act (BBA).

I'd like to ask permission, Mr. Chairman, to have my full written statement, along with the following attachments, included in the hearing record:

- a resolution in support of the industry's Revised Unified PPS Plan signed on to by 50 state home care associations,
- a detailed description of the industry's Revised Unified Plan, and
- a side-by-side comparison of current law with the PPS provisions of the BBA, HR2530, and the industry's new Revised Unified Plan.

Congress has before it a unique opportunity to improve the Medicare home care benefit in a way that the home care industry supports and will stand behind. The Revised Unified PPS plan incorporates the best elements of the home care PPS provisions in the BBA passed by Congress and HR2530. Our goal was to develop a PPS plan that 1) the home care industry could support, 2) would use the best that both the Republican (BBA) and Democratic (HR2530) plans had to offer, 3) would address concerns raised about the PPS plans in both the BBA and HR2530, 4) would accommodate deficit reduction requirements, 5) would substitute for home care copays and bundling, and 6) would address HCFA's concerns about feasibility of implementation on a timely basis.

The Revised Unified PPS Plan represents the most advanced thinking that's been done in developing a PPS plan. It also represents a substantial improvement over the current Medicare cost-based reimbursement system.

Let me be very direct regarding the context in which we are offering this PPS proposal. In 1995, Congress proposed sizable savings from the Medicare program, a portion of which was to come from home care. Since the industry found copayments and bundling unacceptable, Congress challenged us to develop a more acceptable way of achieving the required savings. This PPS proposal was developed as an alternative to home care copays, bundling, and other onerous ideas, and that is the context in which we are offering it today.

Growth in Home Care

Home care encompasses a broad spectrum of both health and social services that can be delivered to recovering, disabled or chronically ill persons in their homes. These services include the traditional core of professional nursing and home care aide services as well as physical therapy, occupational therapy, speech therapy, and medical social services.

Generally home care is appropriate whenever a person needs health care assistance that cannot be easily or effectively provided solely by a family member or friend on an ongoing basis for a short or long period of time. There are many situations and conditions for which home care services are especially appropriate. Technology advancements mean that every day more people are able to be cared for effectively and efficiently at home even if they have illnesses that, at one time, were only treatable in hospitals or institutions.

The home health benefit has been a maturing benefit for most, if not all, of its existence in the Medicare program. In Medicare's earliest years, home health expenditures amounted to only about one percent of the total. Today, approximately 8.7% of Medicare payments are made for home health services. Therefore, while the benefit has increased each year, it still represents a small proportion of Medicare spending.

In 1995, approximately 3.6 million Americans received home health services, representing an estimated $15.9 billion in Medicare spending. Much of the increase over time can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services.

Home health growth, however, is beginning to moderate and it is expected to continue to fall to more modest levels in the next few years. The change in the number of home health visits has dropped from a 25% increase in 1993 to a 13.7% increase in 1995. The HCFA Office of the Actuary expects this rate to continue to slow, from 10.5% in 1996 to 7.3% in 1997, and to steadily decrease to around 2.6% through the year 2000.

The home health benefit increases that occurred in the 1989-1992 period were almost double the 23.5 percent average experienced over the life of the Medicare program but have already begun falling to lower rates. Evidence indicates this peaking is temporary and has been influenced by several recent events.

Coverage Clarification. In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be reimbursed. The result was a "chilling effect" in which some Medicare covered claims were diverted to Medicaid and regrettably some patients went without care. This "denial crisis" led in 1987 to a lawsuit (*Duggan v. Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit led to a rewrite of the Medicare home health payment policies. Just as lack of clarity and arbitrariness had depressed growth rates in the preceding years, the policy clarifications that resulted from the court case allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25 percent) came in 1989 when the clarifications were announced; and an even larger increase took place (50 percent) in 1990, the first full year the new policies were in effect. However, growth in the number of visits is beginning to return to more modest levels.

Personnel Shortage. Throughout much of the 1980s, the home care industry, along with the rest of health care, was experiencing a personnel shortage. Although there are still acute shortages of certain disciplines, conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 8,100 in 1995.

New Legislative Requirements. In the past five years, the home health program has seen the addition of several costly legislative changes, including the OBRA-87 home health aide training

and competency testing requirements and the Clinical Laboratory Improvement Amendments of 1988. The costs associated with these changes are reflected in visit charges.

New Administrative Changes. The 1992 OSHA mandate regarding employee protection from transmission of HIV and Hepatitis B, including employee vaccinations, is a cost that must be borne by employers.

The growth in the Medicare home health benefit, however, is moderating and can be expected to fall to more single digit modest levels in the next two years. A number of factors will cause continued, albeit moderate growth in home health utilization. Foremost among these is the pursuit of cost-effective alternatives to institutional care.

Cost Effectiveness. Home health has moved well beyond its traditional boundaries, making it possible for patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment.

An Aging Population. The aging of the U.S. population will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger home health patients. For example, the National Medical Expenditures Survey found that individuals over age 85 are three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 65 visits whereas individuals over age 85 used an average of 75 visits.

Improved Access. Access to in-home services has also improved over the years, as more home health agencies choose to participate in the Medicare program. In 1967, there were 1,753 agencies certified for Medicare purposes. By 1980, that number had nearly doubled to 2,924. As of January 1995, a total of 8,100 agencies were providing services under the program. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference. The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38 percent of Americans knew about home care; by 1988, over 90 percent of the public understood home care to be an appropriate method of delivering health care, and supported its expansion to cover long-term care services as well. A poll conducted in 1992 by Lou Harris and Associates, found that the American public supports home care by a margin of 9 to 1 over institutional care. Nearly 82 percent of all accredited medical schools now offer home health care in their curricula.

Technological Advances. Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances has been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Additional Factors. Litigation and workers' compensation claims are two additional factors that affect the cost of delivering home health services.

Reductions in home care spending are likely to result in greater Medicare expenditures for hospital inpatient and emergency care, physician services, and nursing home care. Home health care serves as the safety net for patients who are discharged from acute and rehabilitation hospitals after shorter lengths of stay.

Advantages of PPS

PPS offers numerous advantages to the Medicare program over the current cost-based reimbursement methodology. Under current law, home health agencies are reimbursed for the allowable costs which they incur in caring for Medicare patients up to a cap. Cost reimbursement, however, has been criticized because it is complex and costly to administer,

because the amounts that are paid are subject to disallowance and recoupment long after the services have been rendered and because it offers no incentives for provider efficiency.

PPS, by providing desirable, market-like incentives that encourage the efficient and effective provision of care, would avoid these problems because payment rates would be established in advance.

PPS, by providing financial incentives for home care agencies to reduce both visit and total case costs, will achieve Medicare savings without restricting beneficiary access to high quality home care services. PPS properly places the burden to be efficient in the provision of care on providers and not beneficiaries. Alternatives to PPS, like copayments and bundling, create barriers to high quality home care services by increasing a beneficiary's out-of-pocket expenses and restricting access to post-acute care services.

Building on the BBA and HR2530

The Revised Unified PPS Plan builds on the home care PPS plans included in both the BBA and HR2530. In developing this revised plan, we endeavored to take the best elements of both bills. We also listened carefully to the concerns raised by home care providers about both plans, as well as concerns raised by HCFA regarding their ability to implement and administer the plans.

A key aspect of the PPS plan included in the BBA which remains at the heart of the new Revised Unified PPS Plan is the ability to manage the growth in volume of services provided to individuals through aggregate beneficiary caps. The plan would have moved home care toward adopting managed care principles and a more price conscious approach to health care delivery. The BBA built in incentives for home care providers to keep overall case costs as low and efficient as possible while still meeting patient needs.

The BBA would have moved Medicare home care away from cost-based reimbursement. HR2530 would have moved home care into an episodic PPS. Both of these landmark changes are adopted in the Revised Unified PPS plan.

NAHC's concerns with the PPS plan included in the BBA centered around 5 issues.

First, the episode limits were based on the cost of care provided for 120 days, but would have required home care agencies to provide up to 165 days of care for those limits.

Second, payment rates and limits would have been updated with the home health market basket index minus 2 percentage points.

Third, the BBA did not include a plan for developing and implementing a per-episode PPS, so the interim plan would have been in place for at least 7 years.

Fourth, the amount of time required before a new episode limit was recognized would have been increased from 45 days, as proposed by the industry, to 60 days.

Fifth, the bill's failsafe provision might have resulted in additional across the board savings if savings targets were not met.

NAHC was concerned with elements of HR2530 and the Administration's PPS Plan, as well. First, the plan would have retained cost-based reimbursement until October 1, 1999. While many home care providers have voiced the need for time to prepare for payment system changes, others are anxious to eliminate cost-based reimbursement and the problems with retroactive denials as soon as possible.

Second, the plan would have reduced cost limits to 105 percent of the median, an unacceptably high reduction.

Third, the plan lacked a case-mix adjuster. While the case-mix adjuster included in the BBA explains less than 10 percent of the variation in costs, it represents the best available today.

Fourth, the plan had the potential to penalize the most efficient home care providers by delaying implementation of the blended limit for 3 or more months.

Waiver of Liability

Also included in the BBA and closely linked to enactment of PPS was a provision to extend the presumptive status of the waiver of liability for home care, a provision of great importance to NAHC.

In 1972 the Health Care Financing Administration created a presumptive waiver of liability status for Medicare providers. Under the presumptive waiver, providers were presumed to have acted in good faith and were paid for services to a Medicare patient if their low error rate demonstrated a reasonable knowledge of coverage standards in their submission of bills. The presumptive waiver was later incorporated into legislation which after several extensions expired for home care and hospice on December 31, 1995.

The BBA would have extended the presumptive waiver for home care until October 1, 1996, when the Act provided that a prospective payment system would be established for home care. When the Act was vetoed, the presumptive status of the waiver expired.

To make matters worse, HCFA has imposed a system which presumes fraud by assuming providers knew their claims would not be covered, forcing providers to appeal each claim. Reconsideration of claims costs the federal government approximately $400 per claim, and costs providers in the range of $150 for each claim, just to reach the point of requesting waiver protection. If the dispute moves to the Administrative Law Judge level, the federal government and the provider each incur likely costs of $1,000 per claim reviewed.

In order for a home care agency to be compensated under the waiver presumption, its overall denial of claims rate had to be less than 2.5% of the Medicare services provided. Any agency that exceeded this limit was not reimbursed under the presumptive waiver. This requirement forced agencies to use due diligence in determining eligibility and coverage.

Given the vague application of constantly changing regulations, guidelines, and directives, it is difficult enough for home health agencies to be 97.5% correct in their determinations of eligibility. The high number of claims denials that are reversed (25% at reconsideration stage and 70% at the Administrative Law Judge level) shows that coverage decisions are not as clear cut as HCFA asserts. At a time when sicker patients are admitted to home care following earlier hospital discharges, coverage questions are more complex, and the buffer zone of the waiver presumption is particularly important.

Congress enacted the presumptive waiver to encourage home health agencies to provide services to Medicare patients, and to save on the considerable administrative time and expense of handling appeals in cases where agencies are delivering services in the good faith belief that the services are covered by Medicare. In the absence of the waiver presumption, agencies will have no recourse but to reject clients if there are any doubts about coverage. The waiver presumption for home health agencies and hospices should be permanently reinstated and made retroactive to January 1, 1996.

We want to thank you, Mr. Chairman, and Members of this Committee for your support of the extension of the presumptive waiver in the budget reconciliation package that was reported out of the Committee. We would like to extend a special thanks to Representatives Johnson, and Kennelly, for their advocacy in behalf of extending the waiver. Thanks also to Representative Jacobs for introducing HR3678, a bill to extend the home health and hospice waivers, and to Representatives Cardin, Portman, English, Jacobs, and McNulty for introducing the Medicare Hospice Benefit Amendments of 1996 (HR3714) that would permanently extend the presumptive waiver of liability for hospice.

Revised Unified PPS Plan

The Revised Unified PPS Plan that we are testifying in support of today is a modification of the

original unified plan submitted to Congress in 1995 as an alternative to Congressional movement to impose copays on Medicare home care services or to bundle home care payments into payments to hospitals.

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 without jeopardizing beneficiary health and safety. Our goal was to develop an episodic system which would:

- o be developed cooperatively by HHS, the industry, and Congress,
- o be acceptable to the industry,
- o include extended care,
- o be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation,
- o be implemented only after Congressional approval,
  include adjustments for new requirements (such as OSHA)
- o or changes in technology or care practices,.
- o be based on a case-mix adjuster that reflects the differences in cost for different types of patients,
- o prevent the imposition of home care copays, bundling, or other benefit limits,
- o implement a per-episode PPS as soon as possible, and
  do as little harm as possible to home care patients and
- o providers in implementing an untested system.

This plan, which represents months of work and refinement by the home care industry, 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 and would require the development, within five years, of a per-episode PPS with a case-mix adjuster that adequately distinguishes the cost of providing services to various types of patients, using a three phase approach.

Phase 1 of the Plan would implement a prospectively set standard per visit payment with an annual aggregate per patient limit that applies to all visits. Phase 2 would put in place prospectively set standard per visit payments with an annual aggregate episode limit for days 1 - 120 and an annual aggregate per patient limit for visits after 120 days. Phase 3 puts in place a per-episode PPS.

This PPS plan would give home care providers incentives to reduce costs and increase efficiency through a provision in which they would be allowed to keep a portion of the difference between the total per visit payments and the agency's annual aggregate cap. This provision differs from the way PPS for hospitals was implemented, in which hospitals are allowed to retain the entire difference between the DRG payment rate and the cost of care. Under the revised unified PPS proposal, home care providers would be allowed to retain 50 percent of the difference, up to a cap, with the balance of the savings used for the exceptions process.

Scoring

NAHC has been working with the accounting firm of Price Waterhouse in reviewing the potential cost savings available through this proposal. We believe it to represent savings roughly equivalent to the savings offered under the Administration's PPS proposal and have built into the proposal a number of components that can be adjusted to achieve necessary savings.

We are deeply concerned about certain assumptions the Congressional Budget Office has employed in scoring PPS proposals for home care. In assessing the prospective payment proposal included in HR2491, CBO imposed a 66 2/3% offset that had the effect of dramatically reducing potential savings the proposal could have achieved. This offset reflects CBO's assumptions of behavioral changes on the part of home health care providers in response to this

proposal, as well as their assumption of the proposal's effectiveness.

CBO used this two-thirds offset to calculate net savings for the home health prospective payment provision, meaning that the sum of gross savings for each provision of the proposal was reduced by two-thirds. Under this offset, a proposal scored at $14.2 billion in savings over 7 years, as was the PPS proposal in the BBA, actually would reduce Medicare home health expenditures by $42.6 billion over 7 years, or three times the scored amount.

Never before, to our knowledge, has CBO employed such a dramatically high assumption of gaming. An offset of this magnitude is entirely unjustified and makes it much more difficult for home care to present a proposal offering necessary savings that does not inflict great hidden harm to home care beneficiaries.

We greatly appreciate the interest Mrs. Johnson and others on the Committee have demonstrated in this issue and we appeal to the Committee for help in encouraging CBO to employ realistic assumptions that do not penalize home care providers and patients.

History of PPS

NAHC has long supported the development of a prospective payment system for home care. NAHC championed the initial PPS demonstration legislation that Congress passed in 1983 as part of the Orphan Drug Act (P.L. 97-414). In that legislation, Congress required the Medicare program to test alternative reimbursement methodologies to determine the most cost effective and efficient way of providing care, including fee schedules, prospective payment, and capitation payments.

Following the passage of this legislation, the industry, through the National Association for Home Care, created its first Prospective Payment Task Force. When the demonstrations authorized under that legislation were held up in 1985 by the Office of Management and Budget, NAHC stepped in and partially funded the Georgetown University study on patient classification.

The U.S. Department of Health and Human Services (DHHS) did not undertake any serious effort to follow through with the study required in the 1983 legislation. Accordingly, the industry sought a stronger mandate from Congress.

With the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Congress required that DHHS design a prospective payment demonstration in a manner that would enable the Secretary to evaluate the effects of various methods of prospective payments (including payments on a per visit, per case, and per episode basis) on program expenditures, as well as beneficiaries' access to care. An interim report was required by Congress within one year after enactment of the legislation. A final report was due 4 years after enactment. The demonstration was set to begin no later than July 1, 1988.

The Health Care Financing Administration (HCFA) was unable to move the demonstration project forward on a timely basis and sought a delay from Congress. As part of the Medicare Catastrophic Protection Act of 1988, OBRA-87 was amended to modify the effective date from July 1, 1988 to April 1, 1989.

After nearly three years with limited effort by DHHS, Congress, at the request of the home health industry, once again intervened in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). Congress directed HCFA to research and report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. DHHS was required to submit a report to Congress that included a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission was to analyze the DHHS proposal and report to Congress by March 1, 1994.

In developing this proposal, DHHS was required to:

(1) provide for appropriate limits on home care expenditures;

(2) account for changes in patient case-mix, severity of illness, volume of cases, and the development of new technologies and standards of medical practice;

(3) consider the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment;

(4) address the varying wage-related costs among agencies; and

(5) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Ultimately, HCFA initiated a two phase demonstration project to study prospective payment for home health services. In Phase 1, HCFA experimented with a per visit prospective payment methodology. That project, which concluded in 1994, found limited effect on the behavioral actions of home health agencies and expenditure through the use of a per visit method of reimbursement.

Phase 2 of the demonstration project was initiated in March, 1995. Phase 2 is intended to study the behavioral reaction to a per episode based prospective payment system using a case-mix adjustor that classifies patients into one of eighteen categories. As the result of the weaknesses of the case-mix adjustor, explaining only 9.7% of variation in costs for various types of patients, HCFA limited the focus of the demonstration project to analyzing behavioral changes for participant home health agencies. It is expected that a final report will be issued on Phase 2 of the demonstration project in either 1999 or 2000.

NAHC is concerned that Phase 2 as it is currently constructed, will not resolve the case-mix problems that have stymied the development of an acceptable PPS model. NAHC believes that the demonstration should be reoriented to deal with these case-mix problems now rather than set aside and left for some later time. Failure to take an accurate account of the medical acuity of an agency's patient caseload will result in inequitable payment levels that make it uneconomical to serve the most severely ill patients.

NAHC Positions on Alternatives to PPS

We would like to reiterate that this Revised Unified PPS Proposal, while an improvement over the current cost-based reimbursement system, is being offered solely in the context of deficit reduction as an alternative to other home care savings proposals.

Some of the proposed savings alternatives, including shifting some home care from Medicare Part A to Part B, placing copayments on Medicare home health visits, and bundling home care payments into hospital DRGs or other provider payments, would have serious detrimental effects on the 3.5 million Americans who rely on quality home health care. Moreover, these proposals could severely limit access to home care, limiting health care choices for our Nation's elderly and disabled to more costly institutions.

We were extremely gratified that in the BBA, the Committee abandoned home health copayments and bundling in favor of a prospective payment system (PPS) as a way to ensure the efficient delivery of home care services.

A to B Shift

The Administration has proposed, as part of its plan to restore fiscal integrity to the Medicare Hospital Insurance Trust Fund, to transfer a portion of Medicare's home health benefit from Medicare Part A to Part B. NAHC greatly appreciates your leadership, Mr. Chairman, as well as the support from other Members of this Committee, for maintaining home care as a Part A benefit.

Such a shift would have very serious consequences for Medicare home health recipients. Part A services are available to all individuals who qualify for the Medicare program. Medicare Part B is an optional program that individuals can join only through payment of monthly premiums.

In addition to de-emphasizing the importance of home care by eliminating its status as an entitlement, this shift would make a major portion of the benefit dependent on taxpayer financing. As a result, Medicare home health beneficiaries could be subjected to additional coverage restrictions including copayments, deductibles and other measures that would further reduce the benefit. This proposal would decrease cost-effective medical benefits to millions of Americans, many of whom have already contributed to the Medicare system, at a time when the need for home care services is growing.

Copays

Copayments on Medicare home health services also have been discussed by Congress as a way to increase beneficiary accountability and to control home health utilization. Imposition of a home health copayment would create a new "sick" tax on the most frail and vulnerable elderly and disabled Americans -- those who could least likely afford it. Moreover, the policy is "penny wise and pound foolish" and may end up costing the Medicare program more since patients who cannot afford the copayment may defer necessary services, resulting in subsequent nursing home placements, hospitalization or care from other more costly institutions.

Medicare home health copayments do not take into account the in-kind contributions made by Medicare home care patients toward the cost of their care. When Medicare pays for the care of an individual in a nursing home or hospital, it also pays its share of the cost of the building, maintenance, overhead, food, heat, and other significant costs, none of which Medicare incurs with home care. In addition, home care patients, families, and friends make significant contributions to care through "sweat equity." Individuals who receive no Medicare reimbursement provide significant care to Medicare home care patients, as home care nurses train family members and friends to provide care at home.

When the home health benefit was first enacted in 1965, it contained a copayment requirement. This copayment was later dropped because it cost Medicare more to collect in administrative costs than it saved the program. Copayments were a bad idea then, they are a bad idea now.

Bundling

Bundling home care payments into other provider payments would severely compromise both the quality and accessibility of home care available to Medicare beneficiaries in a number of ways. First, many hospitals have limited experience with the provision of non-hospital post-acute care services. Second, home care payments based on DRG rates simply would not meet patients' needs.

Bundling would also vastly 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 -- and would require home care agencies to bill any number of hospitals for the care they provide to post-hospital patients rather than using the current single-billing system. This two-track system would result in uneven Medicare coverage for patients with the same care needs as hospitals interpret coverage rules differently.

Conclusion

Thank you again, Mr. Chairman, for the opportunity to present our views on this important topic. Home care has waited for many years to get to this point in the development and consideration of a prospective payment system for home care. You and the Committee have our thanks for bringing the issue to this level of consideration and we look forward to working closely with you in bringing PPS to enactment.

Chairman THOMAS. We all join in trying to get CBO to offer realistic assumptions.

Mr. Hoffman.

STATEMENT OF PHILLIP I. HOFFMAN, CHIEF FINANCIAL OFFICER, OUTREACH HEALTH SERVICES, AUSTIN, TEXAS, ON BEHALF OF THE PPS WORK GROUP

Mr. HOFFMAN. Mr. Chairman, my name is Phillip Hoffman. I am the chief financial officer of Outreach Health Services which provides Medicare covered home health services throughout the State of Texas for both for-profit and nonprofit organizations. We're only 25 years old.

I am testifying today on behalf of my company and the Prospective Payment System Work Group, a coalition of 20 State and national home health associations. My work experience includes participation in both phase I and phase II of the prospective payment demonstration project administered by the Health Care Financing Administration.

I have also participated in the Prospective Payment System Work Group which together with the National Association of Home Care has crafted the Revised Unified Prospective Payment Plan, which I will briefly describe today, as a substitute for the current cost reimbursement system and as an alternative to copayments. Several elements of this plan are modeled after the phase II demonstration project.

My grandmother, a first-generation American who came of age during the Great Depression, would have made an excellent policy advisor to you on how to run the Medicare home health program. Coping with the scarcities of this era taught her the value of a dollar. Accordingly, she would have cautioned against perpetuating cost-based reimbursement for the Medicare home health program.

Cost reimbursement creates an artificial marketplace governed by reimbursement regulations rather than market forces. The laws of supply and demand do not operate effectively in this environment because competition exists only for the quantity and quality of services. The concept of value is, for all intents and purposes, absent from consideration.

As a result, the Medicare home health care program has forgotten the value of a dollar. With the costs of providing services considered to be of only secondary importance, we should not be surprised that efficiency may be relegated to low-priority status by providers, unless their costs exceed the cost limits.

In fact, the cost reimbursement mechanism can actually create perverse incentives. When a home health agency's costs exceed the cost limits, it has an incentive to seek additional volume to average down its costs until they fall below the limit. However, when these efforts succeed to the point where the agency's costs are well below the limit, it loses any incentive to control its costs. Inevitably, costs creep up and the cycle begins again.

There is broad-based consensus in the home health community that high-quality services can be provided in a more cost-effective manner through a prospective payment system which rewards efficiency and creates disincentives for waste and inefficiency.

The Revised Unified Prospective Payment Plan achieves these objectives while creating significant savings for the Medicare Program. The plan's specifications draw upon three primary sources.

First, the phase II home health prospective payment demonstration project approved by Health Care Financing Administration. Second, the home health prospective payment system passed by Congress during its last session. And third, the administration's home health payment reform proposal.

The plan structure includes the following principal components. First, per-visit payments will be maintained to preserve continuity with current practices and to preserve cash flow for providers. Per-visit payments would, however, be prospectively set based upon average costs in the provider's region during a base period.

Second, annual aggregate limits on payments to home health agencies would be imposed on both per-patient and per-episode bases.

Finally, savings sharing between the home health agency and the trust fund of the difference between total payments to the provider and the aggregate payment limits creates an incentive to control both utilization and cost.

The Revised Unified Plan structure calls for a phase-in of its various components. The phase-in approach was adopted to simplify implementation and address the Health Care Financing Administration's implementation concerns.

Phase I is in place for the first 24 months and includes the imposition of the annual per-patient payment limits to providers covering the full spectrum of covered home health services. This feature is similar to the administration's plan and was added to allay the Health Care Financing Administration's concerns regarding the difficulty in gathering data to implement per-episode payment limits.

In phase II, patient episode payment limits are introduced using the phase II demonstration project 120-day definition of an episode. A case mix adjuster, also borrowed from the phase II demonstration project, is employed to adjust the per-episode payment limits for expected differences in care requirements for different patient episodes.

Care delivered to patients beyond the 120-day episode is subject to an annual per-patient limit. In all cases, the savings sharing provision creates the incentive for home health agencies to provide cost-effective, efficient care. Within 4 years of implementation of the prospective payment system the Secretary will be required to present to Congress a pure per episode prospective payment system to be jointly developed by the Health Care Financing Administration, the industry, and consumers.

The case mix adjuster proposed for use in the Revised Unified Prospective Payment Plan has been criticized for its imprecision because it predicts only 9.7 percent of the variation in resource utilization between episodic categories. However, the hospital DRG system, which serves as the case mix adjuster for payments by the Medicare Program to hospitals and is considered by HCFA to be highly effective, predicts only approximately 35 percent of the variation in resource utilization between case-mix categories.

The primary purpose for the proposed case mix adjuster is to discourage attempts by providers to manipulate the system by chang-

ing their case mix in favor of short stay, low utilization patients. We believe that this case mix adjuster, even with its limitations, is adequate for that task.

To summarize, it is time for the government to become a more cost-conscious buyer of home health services. We need a system that encourages providers to be innovative in creating cost-effective approaches to quality care. The industry is ready. It has developed a realistic plan to accomplish this end and we believe that its implementation will achieve scorable savings comparable to those of the administration's plan over 6 years. But to move forward, we need your help.

I appreciate the opportunity to speak with you today and all three of us would be happy to entertain any of your questions.

[The prepared statement follows:]

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to the Prompt Implementation of Medicare Prospective Payment for Home Care

HEARING BEFORE THE UNITED STATES COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

1100 Longworth Office Building
Tuesday, July 23, 1996

Medicare Payment Delivery for Home Health Agency and Skilled Nursing Facility Services

TESTIMONY OF PHILLIP I. HOFFMAN, M.B.A.

Mr. Chairman, my name is Phillip I. Hoffman. I am the Chief Financial Officer of Outreach Health Services, which provides Medicare covered home health services throughout the State of Texas through both for-profit and nonprofit organizations. I am testifying today on behalf of my company and the PPS Work Group, a coalition of twenty (20) state and national home health associations.

My work experiences includes participation in both Phase I and Phase II of the Prospective Payment Demonstration Project administered by the Health Care Financing Administration. I have also participated in the PPS Work Group which, together with the National Association for Home Care, has crafted the Revised Unified Prospective Payment Plan, which I will briefly describe today, as a substitute for the current cost reimbursement system and as an alternative to copayments. Several elements of this plan are modeled after the Phase II Demonstration project.

My grandmother, a first generation American who came of age during the Great Depression, would have made an excellent policy advisor to you on how to run the Medicare home health program. Coping with the scarcities of this era taught her the value of a dollar. Accordingly, she would have cautioned against the perpetuation of cost-based reimbursement in the Medicare home health program.

Cost reimbursement creates an artificial marketplace governed by reimbursement regulations rather than market forces. The laws of supply and demand do not operate in this environment because competition exists only for the quantity and quality of services. The concept of value is, for all intents and purposes, absent form consideration. In other words, the Medicare home health program has forgotten the value of a dollar. With the cost of providing services considered to be of only secondary importance, we should not be surprised that efficiency may be relegated to low priority status by home health agencies unless their costs exceed the cost limits.

In fact, the cost reimbursement mechanism can actually create perverse incentives. When a home health agency's costs exceed the cost limits, it has an incentive to seek additional volume to "average down" its costs until they are below the limit. However, when these efforts succeed to the point where the agency's costs are well below the limit, it has no incentive to control costs. Inevitably, cost creep up and the cycle begins again.

There is a broad-based consensus in the home health industry that high quality services can be provided in a more cost effective manner through a prospective

payment system which rewards efficiency and creates disincentives for waste and inefficiency.

The Revised Unified Prospective Payment Plan achieves these objectives while creating significant savings for the Medicare program. The plan's specifications draw upon three (3) primary sources:

1. the Phase II Home Health Prospective Payment Demonstration Project approved by HCFA;

2. the home health prospective payment system passed by Congress during its last session; and

3. the Administration's home health payment reform proposal.

The plan's structure includes the following principal components.

1. **Per visit payments** will be maintained to preserve continuity with current practices and to preserve cash flow for home health agencies. Per visit payments would, however, be prospectively set based upon average costs in the provider's region during a base period.

2. **Annual aggregate limits on payments** to home health agencies would be imposed on both per patient and per episode bases.

3. **Savings sharing** between the home health agency and the Trust Fund of the difference between total payments to providers and the aggregate payment limits creates an incentive to reduce both utilization and cost.

The Revised Unified Plan's structure calls for a phase in of its various components and simplification of Phase I. This approach was adopted to address HCFA's implementation concerns. Phase I is in place for the first 24 months and includes the imposition of annual per patient payment limits to providers covering the full spectrum of covered home health services. This feature is similar to the Administration's plan and was added to allay HCFA's concerns regarding the difficulty in gathering data to implement per episode payment limits.

In Phase II, patient episode payment limits are introduced using the Phase II Demonstration Project 120-day definition of an episode. A case mix adjuster, also borrowed from the Phase II Demonstration Project, is employed to adjust the per episode payment limits for expected differences in care requirements for different patient episodes. Care delivered to patients beyond the 120-day episode is subject to an annual per patient limit. In all cases, the savings sharing provision creates the incentive for home health agencies to provide cost effective, efficient care needed by their patients.

Within four (4) years from implementation of the prospective payment system, the Secretary will be required to present to Congress a pure per episode prospective payment system which is to be jointly developed by HCFA, the industry, and consumers.

The case mix adjuster proposed for use in the Revised Unified Prospective Payment Plan has been criticized for its imprecision because it predicts only approximately 10% of the variation in resource utilization between episodic categories. However, the hospital DRG system, which serves as the case mix adjuster for payments by the Medicare program to hospitals and is considered by HCFA to be highly effective, predicts only approximately 35% of the variation in resource utilization between case mix categories. The primary purpose for the case mix adjuster is to

discourage attempts by providers to manipulate the system by changing its case mix in favor of short stay, low utilization patients. We believe that the case mix adjuster, even with its limitations, is adequate for that task.

To summarize, it is time for the government to become a more cost conscious buyer of home health services. We need a system that encourages providers to be innovative in creating cost effective approaches to quality care.

The industry is ready. It has developed a realistic plan to accomplish this end, and we believe that its implementation will achieve scorable savings comparable to those of the Administration's plan over seven (7) years. But to move forward, we need your help.

I appreciate the opportunity to speak with you today and would be glad to answer any questions.

Chairman THOMAS. Well, thank you very much and I want to complement the gentleman for getting 10 minutes of testimony in, in the 5-minute period.

It makes it even more astounding when the gentleman is from Texas. [Laughter.]

Just one question and it was touched on by several of you—in terms of your most recent unified proposal and what it looks like in terms of CBO's analysis in that it probably would not provide savings and, in fact, it may cost more.

We hope that we can create a working environment if that is the case because although I am very much in favor of a prospective payment system, I am not in favor of one that does not reduce the costs, since that's one of the concerns that we have. It might make it more rational and rationality is a goal in terms of the payment structure, but reduction is also something that we need to deal with.

I would invite any comments in terms of all of us agreeing that we want CBO to be as realistic as possible in its estimates and you need to know that since the President's proposal, there has been an enormous growth curve in the understanding of how the health system works, not just by the Members of Congress, but by those folks who try to do estimating in the Congressional Budget Office as well.

The difficulty comes when we go cutting edge and talk about making changes in which there's simply no model that's available then we will always wind up with disagreements on the question of utilization and other problems. So, we certainly complement you in your effort to continue moving in the direction of creating a prospective payment system but we will pledge to you, working together, to make sure that when folks analyze it, they analyze it as fairly as possible.

But this is going to be an ongoing learning experience for all of us.

Mr. HOFFMAN. We appreciate your help.

Chairman THOMAS. I do note that all of you have talked about your opposition to any kind of a, even a modest copay. Historically they had the deductible. Just give me, in as encapsulated a way as possible, what's wrong with a very modest amount which people will use as a very weak screening device for making choices in terms of what they would do?

Most people think it's rather salutary that folks put up a very modest amount. Is it the degree of money that would be involved on the part of the beneficiary, is it that it is an item that could be racheted up, or is it the very concept of requiring a beneficiary to make even a modest copay that is troublesome to you, folk?

Mr. HOLT. Well, I would—I think we are all going to probably want to comment on that—but let me just start off by saying that I think that——

Chairman THOMAS. It's not necessary, but if you want to.

Mr. HOLT. I can not stop them. I think the copay will cause patients to refuse needed services in home health care. I think it will have, even if—I picture a nurse in a home saying to the patient, when the nurse knows and the physician has signed off on this treatment that the patient needs at home and the nurse begins to

approach a patient about a copay, will have a chilling effect on the patient's willingness to accept needed care. And because of that, I think that typically the patient will deteriorate without such home care services and will land back into the hospital or the nursing home.

It's extraordinarily difficult to bill and collect copay for this type of service and it will escalate the cost of the service. It can probably be accurately characterized as a sick tax and one that has a particularly harsh effect on frail elderly.

Peg and Phil may want to join me.

Ms. CUSHMAN. I second the piece on the frail and sick elderly. As was commented earlier, only a small portion, 10 percent, of all Medicare beneficiaries actually use the home care benefit. They tend to be older, they tend to be sicker and they tend to have a higher percentage in the poverty area.

But in addition to that, I would like to second the notion of the expense of the copay and I am certainly not advocating a less than modest or a greater than modest copay, as you suggested. But if, in fact, it were a modest copay, the cost of billing, because we are currently in cost-based reimbursement—and we have per-unit billing which are fairly small amounts compared to a big hospital room day—every single one of those items has to be generated on a duplicated basis, you would then attempt to collect. If we do not collect, it's appropriately Medicare bad debt and goes back to the system.

As I noted in my written testimony, there originally was a copayment in the home care/Medicare and it was more onerous than it was beneficial.

Chairman THOMAS. Before we get a third statement, if Mr. Hoffman wants to make it, it is our understanding that when you look at the patient profile, that payments are made by Medicaid and Medigap for what would amount to about 89 percent of the population. So, if we're talking about out-of-pocket expense, which is the onerous requirement on the nurse to collect the money at the time she's hovering over the patient at home, purporting to deliver a particular service, we're talking 10 to 11 percent of the population, are we not? Or, do you disagree with that 89 percent figure?

Mr. HOFFMAN. I have heard that assertion made on numerous occasions, as well, but I can only——

Chairman THOMAS. I hasten that it came from the Democratic staff, so——[Laughter.]

Mr. HOFFMAN. I can only tell you what the world is like where I come from and 90 percent of our patients are not covered by Medicaid or Medigap for home health care services. And even if a large proportion were covered by Medicaid, the Medicaid coverage for home health in Texas is not terribly liberal.

I think I would like to follow up on what Peg and Steve said, as well, with regard to the copayment and elaborate on the sick tax notion. These are not preventive services that we're talking about here. The services that are received by home health care beneficiaries are because these people are ill and these are exactly not the kind of services that you want them to not receive. There is no copayment for hospital stays, there is a high deductible to be sure but that high deductible is absorbed within the first day of hospital

care. Since there is no copayment for hospitals, for the very same reasons, there should be no copay for home care.

Chairman THOMAS. Truth in packaging requires me to state that our staff agrees with their staff on the 11 percent. But obviously, this is a statistic and it's nationwide and just like we find someone who's fast-talking from Austin, maybe you've got a situation which is an anomaly as well.

I do want to thank all of you though in terms of your clear understanding of what the administration's proposal on the $55 billion shift is. It is no solution. And, in fact, it would create the appearance of having solved the problem and I think all of us are primarily interested in solving problems rather than doing what, in part, has been done in the past and that is, appearing to solve problems.

Now, does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

I just want to see if the panel can clear up my confusion on the suggested prospective payment plan. In the aggregate limits, would those be an aggregate limit per person or would they be an aggregate limit, depending on the diagnosis?

Mr. HOFFMAN. I am sorry, what was the second part of your question?

Mr. STARK. You have episode per-patient limits. Let's just stick with the patient limit, annual aggregate limit.

Mr. HOFFMAN. Right.

Mr. STARK. Would that be the same limit for a hip replacement as it would be for a stroke?

Mr. HOFFMAN. The answer is, yes, in phase I.

Mr. STARK. OK. That does not make sense to me. If you know that somebody normally only takes two or three visits on one diagnosis and 100 visits on the other, we are not saving any money.

Mr. HOFFMAN. Right. What you are suggesting is exactly what a case mix adjuster is designed to take account of. The problem that we have, as we have been told by the Health Care Financing Administration, is that it would take them some time to gather the data in order to implement the case mix adjuster and that is the purpose for phase I.

Mr. STARK. OK. So, that's only initially?

Mr. HOFFMAN. Exactly. And our industry goal would be for that phase I period to be as short as possible.

Mr. STARK. OK, and the per-payment visit would be established by the prospective, whatever, the DRG let's call it for lack of a better word.

Mr. HOFFMAN. The episodic limit?

Mr. STARK. Yes.

Mr. HOFFMAN. Yes.

Mr. STARK. And the per——

Mr. HOFFMAN. The per-visit payments would be established based upon the regional costs in the same fashion, that is, using the same methodology of cost limits.

Mr. STARK. The proprietary charges out when you calculate that, right?

Mr. HOFFMAN. I beg your pardon?

Mr. STARK. You leave the proprietary charges, which are much higher than nonprofit charges, out, calculated on a median charge?

Mr. HOFFMAN. All costs would be averaged in together.

Mr. STARK. Including the proprietaries?

Mr. HOFFMAN. Yes, sir.

Mr. STARK. Oh, come on. How about just the not-for-profit and the municipals?

Mr. HOFFMAN. Well, I think, as a matter of fact, at least for the per-visit costs, the proprietary, the data suggests that the proprietary costs per visit is lower than the not-for-profit and hospital-based costs per visit.

Mr. STARK. I am not sure that's the data I have been seeing, but if that's true then you should agree with me that we should keep them out.

Mr. HOLT. If I may——

Mr. STARK. Yes. Let me just go back on the copayment. While I have never been a great advocate of copays other than minimal, and by minimal, I am talking $5 or $10, whether that is a day or whatever, in capitated HMOs that provide pharmaceutical charges or visits, one has found that there is some minimal amount that seems to discourage overutilization by the patient and, yet, not discourage people from getting needed care. That's hard to find where that is, but let's say, it's $5 or let's say it is $10.

And, there are only 10 or 11 percent of the Medicare beneficiaries that are not either covered by Medicaid or Medigap. So, you're talking about a very small number whose copayment would not be picked up by insurance. And that, my colleagues and I have not had any complaints, that we know of, on the copay for hospitals which is now, since I have been in this racket, up to $730. That would provide 6 or 8 months of copays for home health visits, if you figure every third day at $100 a visit and a $10 copay.

Other than maybe a dislike, a philosophic dislike, which I am not sure is wrong, there might just be some incentive for the patient to save, too, and say, "no, do not come back next Thursday, I think I can make it without you coming back." And, the theory that my mother would not figure out that she is not saving $10 for Prudential, she's saving it, in general.

What's such a big deal about that?

Mr. HOFFMAN. I think that—and I am not as familiar with the data as I probably should be—but I believe that if 90 percent is the number then I would imagine that the vast majority of that 90 percent is Medicaid as opposed to Medigap and I think that Medicaid probably does a much better job of covering the hospital deductible——

Mr. STARK. No, no, no.

I mean Medicaid covers, I am going to guess, one-third of the Medicare beneficiaries and I am going to guess that the biggest balance of 50 or 60 percent on top of that have Medigap insurance. This is widely held. They would pay, most policies would pay some kind of copay.

Mr. HOFFMAN. Again, I cannot comment on that nationally. I know for the patients that we serve, the majority of our patients do not have that Medigap insurance.

Mr. STARK. They have it, but it may not cover you.

Mr. HOFFMAN. That could very well be, yes, sir.

Ms. CUSHMAN. If I could, on the theory that 90 percent does not pay out-of-pocket——

Mr. STARK. Or 85 or whatever, But yes.

Ms. CUSHMAN [continuing]. Then that also is not an out-of-pocket discouraging factor for the beneficiary. So, for that 90 percent, that also would not achieve what I think I am hearing you say we would like to.

In the instance of a prescription drug copay ordinarily the individual is there at the pharmacy and hands the money over. It's not a separate billing. For the modest amount, again, the billing and the added personnel required to literally double-bill and attempt to collect every single unit of service would be extremely expensive.

Mr. STARK. That makes sense.

Mr. Holt, I cut you off but if the chair wants to let you respond, go ahead. I am sorry.

Mr. HOLT. Thank you. One last thing on the copay, I have just been in too many patients homes where the mere mention of it is a chilling effect on the patient's self-denial of care that they need. That would ultimately cost more dollars because the patient will deteriorate in their home and go back into the hospital.

On what I was going to say earlier relating to utilizing a variety of auspices, for-profit, not-for-profit, hospitals to determine these, I, too, had some concerns about that from a nonprofit perspective, since, I am from a nonprofit agency. But, in order to get the industry support, which was necessary, we all had to make compromises along the way. That was one that we made so we could get the industry support needed to carry this to the Hill.

Mr. STARK. And you made a little extra in the bargain.

Thank you.

Mrs. JOHNSON [presiding]. The chairman is temporarily gone but he indicated I should go ahead.

I want to give you this chance to really talk about your unified proposal and particularly to talk about how, in phase I, your proposal would both reduce costs and assure quality of services. And, how you would respond to CBO's claim that there would be so much gaming of the system that they should discount your estimates of savings by two-thirds.

Let's just look at that first phase of the 2 years. I think once we get a case mix adjuster in there, I think it's not going to be so hard to agree on an episode payment. But what we do in the interim is extremely important.

Mr. HOFFMAN. Well, the way the plan saves money in phase I, it saves money really in two ways. On the one hand, by virtue of having the per-patient limit, the maximum amount that Medicare would pay for services on a per-patient basis would be capped, it would be frozen at historical utilization levels.

The second way that the program would save money would be by providing the incentive for providers to actually provide more efficient care because there is a savings sharing provision in the plan.

So, that if——

Mrs. JOHNSON. Excuse me, how does that work?

Mr. HOFFMAN. I am just going to describe that. If I could use a hypothetical example, if the patient cap, the aggregate annual pa-

tient cap for an agency was $1 million but the agency's total per visit payments were $700,000 during a year, that would constitute a savings to the program of $300,000 which the program would split with the provider on a 50/50 basis subject to the provider's profits being limited to 10 percent of the total payments that they receive in a year.

So, the provider would have a very clear incentive to provide efficient care and would have no incentive, whatsoever, to overutilize services. It would work against them to do that.

Mrs. JOHNSON. But if they go over their cap, as a result of the demand——

Mr. HOFFMAN. Then those excess payments would have to be repaid to the program, dollar for dollar.

Mrs. JOHNSON. Where is the disincentive to not care for more patients than you can get reimbursed for? That procedure cap.

Mr. HOFFMAN. Now, we're talking about a problem at the other end of the spectrum and that's where the importance of monitoring comes. As part of our proposal we propose a peer review approach to help control quality.

Mrs. JOHNSON. I can see that peer review might be able to control volume, but would it be possible for an agency to simply charge the maximum and, in a sense, multiply the services for a smaller caseload, and get up to their cap, that's all they can earn. And, say, we've spent all this money, and we are not going to do any more?

Mr. HOFFMAN. During phase I, there is a theoretical potential for the type of gaming that you suggest because the absence of the case mix adjuster, which is why we advocate that that period be for as short a period of time as possible.

However, I can tell you that out there in the home health world, I know my agency and I would think most other agencies would find it to be quite foolish to change one's case mix intentionally to go and seek out those short-stay, low-utilization patients in return for a short-lived gain.

Mrs. JOHNSON. And, the cap during this initial period is based on the average cost of patients for that agency?

Mr. HOFFMAN. During phase I, during the first 12 months, the cap is 75-percent agency specific and 25-percent census region. It's a weighted average. And then, during the second 12 months that weight changes to 50-percent agency specific and 50-percent census region.

Mrs. JOHNSON. Thank you.

Anyone else want to contribute to how that first part works?

Mr. HOLT. Well, I think I agree with Phil that it's theoretically possible in phase I, not practically though, from the home agency standpoint to shift operations for only one year. It's difficult enough just to make a billing change in an agency.

But then also, although certainly even given that, the phase I is vastly superior to what we have now in terms of managing growth, I would say. So, it's not perfect and none of us will say it's perfect but we would go for the good rather than searching for the illusory perfect.

Mrs. JOHNSON. And so, how would you answer the Congressional Budget Office's gaming charges?

Ms. CUSHMAN. I'd like to make one comment in that my understanding is that one of the major issues that Congressional Budget Office is claiming is that agencies could increase the number of beneficiaries receiving home care. That's also possible under the current methodology. I actually fail to understand how agencies could increase the pool of individuals who would want to receive home care while, since those who are in need welcome someone in their home to assist them, most individuals, if they really do not have a need for care and services do not want someone unnecessarily into their home doing things.

There's also the safeguards of medical necessity and all the coverage requirements of the current Medicare law for home care.

Mr. HOFFMAN. I would echo that. There are no meaningful incentives introduced by prospective payment system to scrounge up patients than exist under current law and reimbursement.

Mrs. JOHNSON. Aren't there also criteria in the Medigap policies, that is billing criteria for home care?

Mr. HOFFMAN. I do not know.

Mr. STARK. Would the gentlelady yield?

Mrs. JOHNSON. I would be happy to yield.

Mr. STARK. It seems to me there is an incentive though that you do not deal with in the hospital owned subacute facilities. You got a DRG, the hospital gets the payment. You come in for a hip transplant and that averages 3 days. So, we have set the DRG based on the fact that you're going to be in the hospital for 3 days.

The hospital says to you, you got your hip, we got good subacute care, you go home or you go to our SNF. They boot you out a day or two early into their hospital owned subacute facility or home care facility and then they double dip. They get the full DRG and then they get the payment from the home health or SNF which all goes into the same pot. Basically they get a larger payment when they probably should have kept the patient in there the full 3 days anyway.

Now, how do you deal with that under your plan—where you got this all in one ball of wax, the ownership of the facilities, the home health agency or the subacute agency and the acute care hospital?

Ms. CUSHMAN. If I could——

Mr. STARK. I am saying the hospital ought to keep them longer. We've been spending all our time trying to get the hospital to get them out faster. Now, we say, wait a minute, if you do that, maybe we ought to cut your DRG payments. But that gets——

Ms. CUSHMAN. If I understand the question, it is how does prospective payment in home care address or how does it articulate the hospital's, I gather, appropriately discharging patients earlier, into another setting where they can be treated effectively.

Mr. STARK. Well, there's an incentive for them because they end up getting more money. They save a day or so. There's an incentive to cut short the acute care stay and that's a matter of judgment, it's a close call. But there's a financial incentive now to get them into their hospital owned facility, to get a second reimbursement, if you will, for that third day.

Let's say everybody agrees it's a 3-day stay but if you can get them out at the end of the second day, they get paid in the DRG

for the third day and they also get paid for it in the home health care or acute or SNF care.

Mr. HOFFMAN. I am sure that's true but——

Mrs. JOHNSON. If I could interrupt for a minute.

In a sense every hospital has an incentive because if they get someone out earlier they make more money in the DRG. What I think the gentleman from California is trying to say is that if they also are the ones who receive the payment for the home health care, while they have to provide that service they do get more money because they get both payments. They also have to provide both sets of services.

Mr. HOFFMAN. Right. I have never thought about it that way but I would agree with your analysis. I would think, nevertheless, that it should be the goal of the program to get the earliest possible appropriate discharge of patients out of the hospital.

Mr. STARK. If the gentlelady would yield. There was some data and I have it here in this mess of papers, that shows far higher utilization of home health care agencies from hospitals who owned the facility. I mean significantly higher utilization of SNFs and/or home health care where the discharging hospital owned that facility and I am going to say by a factor of two times.

Mrs. JOHNSON. See, the problem in my estimation is that we really do not have the information and this is what I was trying to bring up with ProPAC as to whether that is a better continuum of care, from the patient's point of view. Was it better to get out a day early with an appropriate home care or not?

So, it may be that where the hospital owns both of these facilities they are more conscious and where they do not, they are not as informed about what home care can do.

Anyway, your comments?

Mr. HOLT. Well, if I may, and then the question was, how does this prospective payment system impact such a situation? It may very well be if you go back to the nature of the prospective payment system is that the incentive is not just to provide more visits. The incentive is to clinically manage the care within your aggregate cap.

Now, they would still have the incentive to discharge to their own home health agency, that has not changed.

Mr. STARK. We're getting dangerously close to a word you do not like which is bundling. So, we'll move away from that, because the minute you begin to—I mean that, you begin to say well, maybe somebody ought to look at this continuum of care and make a decision. Dollars ought not to impact on that.

Ms. CUSHMAN. I would like to add that while it is true that there are many other issues surrounding the prospective payment for home care, we still feel this is an enormous step in the right direction. And the creation of an episodic system would push us in the direction of both gathering the data and designing the episode related to home care which would make it easier to rearticulate that back to the care in other settings in a bigger policy framework at a later date.

Mr. STARK. I agree.

Mr. HOFFMAN. And, I would echo that sentiment as well. If we wait until we know everything before we do anything, we will never do anything.

Mrs. JOHNSON. I think the real strength of your proposal is that it gives us a reasonable place to start and it gives us the incentive to get the work done to move forward.

I thank you for your testimony and yield back to the chairman.

Chairman THOMAS [presiding]. Thank you very much.

Does someone from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman.

Most of the questions I had have been asked. I want some clarification though on the annual aggregate cap. Is that per home health agency?

Mr. HOFFMAN. Yes. In phase I that is home health agency specific because there is a agency specific component to that being 75 percent in the first 12 months and 50 percent in the second 12 months

Mr. MCCRERY. And, explain to me how that cap is derived?

Mr. HOFFMAN. Well, the portion of it that is not agency-specific is based upon the average cost per patient, the average historical cost per patient in the base year in the census region. For the agency-specific component it is based upon that specific agency's historical cost per patient in the base year, if I said that correctly.

Mr. MCCRERY. Yes. But is there some estimate made of the number of patients to be served in that year or is it actual patients served——

Mr. HOFFMAN. No. It's actual patients served in the base year. It's actual cost and actual patients. There's no projection, whatsoever.

Mr. MCCRERY. OK, thank you.

Mr. HOFFMAN. I take that back. There is a projection but it is with regard to the inflation update only but there is no agency-specific projection, whatsoever.

Mr. STARK. Mr. Chairman, I was distracted a moment when you asked the question, Jim. Did you ask and did you say that the aggregate limit is for the home health agency?

Mr. HOFFMAN. In phase I the limit is applied on an annual basis to each home health agency.

Mr. STARK. For their gross income or for their per-patient charge?

Mr. HOFFMAN. The annual aggregate amount of the caps, which is the per-patient cap multiplied by the number of patients that they served during that year, that number is compared with the actual payments that are received by the home health agency. So, the cap is not applied on a per-patient basis, it is applied in the aggregate, but for each agency.

Ms. CUSHMAN. This is a great deal like the hospice per diem aggregated cap in how it's applied where you compare, as Phil was saying, the number of patients served. If some are over and others are under that average annual limit, it can average out for an agency. They must stay within that aggregated annual cap.

Mr. HOFFMAN. Correct.

Mr. MCCRERY. But in phase I, you continue to be paid under the current——

Mr. HOFFMAN. Per visit basis but it is no longer a cost reimbursement. It is no longer a cost reimbursed visit. It is a prospectively set rate based upon the average cost in the base year in your region for nursing visits or home health aid visits

Mr. MCCRERY. OK. And so, what you're saying is because of the aggregate limit, you have an incentive not to take more patients and not to create more visits per patient.

Mr. HOFFMAN. Well, the aggregate limit is for the benefit of the program in that it ensures that the program will not spend more than x dollars per patient per year.

Mr. MCCRERY. Yes, so, it's not a disincentive to not add more patients. It is a disincentive not to add more visits per patient?

Mr. HOFFMAN. That's correct.

Ms. CUSHMAN. And, there is also an incentive under the regionally set visit payment, which would encourage agencies to bring any cost per visit that they have in line with their regional average or less

Mr. MCCRERY. OK. So, you have not really addressed Dr. Johnson's concern that as we go to a prospective payment system, home health agencies will have the incentive to simply add more patients.

Can you address that?

Mr. HOFFMAN. This proposal does not limit access to the system. We reject the notion that there will be a groundswell of additional patients admitted into home care because I think we're serving as many patients as we can right now.

But we reject the notion that there will be that wood-work theory, if you will, but if there is—and we do not think that there is—this proposal does not address that issue.

Mr. HOLT. And the largest portion of the growth has come from utilization per patient. That's been the largest reason for the growth in home care utilization per patient. So, I think that's a key factor in managing this growth through a prospective payment system.

I agree with Peg. Most patients do not want, unless they really need, people coming into their homes. I mean that's just from the trenches, they really do not want clinicians there unless they need them.

I prefer using the words clinically managed, in oppose to, the prospective payment system. Because the physician and the nurse will be saying, within this aggregate cap, I have to be challenged to meet certain patient outcomes within the amount of money I have. The whole headset of the physician and the nurse clinician in the home changes because they say, given this cap, I must achieve certain outcomes.

The whole thinking is, I have this much money and I have to do this with this much money and I have to do this with this kind of resource. That is a way of thinking in terms of unlimited visits that does not exist presently.

Mr. STARK. Mr. Holt, I bet you a nickel that you would not find more than one in 100 doctors that currently signs off on home health care treatment that has the foggiest idea of what it costs or how many visits there will be. They just look at that thing and sign off.

Mr. HOLT. Well, I suspect there is a lot of physician education we still need to be doing.

Mr. STARK. And they are going to resist being held responsible for it. I mean now if you took it out of their pay they might get real responsible real quick, but I do not think we can look to them to have, you know, to control your part of the treatment plans.

Mr. HOLT. Well, this prospective payment system puts it on the back of the provider. You know, it is a provider-based prospective payment system.

Ms. CUSHMAN. Mr. Stark, I would like to say I do see that changing and while I do not see it happening overnight, I expect that within a reasonable period of time you will see far more physicians, far more interested and knowledgeable about what home health care can and should do.

Mr. STARK. But, don't you think that will come with more capitated systems, and more of the staff model HMO type systems where they do own the hospital and the home health service, but they're getting a capitated rate.

Ms. CUSHMAN. It's coming partly from capitation and it's also coming from where physician education had nothing to do with home health care just a few short years ago, and now, something like 8 out of 10 medical schools require information and rotation into home care and community settings.

Mr. HOLT. I think there's a very practical reason. Patients are going to be cared for in the home ultimately anyway. That's where the patients are going to be so the physicians will have to be familiar with it.

Mr. STARK. Thank you.

Chairman THOMAS. The gentleman from Louisiana's time has expired.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Just briefly, Mr. Chairman.

Mr. Holt, you made a comment concerning the copayment that it might have a chilling effect on needed care. You are partially correct. I think it could have a chilling effect but I think it would have a chilling effect on some of the care that may not be needed and bring down the costs there.

So, I guess I would encourage you to look at not taking a hardline position on that issue and seeing if that might be something we could look at.

I also wanted to ask Ms. Cushman if you had any data that showed that the length of stay at hospitals had been significantly reduced or reduced at all by the use of home health care services or if your organization had any of that data at their access?

Ms. CUSHMAN. The National Association for Home Care can provide that information for you subsequent to this hearing. Anecdotally I can share with you as a single agency, we have both been able to get patients out of hospitals earlier and, equally significantly, avoid some hospitalizations that previously would have been necessary that is both made possible now by increased technology that can be used at home and increased sophistications of skills of practitioners.

Mr. CHRISTENSEN. Over the last 5 years your payment per visit has grown 3 percent. During that time, have you had many ancil-

lary type of procedures performed on home health care or has it been pretty much stationary?

Ms. CUSHMAN. Could you explain what you mean by ancillary?

Mr. CHRISTENSEN. Has your procedure changed over the last 5 years in terms of services provided? At the payment per visit rising at 3 percent, I commend you in that area, have your needs for services expanded throughout those 5 years?

Ms. CUSHMAN. What's really quite remarkable is you are saying 3 percent. I have also seen 2 percent on average. That the average increase in the cost per unit is so low when the complexity that we are seeing, the technology that we are using—which is always more expensive—and all of the other things that are required of us, including increased training requirements that have been passed federally for home health aids, the increases in expense due to OSHA requirements and CLIA regulations and everything else to be very, very high, we have actually been able to almost reverse that growth trend in visit costs.

Mr. CHRISTENSEN. I would say good job and I would like to see some of the recommendations from your organization on areas that we can help in terms of OSHA, deregulation in areas that you think that we could improve and help the small business owner in making their job easier, and continue to provide the type of service that we need and protections for the patient. Also, we know that the Federal Government has its hand in too many areas. And oftentimes, it thinks it has the cure for everything. If we can help somewhere, we would be open to find out where you think OSHA has overstepped their boundary.

Ms. CUSHMAN. We will be happy to provide you with that information.

[The following was subsequently received:]

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HOME HEALTH AGENCIES AND HOSPICES SHOULD BE EXEMPT FROM CLINICAL LABS IMPROVEMENTS ACT

CLIA was intended to regulate laboratories in order to increase the safety and quality of laboratory tests performed in the U.S. Unfortunately, this law was written so broadly that it imposed new paperwork and fee requirements on thousands of home health agencies and hospices that perform only simple tests -- tests that are available to any home user over the counter from any drug store.

Nearly 90 percent of all Medicare certified home health agencies and hospices perform simple and routine tests that the FDA agrees pose no health or safety risk to patients. Under CLIA, agencies that perform only these tests must apply every two years to HCFA for a waiver from CLIA requirements. This application includes completion of a four page form plus payment of a $100 fee.

Only about 20 percent of Medicare certified home care agencies and hospices perform tests that are complex and that CLIA was intended to regulate.

Proposal: CLIA should be amended to require that only home health agencies and hospices that perform complex tests must apply to HCFA for certification. Agencies and hospices that do not apply for certification should be assumed to be performing no tests beyond those tests approved by the FDA as simple and routine. The current survey and certification process under which all Medicare certified home care agencies and hospices must prove their compliance with HCFA regulations and requirements would serve as a check on whether agencies who have not applied for and received CLIA certification are performing complex tests.

INFLUENCE OSHA REGULATIONS AND ENFORCEMENT AS APPROPRIATE TO THE HOME CARE AND HOSPICE SETTING

ISSUE: Under OSHA's general duty clause, employers are mandated to ensure the safety of their employees in the work setting. OSHA has several proposed regulations that would affect home care agencies and hospices, including driver safety and ergonomics in the workplace. Also, OSHA is currently enforcing regulations which affect all health care workers who are at risk for exposure to bloodborne pathogens and tuberculosis.

While these rules apply to all home care and hospice employers and subsequently their employees, there are certain workers who contract directly with states (independent providers) who are exempt from the rules, but provide in-home services. These states have evaded their responsibility for public health and safety by determining these contract workers to be employees of the client rather than the state, thereby denying the worker and the client protection from potential harm.

RECOMMENDATION:

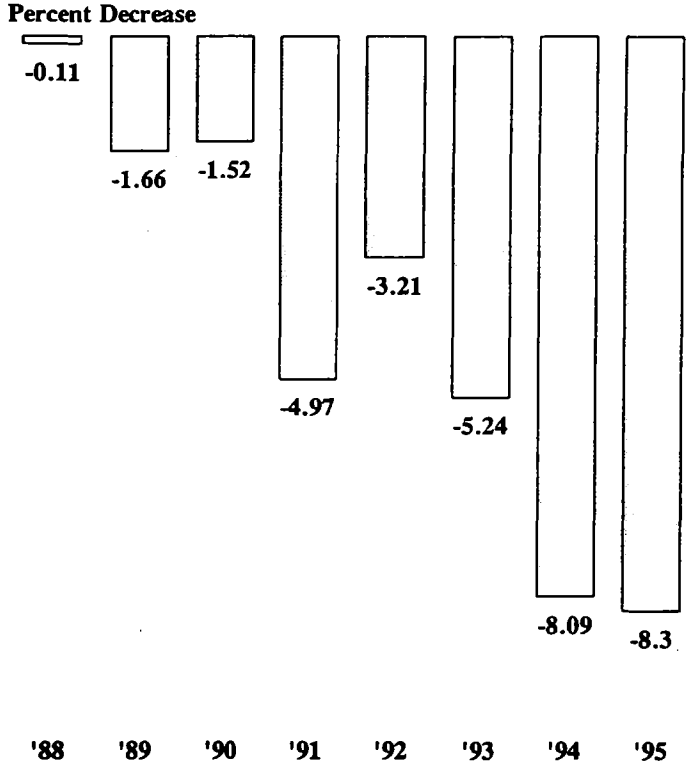
1. OSHA regulations that are applied to the home care and hospice industry should meet the following criteria:

- o There is a demonstrated significant employee safety problem in the home care industry;
- o The proposed remedy is feasible and cost-effective in the home setting;
- o OSHA rules do not duplicate other requirements;
- o Voluntary guidelines have been implemented and did not produce the needed changes; and
- o Home care employers are not held responsible for offsite compliance by the employee.

2. Important client-worker protections should be extended to all home care workers, regardless of who is considered to be the employer. States should be required to ensure that personal care workers who provide services which are financed under federal programs and who run the risk of occupational exposure to hazards are protected.

RATIONALE: All home care workers should be afforded appropriate health and safety protection. Hospice and home care employees are at risk for injuries secondary to auto accidents and musculoskeletal injuries. The potential for exposure to tuberculosis is ever present when providing services in the community. It is incumbent upon NAHC to assist home care agencies and hospices in the application of regulations and guidelines. However, it is critical that OSHA and enforcement inspectors recognize the limitations of imposing restrictions and equipment requirements in a patient's home. Furthermore, employers should not be penalized for employees' failure to conform to safety regulations when outside of the employer's control.

Shortening LOS for Subacute-Related DRGs



Contact: Gary F. Capistrant, Vice-President
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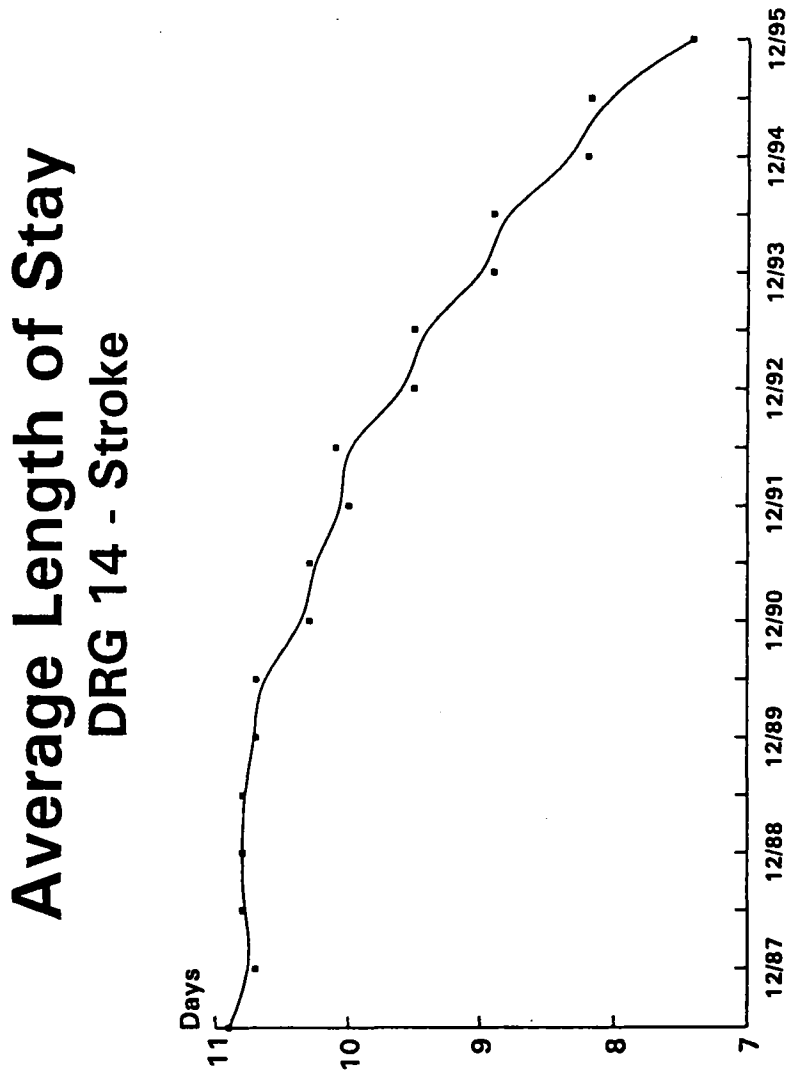
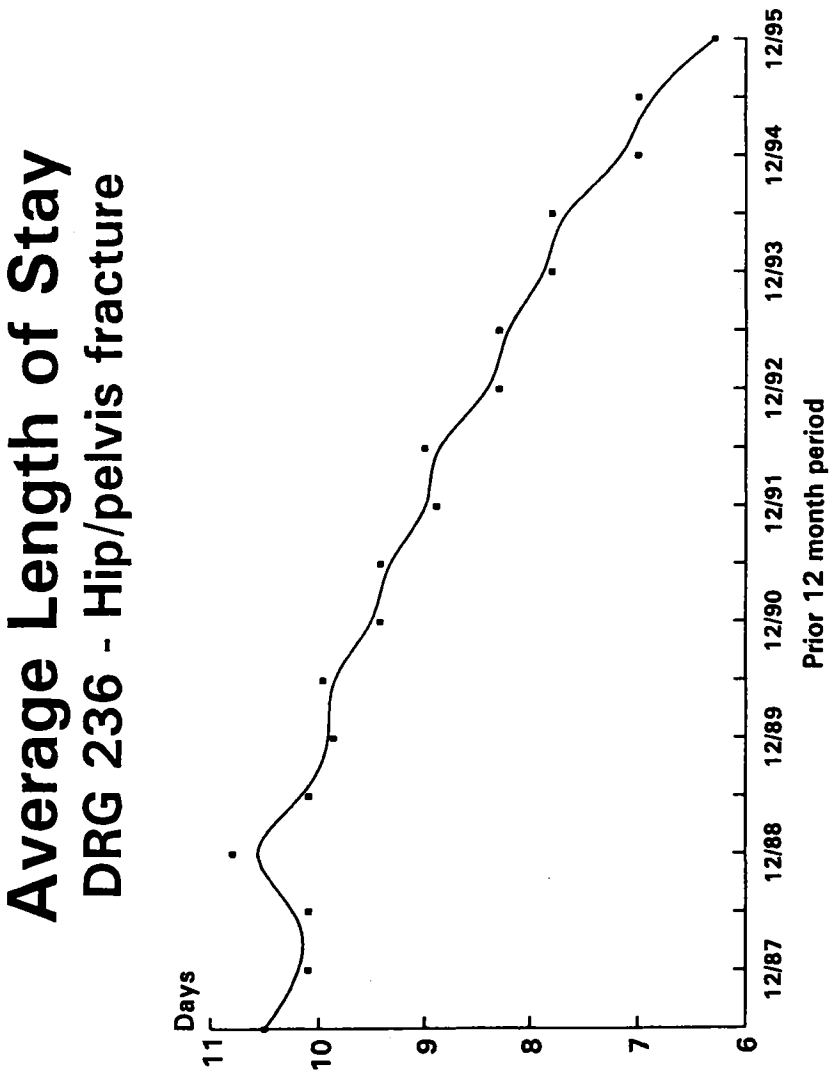

Average Length of Stay
DRG 14 - Stroke
Days
11
10
9
8
7
12/87
12/88
12/89
12/90
12/91
12/92
12/93
12/94
12/95
Prior 12 month period


Average Length of Stay
DRG 236 - Hip/pelvis fracture
Days
11
10
9
8
7
6
12/87
12/88
12/89
12/90
12/91
12/92
12/93
12/94
12/95
Prior 12 month period

Prospective Payment Assessment Commission
Public Handout

December 13, 1995

Post-Acute DRGS: Changes in PPS Hospital Length of Stay

Staff Contact: Karen Fisher
Phone: (202) 401-8859

Post Acute-Care
Length of Stay Analysis

- Post-acute care DRGs identified based on HCFA research
- 1991-1994 period examined
- DRGs with less than 300 discharges excluded

Change In Length of Stay For All DRGs, 1991-1994

	1994 Discharges[a] (In Millions)	LOS (Days) 1991	LOS (Days) 1994	Percent Change[b]
National	10.5	8.1	7.1	-13.1%
Urban	8.3	8.5	7.3	-13.6
Rural	2.1	6.8	6.0	-10.8

[a] Numbers do not add due to rounding.

[b] Percent changes are based on non-rounded numbers.

Change In Length of Stay For Post-Acute Care DRGs, 1991-1994

	For All DRGs	Post-Acute Care DRGS
National	-13.1%	-22.6%
Urban	-13.6	-23.5
Rural	-10.8	-18.2

Change in Length of Stay for Selected DRGs, 1991-1994

DRG	LOS (Days) 1991	LOS (Days) 1994	Percent Change*
209 & 491 (hip)			
National	10.1	7.3	-27.9%
210 (hip)			
National	12.4	9.3	-25.1
014 (stroke)			
National	9.6	7.9	-17.8

* Calculations based on non-rounded numbers.

HOMECARE™

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March 1995

THE FAMILY HOME CARE ACT

Home care keeps families together and can be much less costly than care in hospitals or nursing homes. It allows individuals to receive medical, recuperative, and long-term care in their own homes, with their families, and with greater independence and dignity than in institutions.

Various governmental impediments, however, increase the cost of home care, prevent home care from being available to those in need, and create an administrative nightmare.

Enactment of the Family Home Care Act will enable individuals in need of home care to receive high quality, affordable care in the setting they most prefer -- their own homes -- by simplifying and improving the Medicare and Medicaid home care benefits. Specifically, this proposal will:

- Keep families together;
- Eliminate costly and outdated regulations;
- Streamline administration of the home care benefit;
- Use high technology to make the Medicare and Medicaid programs more efficient; and
- Improve the method of paying for home care.

KEEP FAMILIES TOGETHER

1) Allow payment for home health services for those receiving adult day care.

Homebound home care patients are allowed to attend adult day care centers which provide respite to family caregivers and socialization to isolated home care recipients. These patients, however, are not allowed to receive Medicare home care services while at the day care site. This restriction creates a form of institutionalization in the patient's home. Coverage should be maintained for patients who require special transportation or assistance to reach these centers, and Medicare should cover home care services provided to these patients while at the centers.

Extend spousal impoverishment protections to home care.

When a wife places her husband in a Medicaid nursing home, her assets and income are protected to ensure that she does not have to live in poverty herself. However, if a wife enrolls her husband in a Medicaid home care program to enable him to continue to live at home, she must impoverish herself as well.

The Medicaid program requires that in order for the husband to qualify for Medicaid home care benefits, nearly all of the couple's assets and income have to be spent-down. In 1989, Congress allowed the states to extend "spousal impoverishment" protections to home care, but few states have done so. Congress should enact legislation giving Medicaid individuals the choice of staying at home with their spouses, free from financial pressures to enter a nursing home.

ELIMINATE COSTLY AND OUTDATED REGULATIONS

3) Exempt home health agencies and hospices that perform simple and routine tests from the Clinical Laboratory Improvement Amendments (CLIA).

Some home care agencies perform simple tests that have been determined to pose no risk to patients and therefore have been waived, such as blood glucose testing using devices specifically cleared by the Food and Drug Administration for home use. Others perform moderately complex tests, such as the prothrombin time test using teststrip meters.

These tests are performed under much safer circumstances than full-service labs because there is no danger of confusing patient test results when each test is performed individually in the patient's home. Tests are administered in the home under physicians' orders by nurses who are regulated by state laws. Subjecting these agencies to federal regulations, certification, and registration designed for traditional laboratories is inappropriate, burdensome, and costly.

4) Limit the application of Medicare regulations only to Medicare reimbursed care.

Currently, patients who pay for home health care out of their own pockets or through private insurance must still have their care plan approved by Medicare if they use a Medicare certified home health agency. Under this system, an elderly person who contracts with a Medicare certified agency even for purely custodial care, like bathing, must have this care prescribed by a physician before it can be provided.

Requiring physician's orders in these cases unnecessarily complicates and delays caregiving and increases costs. Home care nurses are qualified and authorized under state regulations to assess needs for unskilled care, order them, and supervise the staff who perform them. In fact, nurses regularly perform these functions outside the Medicare program.

This onerous regulation should be erased, allowing Medicare certified agencies to care for their non-Medicare paying patients as all other agencies do.

STREAMLINE ADMINISTRATION OF THE HOME CARE BENEFIT

5) Allow licensed practical nurses (LPNs) to supervise home care aides.

Currently, only registered nurses (RNs) can supervise home care aides. Allowing licensed practical nurses (LPNs) to supervise home care aides, under the general supervision of RNs, would allow RNs more time to perform complex and highly skilled nursing services and would result in considerable cost savings to the Medicare program. This would conform Medicare rules to standards of practice as regulated by the states.

6) Allow providers to appeal survey and certification deficiencies.

Home health agencies and hospices are sometimes unfairly accused of not complying with the Medicare Conditions of Participation even when they are fully in compliance with these requirements. Agencies may experience public notice of termination from the Medicare program and a requirement to transfer all Medicare patients, prior to review by an Administrative Law Judge (ALJ). Agencies have no formal appeal right in cases where HCFA does not threaten termination, even though the agency may be subject to significant costs and operational changes in correcting nonexistent deficiencies.

Providers should have the opportunity to request a reconsideration of deficiency citations which they believe to be incorrect, and agencies should not be required to submit a plan of correction or take corrective action until the reconsideration has been made. The HCFA Regional Office should review these requests and report its conclusions and supporting rationale to the provider in a timely manner. If the Regional Office reaffirms the surveyor's initial decision, ALJ appeals should be available for all deficiency determinations and no sanctions should be imposed before final appeal decisions are rendered. Of course, deficiencies judged by the state survey agency to involve an immediate and serious threat to patient safety would have to be corrected immediately, pending review by the Regional Office.

7) Permit direct provider appeal rights.

Home health agencies and hospices are not allowed to appeal all Medicare decisions that result in financial liability for the agency or otherwise adversely affect their status with the Medicare program. For example, agencies cannot appeal claims that are denied, but paid under the waiver of liability, even though those claims are counted against the agency's error rate. In addition, providers cannot appeal claims that are denied on technical grounds, such as insufficient physician's orders, nor can they bill patients in these cases. Congress should allow direct provider appeals of all claims where the agency may be harmed.

STREAMLINE ADMINISTRATION (cont.)

8) Implement informal cost report reimbursement appeals.

Increasingly, intermediaries have been arbitrarily and improperly disallowing costs for which home health agencies are requesting reimbursement. Agencies have only two options in appealing these adjustments. Agencies may request: (1) a hearing with the intermediary when the claims involve less than $10,000, or (2) a formal hearing at the Provider Reimbursement Review Board (PRRB) for claims in excess of $10,000. A PRRB appeal is very costly, and there is a substantial backlog of cases leading to long delays. For claims in excess of $10,000, Congress should create an informal appeal at the intermediary level similar to that which is available for Medicare coverage determinations.

9) Improve access to judicial review for Medicare claims.

Congress should allow class action judicial review of Medicare claims involving widespread practices of intermediaries, regional policy interpretations, and challenges to the validity of regulations, without requiring that each party in the class exhaust all administrative remedies. This would eliminate multiple administrative appeals on the same issue and would benefit all affected individuals, regardless of their ability to access the appeals process.

10) Coordinate the OBRA87 training requirements for home care aides and aides in nursing facilities.

Congress should require the Department of Health and Human Services (DHHS) to coordinate the aide training and testing programs for home health agencies and nursing facilities found in the Omnibus Budget Reconciliation Act of 1987 (OBRA87), providing a core subject area that overlaps both home and institutional settings while recognizing the differences in these settings. This would reduce costs by eliminating duplicative and costly certification programs for aides, give aides wider employment opportunities, and give providers greater access to properly trained paraprofessional caregivers.

STREAMLINE ADMINISTRATION (cont.)

11) Require that home care agencies must not only train, but test new home care aides to ensure high quality care and require Medicare to reimburse agencies for these costs.

Medicare certified home health agencies must meet requirements relating to the training and testing of home care aides. The Medicare program should reimburse agencies for the costs of training and testing programs. In addition, Congress should clarify that both training and competency testing is required of nurses aides and home care aides. Under current law, home care aides who complete a competency evaluation program, but are not tested, may work for a Medicare certified home health agency. This measure will help ensure that all providers are properly trained, tested, and supervised.

12) Require cost-effective and sensible systems for ensuring that Medicaid is payor of last resort.

Under pressure to cut their Medicaid budgets, many states are demanding that home health agencies review old claims that Medicaid has paid and submit the claims to Medicare. Under this system, agencies are required to retroactively develop the necessary paperwork to submit the claims to Medicare -- often numerous times due to appeals. If Medicare agrees to pay these old claims, the providers must reimburse the Medicaid agencies the amount that Medicaid paid for those services and wait for Medicare to pay the agencies. This ungainly system, known as "Medicare maximization" or "third party liability (TPL)," is costly and inefficient for all parties -- Medicaid, Medicare, and the home care agencies.

States should be required to use more cost-efficient and sensible systems to ensure that Medicaid is the payor of last resort. And payments should be made directly by Medicare to the Medicaid program.

USE TECHNOLOGY TO MAKE MEDICARE AND MEDICAID MORE EFFICIENT

13) Provide access to Medicare and Medicaid HMO enrollment information and incentives for agencies to care for HMO patients.

Currently, a home care agency has no way to know if a patient who comes to them is already enrolled in an HMO. In many cases, the agency may accept the patient, provide care, and submit for Medicare or Medicaid reimbursement only to be penalized for improperly billing because the patient belongs to an HMO. However, agencies are denied access to up-to-date HMO enrollment information and instead are limited to asking patients and patients' families for enrollment information, which is often incorrect.

Agencies who care for HMO patients in the absence of up-to-date information need to be held harmless in cases where they treat patients only to later find out that the patient was enrolled in an HMO.

14) Require a national data base for home health agency executive compensation.

HCFA uses outdated, unreliable, and inconsistent data to determine compensation for agency administrators. Some intermediaries use data from the 1970s. HCFA should develop a standard up-to-date method of determining administrator compensation.

IMPROVE THE METHOD OF PAYING FOR HOME CARE

15) Develop and test a fair and equitable prospective payment system (PPS) for home care.

In developing a prospective payment system (PPS) for home health agencies, Congress should ensure that the system is equitable for the home health industry as a whole. A PPS must take into account such crucial pricing factors as the medical acuity of an agency's patients and travel time requirements. In addition, any PPS should provide for a predictable payment schedule while minimizing administrative burdens on agencies.

A PPS that pays a flat amount per-visit penalizes agencies whose visit costs are high because their patients need more intensive care or because their patients are located in hard-to-serve locations. Per-visit PPS also penalizes low-utilization agencies (i.e., agencies that provide relatively few visits per patient). Although these agencies provide home care at relatively low cost to the federal government, their per-visit costs tend to be high because they have fewer visits over which to spread the costly initial assessment visit and other fixed costs. Finally, a per-visit PPS could actually increase Medicare expenditures since the incentives in a per-visit PPS are to increase the number of visits. Profits are tied to visits, so the more visits an agency makes, the more profits it earns.

Congress should require DHHS to develop an accurate adjustment for patient acuity, transportation and security costs, labor and other costs as a necessary step toward developing a fair and equitable prospective payment system for home care.

16) Include hospital-based agencies in the home care data base.

One-quarter of all home health agencies are hospital-based. Until recently, Medicare paid hospital-based home care agencies a higher rate of reimbursement than other home health agencies, based on hospital accounting systems. This differential was eliminated in the last Congress. While the differential was in place, the costs and data needed to reimburse hospital-based agencies were kept separate from the costs and data for all other home care agencies. Medicare home care payment rates are based on this data.

Now that the reimbursement for all home care agencies is based on the same data, the hospital-based agency data needs to be added to the reimbursement data base. Continuing to exclude hospital-based home health agency data from Medicare reimbursement calculations leaves one-quarter of the home health industry unaccounted for.

IMPROVE THE METHOD OF PAYING FOR HOME CARE (cont.)

17) Maintain the waiver of liability and presumptive status for home care and hospice providers.

A waiver of liability protects home health and hospice providers who, in good faith, render services to individuals who are ineligible for Medicare or who receive services later determined to be not covered. Under this waiver provision, providers are presumed to have acted in good faith if they demonstrated a reasonable knowledge of coverage standards in their submissions of bills.

The waiver and presumption provisions, however, expire on the last day of 1995. Congress should indefinitely extend both the waiver of liability and presumptive status for home health and hospice providers.

18) Eliminate the lesser-of-cost-or-charges provision.

The lesser-of-cost-or-charges provision (LCC) limits aggregate Medicare home care payments to the providers' charges or costs, whichever is less. In some cases under this provision, Medicare payments would not cover the costs of providing services. In order to recoup these losses, some agencies may try to shift costs to private pay patients.

LCC should be eliminated because it: fails to achieve significant Medicare savings; is inequitable to an agency's private pay patients; prevents certified agencies from competing on an equal footing with noncertified agencies; and is inflationary.

19) Develop alternative payment methods for extended care.

Medicare bases its reimbursement on average visit costs for all patients, Medicare and non-Medicare. Yet, in some instances, there are significant differences between the costs of visits for Medicare and non-Medicare patients. For example, elderly Medicare patients might require substantially longer home care aide visits than younger non-Medicare patients.

Congress should mandate that HCFA implement demonstration projects for alternative payment methods that take account of differences between the average per-visit cost of Medicare and non-Medicare patients. The demonstration projects should study the benefits and costs of alternative methods such as "per hour" or multiple level "per visit" payment systems.

Thank you.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. If there are no additional questions, I want to thank the panel very much. I look forward to working with you as we attempt to create a prospective payment system that not only meets our needs but that we can convince CBO saves some money, as well.

Thank you very much.

Mr. HOLT. Thank you.

Mr. HOFFMAN. Thank you.

Ms. CUSHMAN. Thank you.

Chairman THOMAS. Our last panel for the day will be Susan S. Bailis, president and chief operating officer, of the ADS Group in Massachusetts and she's on behalf of the American Health Care Association; John McMeekin, president and chief executive officer, Crozer-Keystone Health System, Media, Pennsylvania, and the American Hospital Association; and Laurence F. Lane, president, National Association for the Support of Long-Term Care.

All of your written testimony will be made a part of the record and you can inform us any way you see fit. Ms. Bailis, you may begin.

STATEMENT OF SUSAN S. BAILIS, PRESIDENT AND CHIEF OPERATING OFFICER, ADS GROUP, NEWTON, MASSACHUSETTS, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION; ACCOMPANIED BY ROBERT DEANE, PH.D., CHIEF ECONOMIST, AMERICAN HEALTH CARE ASSOCIATION, AND ROB HARTWELL, FORMERLY STAFF OF WAYS AND MEANS COMMITTEE, U.S. HOUSE OF REPRESENTATIVES

Ms. BAILIS. Thank you, Mr. Chairman.

Mr. Chairman, and Members of the Subcommittee, I am Susan Bailis, president and chief operating officer of the ADS Group of Massachusetts. I am accompanied today by Dr. Robert Deane, chief economist of the American Health Care Association and Rob Hartwell, who formerly worked for your Committee.

Almost a year ago, I testified before your Subcommittee and I applaud you for holding today's hearings on prospective payment for post-acute services, a critical followup on a critical Medicare issue.

I am speaking today on behalf of the American Health Care Association, a federation of 51 affiliated associations representing over 11,000 long-term care providers. I also serve on the Prospective Payment Assessment Commission but let me clarify now that I am only speaking as a provider and as an officer of AHCA.

We support the full implementation of an acuity and case-mix adjusted prospective payment system by October 1, 1997. The prospective payment system should incorporate payments for all services provided during the benefit period based on patient needs rather than site of service and we support a targeted approach to repealing the 3-day prior hospital stay.

All of these proposals are in harmony with your approach to reforming Medicare. In a free market, where patients and independent case managers can make informed choices for care, nursing facilities can offer skilled care of high quality at a cost far below comparable acute care settings.

Even in fee-for-service Medicare, according to Bruce Vladeck, the cost of SNF care is an average of 58 percent less than in an acute-based SNF setting. Perhaps more startling is according to our recent studies, our patients are older and sicker than in hospital-based skilled nursing facilities. And the challenge we face is how to best maximize the use of post-acute care to ensure quality and achieve significant cost savings.

One good example is to follow the lead of the private sector in managed care. Managed care has gone a long way in reducing hospital stays by substituting SNF subacute care for acute care days. As you can see on the chart, on my right, you can see the hospital days in the top line coming down, SNF days going up. This is actual experience at Pacifix Care in a Medicare risk program.

And ProPAC in its discussions has confirmed the substitution effect. That is to say, subacute care at a lower cost substitutes for acute care. With 10 percent of Medicare beneficiaries now in Medicare risk contracts and many more coming on, this is clearly a trend.

Just to summarize, we agree with you that there is significant growth in SNF care, as a result of the Catastrophic Act and the clinical coverage guidelines changes in the late eighties. In addition, between 1989 and 1995, as a result of taking patients out of the hospital earlier, the acute length of stay for certain subacute DRGs has gone down by 31 percent. You can see on that chart over there the top line is actually payment going up by 9 percent and the bottom line is the length of stay going down 31 percent, again, for subacute DRG.

So, we believe that the decrease in length of stay is fueled by the availability of subacute care. And clearly, what this says is that payment reform is needed in both the hospitals and the SNF sectors in order to align incentives.

The American Health Care Association endorses prospective payment for SNFs, endorses a fully developed case mix and acuity adjust prospective payment system that covers episodes of care covering all SNF services. Payment should be based on patient needs.

We do not believe that the administration's proposal, which is a per diem proposal, effectively does what's necessary in terms of really controlling costs and providing adequate care. We have hired Price Waterhouse to work on developing an episodic prospective payment system and believe that we will be ready to perfect this system and see implementation for all SNF services by January 1, 1998.

We have other recommendations including post-acute care to save money by recalibrating hospital DRGs. That issue has come up earlier in the discussion. We believe bundling will not be successful in trying to save Medicare moneys and we believe that the 3-day prior hospital stay should be modified. We believe in consolidated billing and extending the waiver of liability and monitoring the OBRA 1995 enforcement rules as a way of ensuring that Medicare dollars are effectively spent.

Thank you for the opportunity to testify and I welcome any questions you may have.

[The prepared statement and attachments follow:]

STATEMENT OF SUSAN S. BAILIS, PRESIDENT AND CHIEF OPERATING OFFICER
THE ADS GROUP
ON BEHALF OF
THE AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and Members of the Subcommittee, I am Susan S. Bailis, Executive Vice President and Chief Operating Officer of The ADS Group of Andover, Massachusetts. I'm accompanied today by Robert Deane Ph.D, Chief Economist with the American Health Care Association, and Rob Hartwell, who formerly worked for your Committee. Three Hundred and Sixty Two days ago exactly, I testified before your Subcommittee, and I applaud you for holding today's hearing on Prospective Payment for post acute care services - a critical follow-up on a critical Medicare issue.

I am speaking today on behalf of the American Health Care Association (AHCA), a federation of 51 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationally. I also serve on the Prospective Payment Commission, but let me clarify now that I am speaking only as a provider and as an officer of AHCA.

Let me again, commend you, Mr. Chairman, for your efforts to expand the scope of America's thinking on Medicare and to truly tackle the critical problem of ensuring the program's solvency and improving the delivery and cost-effectiveness of its services. The task you are undertaking to restructure Medicare and improve the program are daunting, but from our preliminary view of where you are heading, it appears you are up to the task. Increasing options for seniors, reducing regulatory barriers to cost-effective care, and stimulating patient responsibility for savings and choices in care are critical. AHCA joins you in embracing these goals.

We support the full implementation of an acuity and case-mix adjusted Prospective Payment System (PPS) by October 1, 1997; the PPS should incoporate payments for all services provided during the benefit period based on patient needs rather than site of service; and, we support a targeted approach to repealing the 3-day prior hospital stay requirement. All of these proposals are in harmony with your approach to reforming Medicare.

In a free-market, where patients or independent case managers can make informed choices for care, our nursing facilities can offer skilled nursing care of the best quality available and at costs far below a comparable acute care setting. Even in Medicare, according to HCFA Administrator, Bruce Vladeck, the cost of free-standing SNF care is an average of 58% less than in an acute-based setting.[1] Perhaps more startling, is that according to most recent studies, our patients are older and sicker than those in acute-based SNF facilities. The challenge you face, is how to best maximize the use of post acute care to ensure quality and to achieve significant cost savings. One good example is to follow the lead of the private sector and managed care.

POST ACUTE CARE: BENEFICIAL TO THE CONTINUUM

PRIVATE SECTOR EXPERIENCE: SKILLED NURSING CARE UNDER MANAGED CARE

As you examine ways to find cost savings, then obviously you will closely scrutinize managed care. I highly recommend you examine how managed care is utilizing skilled nursing care to reduce acute care stays. Managed care has recognized the benefit of substituting SNF days for more expensive hospital days. In testimony before the Prospective Payment Commission, Dr. Roger Taylor, a Member of the Physician Payment Review Commission, and former Executive Vice President with PacifiCare, one of the fastest growing managed care organizations in the nation, stated that a large percentage of their ability to save money was their ability to reduce hospital Medicare days per thousand through the utilization of SNF day substitution.

In fact, if you will refer to the **chart titled "Sicker and Quicker"**, you will see that PacifiCare has achieved a large part of its savings by reducing hospital stays from 1089 days per thousand members in 1990, to 964 in 1993, through correspondingly increasing their SNF days per thousand from 497 to 676.

[1] Testimony submitted for the record by HCFA Administrator Bruce Vladeck to the Subcommittee on Health, 9/19/95.

Currently, 4.5 million Medicare recipients or over 10% of all eligible beneficiaries are enrolled in managed care plans. Fully 76% of these beneficiaries are in risk contract plans and participation in these plans during 1994 increased by 16%. According to ProPAC, risk contract patients use hospitals less and hospital lengths of stays are much shorter. Conversely, they utilize SNFs at a far greater rate. The reason: Substantial savings. ProPAC confirms this on Page 72 of their 1995 report where they write:

> *"Beneficiaries in risk contracting HMOs were just as likely to use hospital, physician, and home health services as their fee-for-service counterparts, but they used fewer of them, according to the program's 1992 evaluation. This was not true, however, for nursing home use. HMO enrollees were likelier to use a skilled nursing facility, although the length of stay was similar to that of FFS beneficiaries. Apparently, plans were not limiting access to ambulatory and inpatient services, but were using skilled nursing facilities in place of some hospital days."*

AHCA supports the utilization of managed care to provide quality care and control costs. In particular, we commend the Congress for extending and expanding the Medicare Select Demonstration Project and for exploring ways to increase Medicare beneficiaries in managed care risk contracting. We believe the move by Congress to reexamine the entire Medicare program and its relationship to private sector efforts in managed care are welcome and will be fruitful.

In Orange County, California, where over 50% of Medicare eligible residents are enrolled in managed care risk contracts, artificial barriers that drive up costs - such as the 3-day stay rule - are avoided, and consumers are pleased with their coverage and care. The ability of managed care organizations to achieve cost savings by utilizing SNFs is something the Congress must examine. Follow the lead of the private sector and market-based reforms, and I believe you will find it easier to control Medicare costs.

POST ACUTE CARE UTILIZATION IN MEDICARE

Let me now discuss briefly why post acute care utilization is increasing significantly in Medicare. It can be easily summed up by examining the chart on reduced hospital stays in subacute DRG categories. Since 1989, acute lengths of stay have declined by 31% in 62 DRGs with substantial subacute care utilization. During the same time span, average DRG payments for these 62 DRGs increased by 9%.[2] Clearly the DRG system has encouraged the movement of acute care patients into post acute care settings resulting in substantial growth in post acute care. Unfortunately, unlike the private sector, Medicare does not maximize potential savings because the DRG payments have not been properly adjusted to reflect the reduced length of acute stays. If this were done, Medicare would be able to substitute post acute care for a portion of the current DRG payment, saving as much as $9 billion per year!

Mr. Chairman, the American Health Care Association is today releasing detailed length of stay and DRG payment data we think is critical and ask that it be inserted into the hearing record. Copies have been distributed to each Member prior to the hearing.

Clearly, prospective payment reforms that I will discuss today are critical, but so too are the reforms of the acute care payment system necessary to maximize the utilization of post acute care, to reduce costs, and to reflect trends in the private sector and managed care. Reforming one side of the equation without the other, especially if deficit reduction is the driving force, fails to address the fundamental flaws of the acute care payment system, which contributes to increases in post acute utilization, without maximizing potential savings.

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[2] Does not include additions to standard payment for post acute care DRGs, including outlier, disproportionate share and teaching hospital payments.

In a free-market environment, where seniors have the option to participate in different federal plans that offer a variety of benefits, including the current program, skilled nursing care will thrive as it has in managed care. In the marketplace today, subacute care is a reality. In fee-for-service Medicare, it is not fully understood. In the marketplace, there is no three-day prior hospital stay. In Medicare, the three-day stay rule costs the program significant resources. The positive role of subacute care in Medicare has not been fully acknowledged.

We eagerly await the elimination of unnecessary and burdensome rules, regulations and barriers to competition in the current fee-for-service program. In fact, we have specific and long-standing proposals that fit in with what you are attempting to accomplish. Let me outline some of our proposals, beginning with Prospective Payment, which address cost containment and program reforms which are of the utmost importance in attaining a balanced budget.

AHCA COST CONTAINMENT PROPOSALS

PROSPECTIVE PAYMENT

The subject of today's hearing, Prospective Payment Systems (PPS) for post acute care, is one our industry has been working on for at least 14 years. AHCA had adopted as our policy, a model PPS system based on a per diem payment adjusted for a facility's patient case mix, with a capital factor added in and ancillary services passed through. After six years of discussing this with the Congress, and after five different requests from Congress to HCFA to develop a skilled nursing facility PPS, Congress communicated to us in August of 1995 that our per diem system was not the most desirable system from their perspective.

Due to the substantial growth in the utilization of ancillary services, and little if any controls on such growth, Congress, working with ProPAC, requested we move to an episodic based PPS system. Such a system was outlined in the House-passed budget reconciliation bill and we gathered the entire industry to see if we could shift gears from per diem to episodic and went to work on a new system at your request.

The proposal began to take shape in the Conference Report on the Balanced Budget Act of 1995, where we agreed to move to an episodic system and supported the Roth Senate amendment improving on the House and Senate-passed bills and somewhat mitigating the potential damage from interim price controls on ancillary services, directly attacking our ability to compete in the subacute Medicare marketplace. The industry has continued to work on perfecting and expanding the PPS to ensure it will adequately ensure quality, appropriate reimbursement, and include critical factors important to patient care and cost savings.

The industry-backed proposal, now being scored by the Congressional Budget Office, calls for redesigning the Medicare SNF payment system from a retrospective cost-based system to a prospective payment system (PPS), based on:

- Fixed payments for episodes of care covering all services provided during a Part A Medicare SNF stay;
- Payments covering all SNF costs, including routine, ancillary (non-routine) and property costs;
- Reimbursement specific to the individual patient's diagnosis, acuity or case-mix, and covering the full continuum of post-acute, subacute and rehabilitation classifications;
- Payments based on diagnosis and not the location of the delivered services other than geographic region;
- Payments adjusted for local market costs and the cost of facility construction;

- Policies that encourage SNFs to offer higher acuity services and which include sound outlier payment structures addressing cases of extraordinary costs;

- Full recognition of the high costs for the highest acuity SNF patients, including any interim system that is considered;

- Reports on patient outcomes, outlier policies and a move toward an outcome-based quality system vs. the rigid and nearly unworkable OBRA standards in effect at present. Consideration must be given to incorporating a quality of care feedback mechanism in SNF rate setting;

- Policies to reflect intra-SNF transfers during covered stays and ensuring payments are made on the patient classification most accurately reflecting the care provided during the spell of illness at the end of a covered stay; and,

- Recognition of the need for a continuation of the current low-volume SNF PPS.

I want to express our appreciation, Mr. Chairman, for the support from your subcommittee for our proposal in the past, and to ask for your support for our industry proposal now being considered by your Subcommittee and the Congressional Budget Office. In particular, your support, along with Congressman Cardin's, has been very helpful in moving HCFA forward towards our proposal. It is our understanding that they have nearly completed a system to present to your subcommittee. Our major concern, with their proposals, as well as the interim Balanced Budget Act proposals, is the reliance on price control mechanisms or policy changes that will keep us from competing in the higher acuity, or subacute marketplace. Proposals to eliminate the exceptions process allowing for reimbursement for higher acuity patients above the routine cost limits, without fully accounting for case-mix or patient acuity, would devastate our ability to compete in the subacute care marketplace and eliminate the potential for billions in savings to the program.

Another major concern is the Administration's desire to continue to subsidize less efficient and more costly hospital-based SNF care. Your proposal moving to an episodic-based system would dictate payment based on patient needs, not the site of the services provided. Hospital-based SNFs, which cost Medicare an average of $435 per day, compared to $275 per day for freestanding SNFs, already have numerous advantages, which clearly growth patterns demonstrate are being exploited. For instance:

- routine cost limits that are over $80 per patient per day more than for freestanding SNFs;

- new provider exemptions to the RCLs are granted to new facilities entering the skilled nursing Medicare program and that have never before provided a skilled level of care. Exemptions are usually granted for three years. Of the 3035 exemptions granted between 1990 and 1994, 61% were to freestanding facilities and 39% to hospital-based SNFs, representing a disproportionate share of exemptions.

- the ease which hospitals are able to obtain exemptions is also of major concern. HCFA does not recognize the provision of acute care as prior skilled nursing service in determining whether a facility is newly entering the program. Therefore, hospitals can set up SNFs providing skilled care and claim these are new services - freestanding SNFs cannot.

- excess capacity that is easily converted from acute to SNF beds as little capital, unlike building a freestanding SNF, is needed;

- incentives for hospitals to allocate labor, administrative, and general costs over to PPS-exempt SNF units (one Executive identified $50,000 per bed as a common figure); and,

- the ability of hospitals to receive a cost-based payment higher than a freestanding SNF in addition to the full DRG payment, when patients are discharged early from an acute bed;

These factors help to explain the significant growth in hospital-based PPS-exempt units. ProPAC estimates that **hospital-based SNFs have grown by over 200% over the last 8 years, while freestanding SNFs have grown by only 29%.**

This being the case, one would think there is some justification for the "six subsidies" of higher reimbursement and policy advantages granted to hospital-based SNFs. There is none! In particular, a December 1995 study entitled "A Comparison of Hospital-Based and Freestanding Nursing Facilities" conducted by a Joint Legislative Committee based on data collected by the Florida Agency for Health Care Administration, determined that "hospital-based and freestanding nursing facilities provide similar services and treat patients that are comparable."

The study of over 68,000 discharges from both hospital-based and freestanding SNFs found that:

- Patients admitted to freestanding SNFs are older than those admitted to hospital-based SNFs;
- Patients admitted to both SNF types have similar DRG codes, with freestanding SNFs taking more heart failure, shock and chronic obstructive pulmonary disease patients;
- Freestanding SNF patients are sicker on average than hospital-based SNF patients, based on an APR-DRG "extreme" severity of illness level of 19.6% to 15.2%;
- Freestanding SNF patients, due to there higher acuity, are more likely to die and correspondingly have fewer discharges to the home;
- The risk of death (outcomes) "for hospital-based nursing patients is statistically identical to that of nursing home patients once adjustments are made for mortality level, age, nursing home length of stay, and cancer."

One other recent study, "Rehabilitation Outcomes by Site of Service: A Comparison of Hospitals to Subacute Care Units of Freestanding Skilled Nursing Facilities," also found that SNF rehabilitation patients had lower Functional Independence Measure (FIM) scores and thus were more impaired. The study also found identical changes in functional improvement for both settings, again finding freestanding SNF patients have higher acuity than acute-based SNF patients with identical outcomes.

Any PPS for SNFs must therefore eliminate artificial subsidies and base payment on patient needs, adjusting payment for acuity and case-mix, but not for the site of services provided. Under this methodology, competition will thrive and if facilities have sicker patients, the higher costs will be recognized. AHCA recommends that Congress examine Medicare SNF costs and growth for hospital-based and freestanding SNFs in states where the Certificate of Need (CON) process has been eliminated, to determine if state CON laws stem the rapid growth in the conversion of more expensive acute beds to SNF beds.

In addition to these concerns, we are concerned that the Resource Utilization Group (RUG) patient classification system does not include the full array of SNF services, especially those in many subacute care DRG categories. RUGs III in particular is examining many rehabilitation SNF services, but is not nearly comprehensive enough to cover the full continuum of SNF services. RUGs III may provide some assistance on a per diem system, but it does not provide an accurate assessment of resource needs in the case of an episodic system. RUGs III is based upon activities of daily living (ADLs) which are primarily CNA functions, which do not address medical severity.

Once again, the private sector is far ahead of HCFA in this regard. Many of our leading companies have developed detailed assessment protocols which they are using to great success in the marketplace, especially for managed care patients. The reluctance of some health care policy experts to acknowledge the capability of moving to a fully developed PPS based on episodes of care is not surprising, given the inability to develop even a rudimentary per diem PPS over 14 years.

In many ways, this reminds me of the naysayers and doomsayers back in the early 1980's when the hospital DRG system was first proposed. Yes, it has needed fine tuning, and, yes, it has not compensated for reduced stays, but it has not caused the earth to move or wreaked a widespread plague upon our citizens either.

We also note that the Administration's proposal does not fold in ancillary services or capital into the per diem payment. In this case, we question whether it addresses your major concerns on the increased utilization of ancillary services. Perhaps our largest frustration, and one that you probably share, is that Congress has at least five times requested, most recently in OBRA'90 and again in OBRA'93, that we move to a PPS by October of 1995. HCFA promised the House Ways and Means Committee in testimony during late 1993 to have an interim system to the Congress by June of 1994.

Rather than waiting again, AHCA has joined with the National Subacute Care Association in hiring the accounting firm of Price Waterhouse to work with a joint industry PPS "Oversight Committee" to develop a new PPS system that meets your goals of cost containment and quality. It is absolutely critical that patient needs are adequately assessed in developing a patient classification system. The system must take into account not only the diagnosis but also medical severity (i.e. comorbidities), and functional and behavioral factors.

We are meeting continuously to generate the data needed to develop an episodic-based system and to work toward setting up a PPS reflecting our desire to compete in a market oriented post acute continuum. In the interim, HCFA should consider revising its Minimum Data Set (MDS) data base to include medical severity, comorbidity and functional behavior data in order to facilitate efforts to develop a system to assess patient resource needs in any episodic PPS. This PPS Oversight Committee will offer the "finishing touches" on the industry proposal currently in your possession toward the end of year, in time for study and deliberation during 1997 and implementation by January 1, 1998. Administrator Vladeck has committed to us to implement a system by that time and we are hoping it will be jointly developed by the industry, the Congress and HCFA, based on the Price Waterhouse and Oversight Committee's work.

Our model PPS is designed to promote quality care; to ensure equal access for high-acuity beneficiaries; maintain adequate capital formation to address future demographic trends; and to achieve cost containment. It will also easily allow you, in one clean and concise stroke, to reduce reimbursement across the board on all nursing services, eliminating incentives to increase ancillary service utilization, by a percentage, thus allowing you to obtain savings required to balance the budget.

MAXIMIZE SAVINGS FROM SUBACUTE CARE

A report by Abt Associates, Inc. issued in June of 1994, identified 62 DRGs where SNFs are currently providing subacute care and estimated potential cost savings to Medicare if percentages of patients in these groups were treated in SNFs rather than in hospitals. Abt found a potential savings to Medicare of between $7.535 and $8.906 billion per year depending upon the accounting for empty hospital beds and partial waiver of the 3-day stay rule.

I recommend that the Subcommittee examine the Abt report in detail, along with our data submission on DRG payments and acute lengths of stay, to see how legislative initiatives proposed by AHCA could potentially save billions of dollars to the Medicare program. In short, as SNF spending increases on Medicare subacute care, there is a corresponding decrease in acute care spending, especially for outlier patients. The question for you, is how to maximize the potential of this savings stream?

AHCA proposes that hospital subacute DRGs be examined and recalibrated according to severity of illness and length of stay. Particular attention should be paid to the relative costs of SNF subacute care compared to hospital-based subacute care. For instance, HCFA's estimate released last year found that hospital-based SNF care is on average $150 per day more expensive than identical care in a free-standing SNF.

MODIFY THE THREE DAY HOSPITAL STAY RULE

It is absolutely clear, however, that SNFs can provide subacute care at substantially lower costs than hospitals, and in many case, as a direct substitute for hospitalization. In order to test this, AHCA proposes that the Secretary of Health and Human Services immediately waive the 3-day hospital stay requirement for patients in a group of five DRGs, including skin ulcers and chemotherapy, and achieve an estimated $500 million per year in savings in just a few years. For chemotherapy alone, our analysis of HCFA data found that lengths of stay declined by 7.1% from 1989 through 1995, while the DRG payment increased by 48%. Bypassing a hospital stay altogether, which Abt Associates, Inc. estimates could take place half the time, would save Medicare between $2,700 and $4,000 per patient. The SNF stay would be allowed only as a substitute to an acute stay as certified by the admitting physician.

AHCA proposes pilot legislation to explore these cost-savings concepts, gradually expanding the list of DRGs to maximize savings after trial periods with data collection and analysis. The Secretary actually has this authority under current law, but should be required to begin this process as soon as possible.

CONSOLIDATED BILLING

In order to respond to reports of billing abuses by providers of services in SNFs, AHCA proposes to eliminate all third-party billing for Part A services under Medicare and provide SNFs with an option to bill for all Part B services as well. The vast majority of abuses outlined by the General Accounting Office and the Inspector General involved over-charging and fraudulent billing for services provided under arrangement between outside providers and SNFs. AHCA's proposal will require point of service billing and that SNFs directly oversee the provision of services to our patients, verify the services were truly provided for, and bill for these services directly. It is our responsibility to ensure billing in our facilities is accurate and honest and we intend to do so.

FRAUD AND ABUSE

In addition to developing proposals, such as consolidated billing that discourages fraud and abuse in our industry, AHCA has been actively working to eliminate fraud and abuse from the health care industry in general. AHCA is a founding member of the Coalition of Health Associations United Against Fraud and Abuse, which consists of 17 health care associations who are working with Congress and the Administration to eliminate fraud and abuse. The Coalition has developed an anti-fraud and abuse proposal and is actively seeking its enactment by the Congress.

The proposal is based on the following tenets:

- Increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;

- Provide adequate and thorough education for providers, consumers, and payers to prevent violations;

- Protect Federal health care programs from unnecessary cost, utilization, and failure to deliver appropriate levels of care;

- Be appropriate for the changing health care market; and

-Separate willful from technical violations.

The Coalition's proposal will go a long way toward eliminating fraud and abuse from the health care industry by combining tough enforcement against those who intentionally violate the law, with education for those who seek to provide care within the complex rules of Medicare and Medicaid.

POST-ACUTE CARE BUNDLING: ANTI-FREE MARKET, ANTI-QUALITY

One recommendation that was suggested as an option by the House Budget Committee in 1995 was bundling all post-acute care services into the hospital DRG system. This is an extremely flawed and unreasonable proposal which would not obtain the cost savings estimated by the Congressional Budget Office. Chairman Thomas, your opposition to the proposal is very much appreciated and warranted. For example:

- Post-Acute care was designed to reduce higher acute hospital costs - the bundling proposal would shift services back to higher cost centers

- providing acute care providers with the control of post acute care services would be a mistake as these providers traditionally have a poor understanding of how to best utilize post acute care

- freestanding SNFs and home care are cost effective alternatives to hospitals - this proposal would encourage continued institutionalization in acute settings, contrary to the intent of the hospital PPS system

- SNFs and home care offer free-market options for consumers - this proposal eliminates competition for services by bringing all services under hospital control

- HCFA is years away from having the data to implement such a system - HCFA has taken 12 years to developing a still to be seen PPS for SNFs

- Hospitals are ill-prepared and do not have the immediate service capacity to offer cost effective post acute services

- This is an antiquated proposal that has found little support - studies show serious design and accountability problems with such a system. A bundling system of this type is unworkable.

Bundling in theory may sound like it makes sense. In fact, as proposed in the House, it would strike at the heart of free-market competition, access to care and most importantly, quality of care. Hospitals would attempt to dump costly outlier patients on SNF, rehab and Home Health providers that would have to refuse to take these patients they could not possibly afford to take with a DRG add-on. Much less one reduced by whatever the hospital determines to be a reasonable mark-up or administrative charge. The proper way to achieve savings is to substitute post acute care for acute care wherever possible and to recalibrate DRG payments to reflect reduced lengths of stay and severity of illness.

RELATED MEDICARE RECOMMENDATIONS

Let me briefly make a few final recommendations to the Committee before wrapping up. These include:

- extend the waiver of liability provisions protecting innocent providers who make unintentional coverage mistakes

- allow providers to make reasonable and customary charges for services rendered under the related party rules

- oppose HCFA attempts to "fully certify" Medicaid and Medicare beds in nursing facilities. This proposed policy could lead to upcoding and over-utilization due to the huge number of new Medicare beds that would be made available for services. The potential cost of this proposed rule should be examined closely by this Committee

- carefully monitor the implementation of the 1995 Survey, Certification and Enforcement rules to ensure they are cost-effective, are not abused by over-zealous inspectors and are enforced fairly and evenly

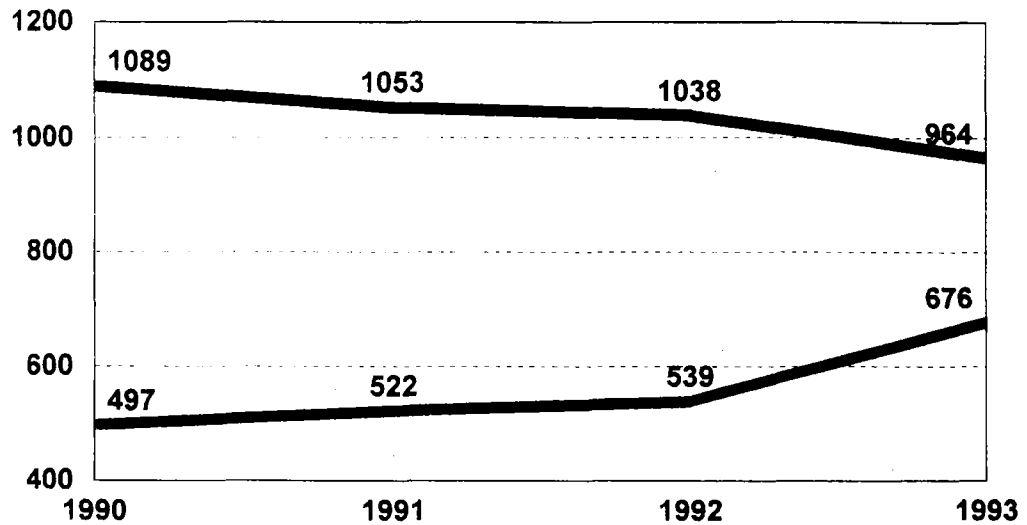
- support previous agency and Congressional efforts to place a moratorium on long term hospitals and determine why costs in such settings for identical care provided in SNFs is so much higher.

Mr. Chairman, thank you for holding this hearing. America's nursing facilities are capturing a greater share of Medicare patients for a reason - competition and innovation. We hope you will take notice of what the marketplace is doing and remove barriers to competition that remain in place in an antiquated and broken fee for services system. Most importantly, we urge you to adopt the industry PPS proposal and to work with our joint industry oversight group in refining the proposal for action by Congress next year and implementation no later than January 1, 1998.

Thank you Mr. Chairman. I'll be glad to answer any questions.

Quicker and Sicker

Utilization Trends 1990 - 1993 *



* Per Thousand Members Per Year
Data from PacifiCare of California

All Post-Acute Hospital DRGs

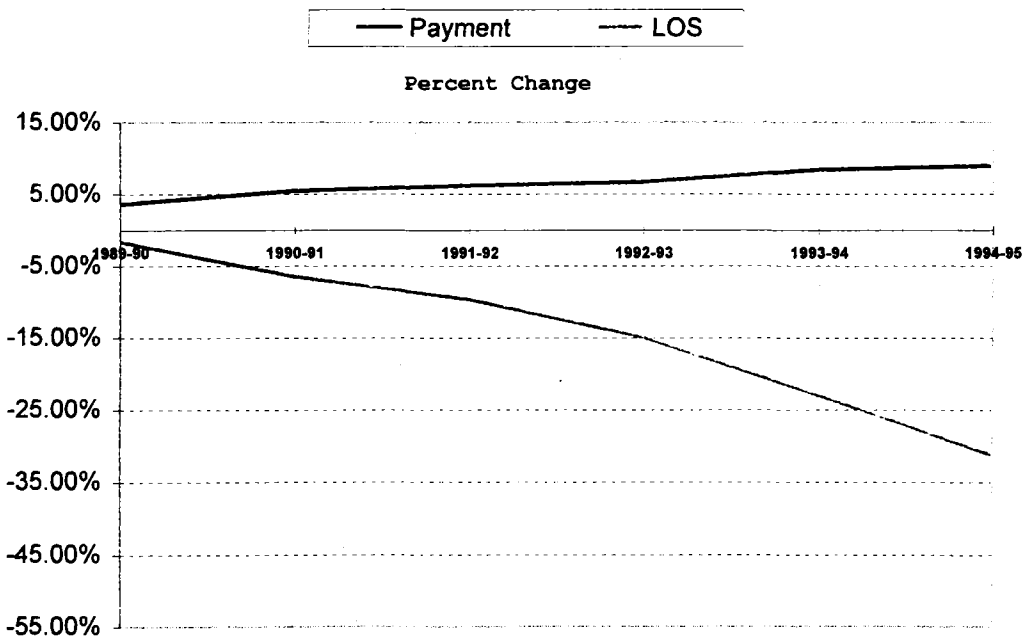


Table 1

POST-ACUTE HOSPITAL DRGs				Annual Percentage Change													
				1988-90		1990-91		1991-92		1992-93		1993-94		1994-95		1988-95	
DRG Description	Hospital Discharges 12/89	Hospital Discharges 12/95	Percent Transition to Post-Acute	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT	LENGTH OF STAY	PAYMENT
1 Craniotomy age > 17 except for trauma	26,393	32,723	no	-8.54%	7.45%	-8.20%	-3.80%	-6.44%	0.79%	-8.01%	-2.31%	-8.49%	-0.85%	-10.98%	1.21%	-50.66%	2.49%
12 Degenerative nervous system disorders	24,527	23,355	no	-2.99%	6.12%	-0.48%	0.72%	-3.39%	1.88%	-7.68%	3.59%	-7.40%	0.49%	-11.77%	2.52%	-33.71%	15.32%
14 Specific cerebrovascular disorders except TIA	326,880	351,205	no	-3.51%	4.30%	-3.07%	1.79%	-4.46%	0.30%	-6.28%	1.55%	-8.40%	0.69%	-9.27%	0.34%	-34.99%	8.97%
75 Major chest procedures	30,296	39,401	no	-1.70%	2.51%	-2.70%	3.01%	-4.31%	1.31%	-3.86%	2.80%	-6.00%	1.55%	-6.26%	1.69%	-24.83%	12.94%
76 Other respiratory system O.R. procedures w cc	31,437	36,785	no	0.01%	-0.51%	3.27%	2.35%	1.03%	3.81%	-2.34%	2.38%	-5.70%	4.94%	-6.53%	2.63%	-16.81%	15.60%
79 Respiratory infections & inflammations age > 17 w cc	103,828	207,606	no	1.37%	-4.46%	-4.95%	0.06%	-1.83%	-1.21%	-5.10%	-0.07%	-5.92%	0.53%	-7.99%	-1.02%	-28.26%	-6.18%
85 Pleural effusion w cc	15,288	18,398	no	1.25%	3.01%	-2.03%	2.83%	-2.09%	1.80%	-5.07%	4.51%	-5.72%	0.90%	-5.93%	1.17%	-21.89%	14.21%
88 Chronic obstructive pulmonary disease	93,088	345,765	no	2.22%	4.86%	2.02%	0.37%	1.08%	0.31%	-3.58%	1.65%	-6.18%	2.85%	-7.70%	1.04%	-22.77%	1.36%
89 Simple pneumonia & pleurisy age > 17 w cc	332,396	415,072	no	1.27%	-0.21%	-3.46%	0.65%	-1.96%	-1.24%	-4.40%	0.99%	-6.56%	0.39%	-6.51%	0.03%	-24.15%	0.60%
90 Simple pneumonia & pleurisy age > 17 w/o cc	62,797	60,306	no	26.36%	-1.02%	-26.63%	-1.12%	-3.45%	-2.79%	3.69%	-1.02%	-6.18%	0.13%	-4.72%	0.72%	-18.30%	-5.61%
96 Bronchitis & asthma age > 17 w cc	208,695	60,881	no	-0.41%	0.87%	-2.52%	0.44%	-4.74%	-0.54%	-5.76%	0.71%	-7.20%	-4.87%	-8.29%	-2.14%	-26.96%	-5.52%
104 Cardiac valve procedure w cardiac cath	11,480	22,854	no	-2.74%	6.94%	-9.11%	5.06%	-3.55%	3.04%	-7.59%	-4.56%	-11.25%	0.30%	-9.20%	0.84%	-43.44%	13.32%
105 Cardiac valve procedure w/o cardiac cath	12,103	19,821	no	-3.61%	5.96%	-11.01%	3.52%	-2.92%	2.00%	-4.82%	-3.77%	-10.05%	1.04%	-8.87%	0.60%	-41.28%	9.36%
106 Coronary bypass w cardiac cath	62,031	99,116	no	-4.24%	7.06%	-2.64%	-2.03%	-3.20%	1.07%	-5.89%	5.69%	-8.20%	1.93%	-7.95%	0.99%	-32.12%	14.64%
107 Coronary bypass w/o cardiac cath	41,468	81,255	no	10.36%	5.44%	-14.89%	15.82%	-4.57%	4.23%	-5.20%	-13.23%	-8.28%	0.74%	-9.51%	1.11%	-32.08%	14.10%
113 Amputation for circ system disorders except upper limb & toe	33,301	45,003	no	5.91%	4.81%	-2.47%	9.09%	-1.80%	3.10%	-5.82%	4.92%	-8.70%	2.08%	-9.61%	0.58%	-22.49%	24.57%
121 Circulatory disorders w AMI & c.v. comp disch alive	139,310	158,928	no	-1.38%	3.04%	-4.06%	-0.69%	-4.15%	3.47%	-5.24%	1.06%	-7.93%	0.95%	-7.69%	1.21%	-30.46%	8.99%
126 Acute & subacute endocarditis	3,762	4,619	no	1.11%	2.82%	-6.81%	0.99%	-5.28%	-1.65%	-5.72%	0.22%	-13.13%	-2.60%	-11.60%	2.76%	-43.46%	2.56%
127 Heart failure & shock	530,476	670,461	no	-1.29%	3.06%	-2.38%	0.89%	-2.26%	0.92%	-4.54%	2.47%	-6.74%	2.40%	-7.46%	1.23%	-24.68%	10.97%
128 Deep vein thrombophlebitis	31,570	19,612	no	-2.55%	2.16%	-1.65%	1.33%	-3.57%	-1.31%	-5.08%	1.73%	-6.22%	0.94%	-6.79%	1.12%	-25.86%	5.47%
130 Peripheral vascular disorders w cc	80,002	91,826	no	-6.23%	5.34%	-1.82%	2.74%	-3.80%	2.30%	-3.38%	1.53%	-5.46%	0.85%	-6.17%	1.69%	-20.57%	15.44%
148 Major small & large bowel procedures w cc	129,312	140,141	no	-3.06%	4.92%	-4.90%	-0.03%	-2.24%	0.02%	-3.76%	0.22%	-5.65%	2.75%	-4.67%	2.78%	-24.28%	10.65%
150 Peritoneal adhesiolysis w cc	17,667	21,516	no	-3.04%	2.90%	-0.95%	-2.82%	-3.61%	-0.34%	-3.68%	3.34%	-4.88%	1.64%	-4.73%	1.76%	-20.89%	6.48%
154 Stomach, esophageal & duodenal procedures age > 17 w cc	48,511	35,661	no	9.78%	5.18%	-4.62%	-2.77%	-1.03%	15.66%	-3.32%	-1.40%	-6.78%	3.98%	-6.50%	2.16%	-12.47%	22.51%
170 Other digestive system O.R. procedures w cc	12,505	12,467	no	-1.11%	6.62%	-4.64%	-1.16%	-1.17%	2.15%	-4.80%	0.66%	-9.80%	2.36%	-6.20%	2.24%	-27.71%	12.86%
172 Digestive malignancy w cc	30,622	30,820	no	-2.39%	6.71%	-0.87%	4.10%	-2.28%	1.46%	-6.27%	5.23%	-7.91%	2.13%	-6.56%	0.61%	-26.29%	20.25%
195 Cholecystectomy w C.D.E. w cc	22,808	9,196	no	-3.48%	2.55%	-2.02%	0.66%	-0.75%	0.28%	-3.29%	4.63%	-5.46%	7.46%	-6.27%	3.32%	-21.25%	17.82%
197 Cholecystectomy except by laparoscope w/o C.D.E. w cc	50,303	28,016	no		3.81%		-2.07%		-2.07%	22.65%	-3.29%	-3.80%	20.57%	-4.57%	4.78%	-14.28%	29.96%
199 Hepatobiliary diagnostic procedure for malignancy	3,424	2,205	no	1.27%	3.63%	-6.65%	4.82%	-3.55%	4.45%	-2.92%	-1.19%	-7.31%	2.35%	-10.31%	1.38%	-29.48%	15.44%
205 Disorders of liver except malig cirr alc hepa w cc	19,670	21,512	no	-1.39%	2.35%	-2.74%	1.48%	-1.23%	4.12%	-6.13%	0.40%	-6.17%	3.39%	-9.28%	-0.33%	-26.93%	11.43%
208 Major joint & limb reattachment procedures of lower extremity	206,383	328,015	no		3.22%	-6.32%	3.28%	-7.79%	1.07%	-9.93%	1.19%	-12.75%	0.72%	-12.95%	-0.18%	-49.75%	8.41%
210 Hip & femur procedures except major joint age > 17 w cc	92,997	131,592	no	-5.90%	1.56%	-5.94%	-0.78%	-7.03%	-2.17%	-9.63%	0.04%	-10.58%	-0.44%	-12.37%	-0.31%	-51.44%	-2.08%
211 Hip & femur procedures except major joint age > 17 w/o cc	45,414	25,325	no	-5.73%	0.27%	-7.30%	-0.68%	-8.20%	-3.28%	-8.08%	-1.59%	-10.91%	-0.55%	-11.80%	0.86%	-52.02%	-4.98%
213 Amputation for musculoskeletal system & conn tissue disorders	5,873	6,788	no	-3.36%	3.25%	-3.37%	-1.36%	-2.36%	0.10%	-6.65%	2.91%	-9.31%	0.41%	-9.37%	-0.27%	-34.33%	9.78%
214 Back & neck procedures w cc	26,992	51,282	no	-10.56%	1.75%	-9.37%	-1.25%	-8.88%	-2.24%	-10.44%	1.32%	-12.06%	2.49%	-12.10%	3.22%	-63.40%	5.28%
217 Wnd debrid & skin grft except hand, for musculoskel & conn tissue dis	14,593	19,341	no	-2.88%	7.34%	-3.97%	3.96%	-2.88%	2.13%	-6.99%	-1.68%	-10.57%	1.43%	-9.90%	-0.41%	-37.20%	12.79%
235 Fractures of femur	8,500	5,543	no	-6.77%	1.70%	-9.72%	0.49%	-7.64%	-2.99%	-13.03%	-5.43%	-14.64%	-3.20%	-12.34%	-6.79%	-63.64%	-16.22%
236 Fractures of hip & pelvis	39,795	37,805	no	-4.10%	1.45%	-5.14%	1.60%	-7.25%	-0.42%	-9.41%	-1.98%	-10.72%	-1.61%	-9.92%	-0.74%	-42.55%	-1.08%
238 Osteomyelitis	5,436	7,538	no	1.49%	0.43%	-2.58%	1.56%	-6.66%	1.92%	-1.94%	-1.21%	-10.92%	-0.76%	-11.21%	0.22%	-32.12%	2.16%
239 Pathological fractures & musculoskeletal & conn tissue malignancy	56,806	59,561	no	-0.27%	5.85%	-2.71%	4.18%	-3.16%	2.97%	-5.27%	3.10%	-8.67%	1.30%	-9.17%	0.69%	-29.45%	17.89%
243 Medical back problems	132,108	79,979	no	-1.29%	4.10%	-0.02%	3.43%	-1.15%	2.01%	-3.46%	4.13%	-5.89%	4.19%	-8.51%	2.78%	-20.25%	20.66%
254 Fx sprn strn & dst of uparm lowleg ex foot age > 17 w/o cc	16,840	9,205	no	-1.73%	3.15%	-5.30%	1.17%	3.33%	-0.90%	-3.44%	1.49%	-9.17%	2.54%	-3.63%	2.41%	-26.59%	9.88%
263 Skin graft &/or debrid for skin ulcer or cellulitis w cc	29,385	29,088	no	-4.87%	3.78%	-7.65%	8.24%	-4.59%	-2.58%	-7.89%	-3.86%	-11.61%	-7.21%	-11.66%	-2.63%	-48.29%	-1.28%
264 Skin graft &/or debrid for skin ulcer or cellulitis w/o cc	7,028	3,559	no	-6.64%	-6.09%	-5.10%	-2.33%	-3.23%	3.73%	-11.01%	-2.85%	-7.30%	-0.97%	-7.92%	-4.42%	-41.20%	18.39%
271 Skin ulcers	17,177	21,515	no	-2.03%	1.89%	-6.91%	8.76%	-3.95%	-0.08%	-6.53%	-2.50%	-8.65%	-0.03%	-9.66%	-2.60%	-37.81%	5.45%
277 Cellulitis age > 17 w cc	55,693	79,054	no	-2.30%	2.52%	-2.82%	0.85%	-3.21%	-0.15%	-4.43%	-0.13%	-7.14%	0.22%	-7.55%	-0.10%	-27.48%	3.71%
278 Cellulitis age > 17 w/o cc	27,739	26,008	no	-1.61%	-0.14%	-3.66%	-1.18%	-2.80%	-1.76%	-3.67%	-1.46%	-5.80%	-0.37%	-5.29%	1.56%	-23.13%	-3.35%
285 Amputat of lower limb for endocrine, nutrit, & metabol disorders	3,717	4,880	no	-2.66%	2.21%	-1.92%	0.85%	-2.96%	1.59%	-5.24%	-1.39%	-12.95%	-5.39%	-12.07%	-0.27%	-43.86%	-5.79%
287 Skin grafts & wound debrid for endoc nutrit & metab disorders	7,836	6,284	no	0.04%	5.86%	-6.93%	1.91%	-1.47%	1.62%	-9.88%	-1.90%	-8.68%	2.42%	-13.64%	-2.84%	-38.57%	6.97%
294 Diabetes age > 35	100,709	86,024	no	-1.35%	3.87%	-3.24%	2.51%	-2.63%	0.40%	-4.81%	1.32%	-8.59%	1.22%	-7.78%	1.14%	-26.40%	10.56%
296 Nutritional & misc metabolic disorders age > 17 w cc	187,031	218,940	no	-2.34%	5.14%	-2.20%	2.00%	-3.69%	0.53%	-5.74%	2.01%	-7.39%	0.51%	-9.28%	-0.26%	-30.49%	9.91%
320 Kidney & urinary tract infections age > 17 w cc	143,597	169,078	no	-1.42%	3.36%	-2.79%	0.13%	-3.02%	0.09%	-6.40%	-0.32%	-7.50%	0.21%	-8.50%	-1.18%	-29.64%	2.31%
331 Other kidney & urinary tract diagnoses age > 17 w cc	26,730	38,181	no	-0.93%	9.16%	-1.63%	2.10%	-1.78%	1.40%	-2.75%	3.77%	-5.29%	2.23%	-8.55%	2.35%	-20.93%	21.01%
403 Lymphoma & non-acute leukemia w cc	24,880	34,612	no	-2.50%	6.51%	-0.33%	2.03%	-5.23%	1.29%	-4.63%	6.08%	-7.67%	1.14%	-6.25%	2.38%	-26.87%	19.43%
410 Chemotherapy w/o acute leukemia as secondary diagnosis	135,537	87,777	no		7.77%	0.93%	0.80%	0.80%	8.51%	-8.05%	11.64%	-2.47%	11.29%	-2.24%	-7.01%	-8.02%	68.02%
413 Other myeloprolif dis or poorly diff neopl diag w cc	10,418	8,421	no	-7.72%	8.78%	-3.16%	3.93%	-0.35%	2.36%	-6.71%	1.83%	-8.13%	5.48%	-9.11%	-0.68%	-30.20%	21.81%
425 Splenectomy age > 17	106,864	192,133	no	-0.97%	1.41%	-2.56%	2.01%	-2.93%	0.54%	-4.72%	1.09%	-7.46%	1.02%	-7.20%	-0.25%	-25.85%	5.83%
439 Skin grafts for injuries	1,242	867	no	-12.04%	2.68%	-16.47%	1.93%	12.35%	-7.95%	-9.81%	-19.26%	-3.18%	16.02%	-3.15%	-2.90%	-32.30%	-9.67%
462 Rehabilitation	6,358	9,361	no	-1.06%	10.64%	3.21%	-1.10%	-5.27%	0.14%	-1.92%	-1.34%	-9.70%	-1.86%	-7.57%	-2.24%	-28.73%	4.23%
468 Extensive O.R. procedure unrelated to principal diagnosis	70,101	58,649	no	-0.75%	5.38%	-6.21%	5.26%	1.01%	0.89%	-3.48%	1.53%	-8.20%	3.48%	-6.36%	3.87%	-23.87%	20.42%
471 Bilateral or multiple major joint procs of lower extremity	5,027	9,111	no	-4.76%	0.41%	-10.37%	1.72%	-9.65%	0.96%	-11.09%	0.06%	-15.06%	0.71%	-16.24%	1.84%	-67.17%	1.97%
475 Respiratory system diagnosis with ventilator support	87,782	89,514	no	1.52%	21.26%	-4.32%	-0.06%	3.60%	2.33%	-3.34%	1.30%	-5.79%	4.96%	-5.83%	0.72%	-14.17%	30.52%
Total Average for All Post-Acute DRGs	4,228,555	4,999,533		-1.55%	3.85%	-4.84%	1.81%	-3.21%	0.79%	-5.24%	0.48%	-8.09%	1.79%	-8.30%	0.53%	-31.03%	8.99%

Sources: 1) U.S. Federal Register: Final Rule September 1, 1989-1993 2) U.S. Federal Register: Proposed Rule May 31, 1989-1995 3) ProPAC Report and Recommendations to Congress, March 1, 1989-1996

Chairman THOMAS. Thank you very much, Ms. Bailis.
Mr. McMeekin.

STATEMENT OF JOHN C. McMEEKIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CROZER-KEYSTONE HEALTH SYSTEM, MEDIA, PENNSYLVANIA; ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. MCMEEKIN. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman, and Members of the Subcommittee on Health, I am John McMeekin, president and chief executive officer of the Crozer-Keystone Health System. I am here today representing the American Hospital Association and our 5,000 members, all concerned with the matters you are discussing.

Crozer-Keystone Health System is a nonprofit, integrated health system that provides a broad range of services to many of the residents living in Delaware County, a population of 550,000 and in many of the surrounding Philadelphia communities. Our system includes 100 employed primary care physicians, three community hospitals, a very large tertiary teaching hospital and six long-term care facilities.

Four of the long-term care facilities are freestanding, with a total of 800 skilled nursing beds; 2 are hospital-based with a total of 51 skilled nursing beds.

As the 24-hour-a-day, 7-day-a-week community health resource, a hospital brings together a broad array of services and practitioners to provide comprehensive care for its community. Because Medicare is the largest payer for health services, payment policies being considered by this Subcommittee are of critical interest to us and our colleagues across the country. Hospitals and health systems supported adoption of Medicare's in-patient prospective payment system and we believe that a properly structured prospective payment system for skilled nursing facilities and home health services is a move in the right direction.

To make that move a more successful one, we strongly recommend that prospective payment for home health and skilled nursing reflect the following key criteria.

One, they must recognize the variations in cost that result from the different nursing and rehabilitative needs of individual patients.

Two, payments must be adjusted to recognize the geographical differences that are beyond the control of any health care system.

Three, the new system should incorporate administrative and general service costs that government mandated accounting rules can add to a skilled nursing unit. This is particularly true of a hospital-based unit that has to bear both the regulatory burden as a hospital and, as well, as a hospital-based skilled nursing facility.

The new payment system should provide clear public recognition of the uncompensated care mission that hospitals fulfill in our Nation. Different than freestanding facilities, the hospital-based skilled nursing facility, because it is a part of the hospital, is less able to pick and choose which patients it cares for. Those who present themselves in our emergency rooms are cared for regardless of their ability to pay. That's part of our mission and part of

your regulations. Many of those patients end up in our skilled nursing facilities.

Finally, the new system should recognize the higher costs of hospital-based services. These costs are the result of a hospital's ability to perform many services at any time, it's greater availability of laboratory and x ray services, and again, the requirements imposed by accreditation.

The intensity of care provided in a hospital-based skilled nursing facility is significantly higher than that provided in a freestanding facility. This is due to most patients coming from the acute stay. I would differ from those who have testified to the contrary, there is little evidence that I could present to this Subcommittee to support the fact that care is equal across the freestanding and the hospital-based skilled nursing facilities. Our own experience is that the more acutely ill patients are in the hospital-based facility, and that's where the physicians feel most comfortable in transferring their patients.

In my health system, physicians are very careful to discharge patients to the proper care setting. As a result, some patients are discharged to the higher intensity hospital-based units, while others are moved and more appropriately discharged to our freestanding facilities.

There are considerable differences in the cost of providing higher intensity rather than lower intensity services. Our 4 freestanding skilled nursing facilities average 200 beds, compared to 24, on average, in our hospital-based units. This allows us to spread our costs over a larger economic unit and also to get more balance in the patient mix.

In conclusion, Mr. Chairman, it is important to remember that while great changes are occurring in the health care delivery system, hospitals still have one foot deeply rooted in fee-for-service. Crozer-Keystone, for example, is making a strong move toward being a fully-integrated delivery system. As a result, we consider a new prospective payment system for home health and skilled nursing services to be a transition on our way to full capitation.

However, fee-for-service is still a big part of health care, especially for America's seniors. It is clear that changes being considered by this Subcommittee will have a deep and immediate effect on our ability, as hospitals and health systems, to serve our community. As you deliberate new payment policies for home health and skilled nursing facilities, it is important to keep in mind the unique characteristics of hospitals and the bigger changes occurring in our field.

We look forward to working with you and your Subcommittee on developing policies that enhance the ability of hospitals and health systems to serve our communities.

Thank you.

[The prepared statement follows:]

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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
Medicare Payment Policies
for
Home Health Agency and Skilled Nursing Facility Services

July 23, 1996

Mr. Chairman, I am John C. McMeekin, president and CEO of Crozer-Keystone Health System. I am pleased to testify on behalf of the American Hospital Association (AHA) and its 5,000 members -- hospitals, health systems, networks and other providers of care -- on Medicare payment for home health agency and skilled nursing facility services.

Crozer-Keystone Health System is a not-for-profit, integrated health system that provides a broad continuum of care to 550,000 people in Delaware County and surrounding communities. Our system includes 100 employed primary care physicians, three community hospitals, one tertiary medical center and six long-term care facilities. Four of these long-term care facilities are freestanding, with a total of 800 skilled nursing beds; two are hospital-based, with a total of 51 skilled nursing beds.

BACKGROUND

While the traditional hospital historically provided acute inpatient care, emergency room, and limited outpatient services, the contemporary hospital offers its community a much broader array of services. Today, hospitals and integrated health care networks provide:

- routine and intensive inpatient care
- comprehensive ambulatory services, including ambulatory surgery
- sub- and post-acute services
- skilled nursing care
- community-based health and mental health centers
- home and community health services
- hospice care
- and, for many, an array of community-based physician primary care services

As the 24-hour-a-day, seven-day-a-week community health resource, hospitals increasingly bring together a broad array of services and practitioners to provide comprehensive care for their communities. Payment policies being considered by this subcommittee are of critical interest to us and our colleagues across the country, and will assist hospitals and health systems as they develop integrated delivery systems.

Because Medicare is the largest payer for health service, its policies have an impact far beyond the monies spent. They set the social benchmark for other payers--private and public. Thus, my testimony today will focus on the following points as you examine policies for paying home health and skilled nursing services.

America's hospitals and health systems believe that Medicare payment policies should:

- Clearly recognize the variation in costs that results from the different nursing and rehabilitative needs presented by individual patients.

- Adjust payments to recognize geographic differences in costs that are beyond the control of the health care system.

- Recognize the higher costs of hospital-based services, costs that result from a hospital's ability to perform a number of different services at any time; its greater availability of laboratory and x-ray services; and requirements imposed on the hospital by accreditation.

- Incorporate legitimate administrative and general service costs of the hospital or health system that are added to a skilled nursing unit as a result of government-mandated accounting rules.

- Provide clear public recognition of the uncompensated care mission that hospitals fulfill in our nation.

HOSPITALS SUPPORT AN IMPROVED PAYMENT SYSTEM

The AHA has been and remains a proponent of improved payment arrangements that promote cost-effective utilization of appropriate patient care services. In the early 1980s, despite limitations in some of the technical features and implementation steps, the AHA supported adoption of Medicare's hospital inpatient prospective payment system (PPS).

For almost a decade, the AHA has consistently called for a comprehensive, easy-to-administer prospective payment system for hospital ambulatory services. Similarly, hospitals and health systems believe a properly structured prospective payment system for skilled nursing facility and home health services is a move in the right direction. Beyond prospective payment, the AHA has been an advocate for more than five years for a capitation-based payment system that aligns the incentives of purchasers, providers, and practitioners, and encourages improved efficiency in the health care system.

The AHA has also supported new organizational arrangements that would facilitate the use of new methods of payment for health services. For example, the AHA is sponsoring, through a major grant from the Kellogg Foundation, a demonstration project to create Community Care Networks that provide a comprehensive range of ambulatory, inpatient, and community-based services. For two years, the AHA has encouraged legislation to develop Provider Sponsored Organizations (PSOs), which would provide a means for highly integrated, at-risk health delivery systems developed by providers and practitioners to contract directly with Medicare for the care of beneficiaries.

And Crozer-Keystone is proud to have been chosen by the Health Care Financing Administration to participate in its Medicare Choices demonstration program. Our goal is to demonstrate that we can build on our existing relationship with our senior community to overcome their concerns about managed care, and to focus on keeping them healthy while providing superior service when they get sick. Medicare's payment policies are critical to our success.

KEY CRITERIA FOR A NEW PAYMENT SYSTEM

Hospitals and health systems strongly recommend that Medicare's home health and skilled nursing facility services payment policies reflect these key criteria.

- **Medicare should recognize, at a minimum, differences in levels of physical functioning, cognitive capabilities and behavior of the patient, and intensity of rehabilitation and therapy services.** A clear variation in costs results from the different nursing and rehabilitation needs of each patient. Hospitals discharge patients

to different skilled nursing facilities that have different capabilities. Some provide more intensive nursing and therapy; some admit more severely ill or more disruptive patients; some are more capable of responding to medical episodes. These differences need to be recognized in the payment. Otherwise, low intensity nursing facilities would receive a windfall and high intensity facilities would be penalized.

For example, within my own health system physicians are careful to discharge patients to a setting that offers the necessary intensity of services and therapies. As a result, some patients are discharged to our higher-intensity, hospital-based skilled nursing units, while others are more appropriately discharged to our lower-intensity, lower-cost, freestanding skilled nursing facilities.

These differences in patients' needs and costs are known as "case mix" costs. They are recognized in the Medicare hospital inpatient PPS system through a combination of the Diagnosis-Related Groups (DRG) classification system, supplemental payments for outlier cases, and other payment add-ons for the higher costs associated with indirect medical education and treating large numbers of low-income individuals. While the hospital inpatient PPS system is inappropriate for long-term care and home care patients, the underlying principle of recognizing certain patient-related cost differences is the same.

- **Medicare should recognize geographic differences in costs, which are beyond the control of the health care system.** Providers serve Medicare patients in communities with different costs of delivering care. Some communities have higher wage rates than others; some have higher supply or operational costs than others. While PPS and the Resource-Based Relative Value Scale (RBRVS) revealed the difficulty of drawing geographic boundaries for payment purposes, the difficulties are minor compared to the inequities that would result from failing to recognize geographic cost differences.

- **Medicare should recognize the added operational costs associated with hospital-based skilled nursing services.** Hospital-based services are provided by delivery systems that have a broad array of services and responsibilities. As a result, additional costs result from: a hospital's ability to provide services on demand (often referred to as "standby" services) that are not available from limited service providers; greater availability of laboratory and x-ray services that support hospital-based as well as freestanding providers; and requirements imposed on the hospital by licensure and accreditation.

- **Medicare should incorporate accounting costs that result from government-mandated cost-finding practices, which historically over-allocated hospital overhead from inpatient care units to ambulatory, community-based, and nursing home units. Or, Medicare should increase inpatient PPS payments to adjust for prior accounting requirements.** Under Medicare's original policies, services provided under Medicare Part A were reimbursed on a cost basis using accounting procedures prescribed by Medicare. While there were many concerns with these procedures, they were equitable because they applied to all Medicare Part A services. Because Medicare accounting procedures require allocation of all general service and administrative costs among the various Part A facilities and units, any over-allocation of costs in one area would result in under-allocation in another.

  When Medicare hospital inpatient PPS was established, it based inpatient payments on the level of costs determined using the accounting practices that had been used for cost-based reimbursement. Nevertheless, equity was preserved in part by continuing to recognize the consequences of Medicare's accounting requirements through the payment differential for hospital-based facilities and services.

- **Medicare payments should provide clear public recognition of the uncompensated care missions that hospitals and hospital-based services fulfill in our nation.**

Hospitals, by legislation (Emergency Medical Treatment and Active Labor Act -- EMTALA) and commitment to community service, provide emergency services that evaluate and treat all individuals regardless of ability to pay. Once admitted and treated, the patient may be reassigned to a hospital-based home health or nursing home service that is medically appropriate and lower in cost than an inpatient unit.

However, the uncompensated care patient brings no revenue, regardless of where the patient receives care. Unlike freestanding home health agencies and nursing home facilities that have no emergency room entrance for uninsured or underinsured individuals, the hospital-based facility bears a disproportionate share of the costs of uncompensated care.

CONCLUSION

Taking these issues into consideration, it is clear that changes being considered by the subcommittee will have a deep and immediate effect on the ability of hospitals and health systems to serve their communities. As you deliberate new payment policies for home health agency and skilled nursing facility services, it is important to keep in mind the unique characteristics of hospitals, and the important role they play in their communities. We look forward to working with you in ensuring that new payment policies enhance, not hinder, our ability to serve our communities.

Chairman THOMAS. Thank you, Mr. McMeekin.
Mr. Lane.

STATEMENT OF LAURENCE F. LANE, PRESIDENT, NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG-TERM CARE

Mr. LANE. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman, and Members of the Committee.

My name is Larry Lane and I am president of the National Association for the Support of Long-Term Care. NASL was founded in 1989 and it is the only national organization that concentrates exclusively on legislative and regulatory matters regarding the professional services and supplies provided to beneficiaries in a skilled nursing setting.

I ask for permission to submit the materials with my statement and also to submit, for the record, a statement from the Post-Acute Coalition.

[The statement from the Post-Acute Coalition was not available at the time of printing.]

Chairman THOMAS. Without objection.

Mr. LANE. I have been asked by the Subcommittee to focus my comments on part A and part B ancillary services in contracting relationships. As the data that I submitted to the Subcommittee underscores, the growth of ancillary services reflects the changing roles, case mix both intended and unintended in the skilled nursing setting.

Facilities have three options in providing ancillary services to skilled nursing patients. One, hire staff and develop services; two, enter into an under-arrangement contract with a supplier or provider and bill for the services through the facility; or, three, enter into an under-agreement contract with a supplier or provider and let the supplier or provider bill the program for the services.

This contracting authority permits SNFs to purchase ancillary services for residents only when they are medically necessary and without incurring excess overhead or excess capacity.

The decision to secure products or services either under arrangement or under agreement depend upon demand, focus and availability. From a facilities standpoint, the current cost-based reimbursement system provides an incentive to either hire staff or secure services or products under arrangement. Medicare pays the lower of reasonable costs or charges.

Whatever approach is taken by the facility, the facility still has the responsibility for the clinical management and for the care and services provided in the facility. Let me make it very clear that the way that ancillary services are billed under Medicare is confusing and should be changed.

As an example, just reading a skilled nursing handbook transmittal 341 that just came out, it is clear that even HCFA is struggling in offering guidance on billing and coding instructions. The present system is illogical and it should be changed. Any reform of post-acute services part A should be billed for part A services and part B should be billed for part B services.

In calculating what part A reimbursement should be, there is a need to make appropriate adjustments to compensate for services currently billed under part B.

We do not have the data nor do nursing facilities have the experience to justify applying these consolidated billing principles immediately to part B services that are provided after part A eligibility is exhausted.

The issues that we are discussing today are the logical and foreseeable result of policy decisions made to improve access and beneficiary services. Statute and regulations have not kept pace with changes in the care system and, in some instances, act as barriers in providing low-cost, high-quality services.

There are conflicting rules and outdated provisions. We urge the Congress to replace the cost-based reimbursement for part A benefit. We need to develop a prospective payment system for the part A benefit that one, recognizes legitimate differences in factors that affect cost; two, encourages appropriate access to care for Medicare beneficiaries; three, encourages the provision of high-quality care; and four, provides incentives for efficient use of resources.

A system which is designed solely to secure cost savings will not achieve these goals. The development of a prospective payment system must reflect patient need and the accuracy of the data used to identify patient need in constructing the prospective payment system is crucial. It must include appropriate patient assessment tools that accurately reflect all that is involved in patient care.

There is a need to encourage quality outcomes, offer ease of administration and establish reasonable payment levels. At the same time, it is important to establish objectives that can be implemented in a realistic timeframe.

Let me conclude by making these specific recommendations. First, consolidate the part A and part B billing during the part A stay. Second, do not consolidate billing for part B services after the exhaustion of the part A benefit, or when part A is not being billed. Third, address the complexities caused by current law, eliminate hospital transfer requirements for such services as respiratory therapy, x ray, and lab. Fourth, implement a part A SNF prospective payment system which reflects patient need and facility-specific variation.

I appreciate this opportunity to submit information and I look forward to working with the Subcommittee.

[The prepared statement follows:]

STATEMENT OF LAURENCE F. LANE, PRESIDENT
THE NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE

Mr. Chairman:

Good afternoon Mr. Chairman and Members of the Committee. My name is Larry Lane, and I am President of the National Association for the Support of Long Term Care. NASL was founded in 1989 and is the only national organization that concentrates exclusively on legislative and regulatory matters regarding the professional services and supplies provided to beneficiaries in a skilled nursing facility.

We have been asked by the staff to comment on the following five areas:

- Explain the reasons for growth of SNF ancillary services;
- Clarify relationships of Part A and Part B ancillary services;
- Overview contractual arrangements between facilities, suppliers and providers;
- Clarify reimbursement for SNF therapy services; and
- Offer our recommendations for policy changes.

In short, NASL supports:

1) Reforms that require billing Part A for Part A services;
2) Elimination of artificial legal barriers to services for nursing home residents, such as transfer agreements and three day stay requirements; and
3) Transitioning to a PPS system under Part A for skilled nursing services.

With your permission, I will summarize the key points and request the text and accompanying materials be submitted as part of the hearing record.

GROWTH OF ANCILLARY SERVICES

The growth of ancillary services reflect the changing role and case-mix, both intended and unintended, of skilled nursing facilities. Moving patients out of hospitals into more cost-effective and appropriate settings was one of the goals of hospital prospective payment reform enacted in 1983. This has been a substantial success with clear benefits for both the Medicare program and for Medicare beneficiaries. Due to this success, the patient demographics of SNFs have changed. SNFs are now admitting higher acuity patients who require more services than the typical SNF resident of 10 years ago. The type of health care delivered within the SNF has changed.

Over the past 10 years, the nursing home sector assumed greater responsibility for post acute medical services, and the changes can be summarized as follows:

- **Higher patient acuity** often caused by hospital discharging patients "sicker and quicker;"

- **Regulatory mandates** such as OBRA 87 which required facilities to help residents achieve "the highest practicable level of functioning" and

- **Increased Medicare utilization** in both the number of SNF beds and the number of patients.

With few exceptions, nursing facilities meet the needs of two significantly different populations: a short-stay patient requiring intense medical and professional support, and a long-stay resident requiring intermittent medical management. Congress should evaluate whether any changes made adversely effect either type of patient.

As we look at ways to reform SNF reimbursement, we must design a system that recognizes the significant differences in patient acuity and case-mix, and we must retain the incentives to move patients into a more cost-effective and appropriate settings.

PART A/PART B AND CONTRACTING RELATIONSHIPS:

Facilities have three options in providing ancillary services to SNF patients: 1) hire staff to deliver the service, 2) enter into an "under arrangement" contract with a supplier or provider and bill for the services through the facility; or 3) enter into an "under agreement" contract with a supplier or provider and let the supplier or provider bill the program for the services.

While nearly 13,000 nursing facilities participate in the Medicare program, fewer than 2,000 facilities account for 50% of Medicare reimbursed days of care and less than 5,000 facilities account for 90% of the Medicare reimbursed days of care. Facilities admitting more than 10-20 new admissions per month may sustain a patient flow sufficient to justify a broad array of medical professional services. However, most facilities experience a significantly lower turn-over of resident and, therefore, offer a more narrow scope of core services. These facilities, under arrangement or under agreement, deliver specialized services on an as-needed basis.

Diverse patient needs drive program development. Most facilities, especially those with a small number of admissions/discharges per month, have strengthened professional medical services and supplies and specialty programs through contractual relations.

The demand for professional medical services is based upon patient need. Unless a facility has a relatively high volume of admission and discharges, demand will fluctuate. Where there is fluctuating demand for ancillary services, it is often less costly to contact with an outside provider or supplier. Even for higher volume ancillary services, such as therapy services, market studies have affirmed lower per unit cost of delivery in contracting relationships. There are savings to Medicare when services are purchased only when they are needed.

The decision to secure products or services either under arrangement and/or under agreement depends upon demand, focus, and availability. From a facility standpoint, the current cost-based reimbursement system provides an incentive to hire staff or secure services or products under arrangement. Medicare pays the lower of reasonable costs or charges. Whatever approach used by the facility, the facility still has the responsibility for the clinical management and for the care and services provided in the facility.

The way ancillary services are billed under Medicare is confusing and should be changed. Services are billed under Part B during a Part A stay not because of patient care needs but simply because HCFA often requires it. It is clear from reading the recent SNF Handbook Transmittal 341 (November 1, 1995) that even the agency is struggling to offer guidance on billing and coding instructions.

The present system is illogical, and it should be changed. In any reform of post-acute services, Part A should be billed for Part A services and Part B should be billed for Part B services. In calculating what Part A reimbursement should be, there is need to make appropriate adjustments to compensate for services currently billed under Part B. This is essential to ensure that future Part A reimbursement will accurately reflect how post-acute care services and products are presently being delivered. We do not have the data nor do many SNFs have the experience to justify applying these consolidated billing principles immediately to part B services that are provided after Part A eligibility is exhausted.

THERAPY REIMBURSEMENT

As stated above, facilities have options in securing therapy services. Services can be provided by facility staff, under arrangement with a therapy company, under agreement with a rehabilitation agency and/or under agreement with an independent therapist. Under existing rules, each therapy is individually recognized, and therefore, the facility can receive different therapies in a different manner.

When services are provided "under arrangement," the Medicare statute gives the Secretary authority to establish "salary equivalency guidelines" as limits for evaluating reasonable costs. Guidelines have been promulgated only for physical therapy and respiratory therapy. It is our understanding that HCFA is recalculating these guidelines and promulgating new guidelines for occupational therapy and speech language pathology services.

Members of NASL have been working closely, and cooperatively, with HCFA in developing these new rules.

MEDICARE POLICY RECOMMENDATIONS:

Our recommendations are the logical and foreseeable result of policy decisions made to improve access and beneficiary services. A decade ago, we were debating how to reduce unnecessary hospital stays and improve the quality of nursing home services. The increased utilization of post-acute services is proof that patients are receiving services in more appropriate settings.

Statutes and regulations have not kept pace with market changes, and in some instances act as barriers in providing low cost, high quality services. There are conflicting rules and outdated provisions.

We urge the Congress to replace the cost based reimbursement for the Part A benefit. A number of technical changes clarifying the existing Part A benefit can be done through regulation, but some may need Congressional action.

We need to develop a prospective payment system for the Part A benefit that 1) recognizes legitimate differences in factors that affect cost, 2) encourages appropriate access to care for Medicare beneficiaries, 3) encourages the provision of high quality care, and 4) provides incentives for efficient use of resources. A system which is designed solely to secure cost savings will not achieve these goals.

The development of a prospective payment system must reflect patient need. The patient must come first. The accuracy of the data used to identify patient needs in constructing the PPS system is crucial. It must include a patient assessment tool that accurately reflects all that is involved in patient care. It should also encourage quality outcomes, offer ease of administration, and establish reasonable payment levels. It is important to establish objectives that can be implemented in a realistic time frame.

Bundling the payment into the hospital DRG would greatly disrupt the delivery of patient care and reverse the incentives to move patients into the most cost-effective setting. DRGs should probably be recalibrated to reflect changes in the health care marketplace and medical innovations that would provide substantial savings to Medicare. It is noteworthy that in the private sector, most payers do not premise payment for post-acute care on hospital reimbursement. Private payers are aware that diagnosis is not a good predictor of post acute services, that the hospital payment is based on the highest cost model, and that hospitals may not be best suited to deliver post-acute care.

With regard to skilled nursing facilities, the HCFA sponsored case-mix demonstration project is focused on a limited number of facilities. While this information is critical in developing a national PPS system, it may not be reflective of all types of SNF patients and the Committee should evaluate what additional data should be collected. The implementation of a national program might require a first step that focuses on facility-specific variations. It may be unrealistic to expect an all-inclusive payment system in place within twelve months; however, it may be realistic to work from the existing routine cost limits and add specific dates for incorporating ancillary services. The base years used to establish the prospective payment system and the manner in which those measures are updated and trended forward are critical. A phased implementation period would facilitate a smooth transition. Timely, accurate and relevant data is essential.

Safeguards should be written to require that services reach beneficiaries, that suppliers and providers will receive timely payment and that quality will be maintained. A realistic SNF prospective payment system for Part A services will focus attention on the need for consolidated reporting and coding of services for Part A patients across care settings. Such information will help in evaluating the appropriateness of services. Usable, uniformed measures for clinical outcomes should be developed as the current system relies too heavily on factors which add costs, but do not necessarily ensure meaningful results.

Likewise, any prospective payment system must enable the dynamic health care market to continue to progress and not lock-in the status-quo. The reimbursement system should encourage medical and therapeutic innovation and permit services to evolve to meet changing patient needs.

To begin implementation of this system, let me conclude by making these specific recommendations:

First: Consolidate the Part A and Part B billings during the Part A stay. This permits the collection of data crucial in developing an appropriate prospective payment system and the obligation of the SNF to reimburse the ancillary provider would not be affected.

Second: There should not be consolidated billing for Part B services after the exhaustion of the Part A benefit or when there is not Part A billing.

Third: Address the complexities caused by current law. Eliminate hospital transfer requirements for such services as respiratory therapy, X-ray and labs. These requirements increase Medicare expenditures by locking in higher cost and non-competitive providers.

CONCLUSION:

Two decades ago there was an article in the Milbank Journal on nursing homes as the "after thought" industry. The fact that this hearing is focused on the services we provide is recognition that we have evolved into essential care providers.

We appreciate this opportunity to clarify trends, comment on delivery and offer suggestions for future policy changes, and urge your support of our recommendations.

I will be pleased to answer questions on any of the points I have made in this testimony or respond to any issues that may have been raised earlier. NASL shares this Committee's goal of ensuring that every Medicare dollar buys affordable, quality health care for the patient. We pledge to work with you to reach this goal.

Mr. CHRISTENSEN [presiding]. Thank you.

I would like to thank the panel also for being here all afternoon and waiting to testify. I appreciate your patience. Ms. Bailis, I wanted to go over a question that came up earlier today while Mr. Newhouse and Dr. Young were testifying.

They said in their written statement that no information exists or prospective payment system do not indicate strong association between the changes in length of stay and increases in SNF service use. Thus, we do not believe the increased use in the nineties is much related to change patterns in, in-patient use.

Looking at your chart there, it appears to me that there is some data out there that reflects that SNFs have been able to make a real positive effect on this. Would you elaborate on that?

Ms. BAILIS. Yes. I am familiar with the ProPAC data related to length of stay and, in fact, when you look at the initiation of DRGs in 1983, you can see a gradual diminution of the length of stay. If one looks only at that factor, hidden in there is no information that would lead to the conclusion that I came to. But, I suggest to you that it's more complex than that. That when you pull out DRGs, specifically those which generate post-acute care or subacute care—hip replacements, strokes, certain diagnoses that tend to lead to or require the use of post-acute care—when you look specifically at those DRGs and pull out that data related to length of stay, you see a real indication of decline in the DRG with the escalation of subacute care, which is to say that subacute care fueled the decreased utilization of the hospital DRG or the acute stay.

Mr. CHRISTENSEN. Looking at the ancillary services that you provided, you are the chief operating officer of the ADS Group, and how many facilities do you operate?

Ms. BAILIS. Sixty.

Mr. CHRISTENSEN. And over the last 5 years, have the ancillary services provided in all of your operations continued to increase?

Ms. BAILIS. My operations include freestanding SNFs, freestanding subacute units, and hospital-based skilled nursing facilities and assisted living facilities.

The assisted living facilities do not particularly make use of ancillaries. In all the other facilities there has been a significant increase in ancillary utilization over the last 5 years.

And it is my belief, by the way, that an episodic prospective payment system akin to the kinds of payment systems that managed care, Medicare risk programs are using would help the control that, quite frankly, is necessary because the incentives are not there to control ancillary utilization currently in our payment system.

Mr. CHRISTENSEN. Mr. McMeekin, would you answer the question that I asked her about the statement by Mr. Newhouse?

Mr. MCMEEKIN. I would be happy to, Mr. Christensen.

First of all, let me just amplify on Ms. Bailis' last point. I do think as we move closer and closer and hopefully sooner to a totally capitated payment plan we will have erased a lot of the problems, whether they are by design or by default, that we have today.

In our own situation, the utilization of our skilled nursing facilities, be they either hospital-based or free standing, is very much driven by the growing managed care environment that we have in the Philadelphia area. It is also driven by the very appropriate up-

grading of those facilities and the kind of services that they can provide today as compared to what possibly a skilled nursing facility looked like 10 or 20 years ago. I think our physicians are much more comfortable that the level of support their patients need is now available in either kind of facility.

Again, the higher intensity needs of patients tend to be closer to home and in the hospital setting.

Mr. CHRISTENSEN. Mr. Lane.

Mr. LANE. On the comment with regard to hospital discharge, in the materials I submitted to the Committee I show with data specific to discharges from hospital lengths of stay in four different timeframes, 1980, 1981, 1984, 1988, and 1994. For individuals who are, in fact, discharged to the skilled nursing setting for specific diagnoses, those diagnoses account for approximately 50 percent of admitting skilled nursing facilities diagnoses today.

If you take the delta change from 1984 to 1994 of hospital days, that lengths of stay have been decreased because skilled nursing facilities have stepped up to take those heavier care patients. You will see a change in cost savings that could be estimated in the range of $1.5 to $2 billion. That, in essence, says that the policies that this Committee adopted during the late seventies and early eighties to deal with the access and to remove, to overcome the problems of admission to the skilled nursing setting, clearly did have some economic impact. And this is using some of ProPAC's data to, in fact, look specifically at diagnoses.

Now, that's been uneven in different markets. But it does show that there has been a tremendous improvement.

Mr. CHRISTENSEN. Mr. McMeekin, earlier Mr. Stark stated that a hospital may be kicking out a patient earlier and sending them to a SNF and, in effect, may be double dipping.

I guess what is your statement on that and have you, obviously, seen any effect of that going on in the industry, and what is your personal take on that?

Mr. MCMEEKIN. Well, I do not agree with Congressman Stark. I do not think——

Mr. CHRISTENSEN. I did not think you would.

Mr. MCMEEKIN. I think what we're seeing is, again, a recognition by our physicians, the ones who admit and discharge our patients from hospitals, that there is a very appropriate alternative in a skilled facility for a patient that has passed that very acute point of illness.

Hospital-based units are basically paid a lump sum and the ability to game is really minimized when you look at the reduction in the length of stay, and what little data seems to be available, that I think the ProPAC testimony talked about today, would not suggest to me that there is any gaming. I think there is an opportunity to put patients in more appropriate settings than there used to be. Again, as you move to prospective payment and then to a capitated payment system, whether I am right or others are right who feel differently, it all gets eliminated. And, that truly is the direction we need to move.

It's also why the American Hospital Association supports an interim step and is very happy to support the Subcommittee's inter-

est in looking at a prospective payment system for skilled care and home care.

Mr. CHRISTENSEN. Ms. Bailis.

Ms. BAILIS. Well, I think the use of the term, double dipping, carries with it a kind of willful abuse connotation that I think would be unfair to attribute to hospitals because I do not think that that drives the motivation.

I think the problem is that there are reverse incentives in place. And when you have, under one roof, cost-based settings and prospective paid settings, they are at war with one another in terms of the payment incentives and the result is that hospitals receive payments for services without a recalibration of the DRG that may be at times in excess of what would be an appropriate cost for the care of a patient. That may or may not be the case, but it certainly is open for that with the lack of alignment of incentives and payment systems that currently exist.

I suggest to you that payment be made irrespective of site of service, but really related to the type of patient, the care that patient needs and let the system and the market drive where that patient ends of getting the care, whether it is in a hospital-based SNF, a freestanding SNF or, for that matter, at home.

Mr. CHRISTENSEN. Mr. Vladeck, our first witness today—and I do not know if you were here for his testimony—but he talked about the HCFA looking at maybe moving to a continuous or holistic approach. How would that affect each of your industries?

Mr. MCMEEKIN. I, for one, would welcome it. I think it would move us dramatically in the direction of treating the whole patient, of looking at the Medicare beneficiary as really the focus of our payment system. As Ms. Bailis has already commented, I think it removes a lot of the artificiality that is currently at work in our payment systems today. I do not think it is by design but I do think it's just a product of the kind of system we have. And when we talk about the development of integrated delivery systems, as we're trying to develop in our community, and a continuum of services and then add, on top of that, a capitated payment for a population that you have responsibility for, you really align everything to provide the proper care in the right amounts in the right place at the right time in a way that, in my career, we have never yet been able to do.

So, I would support Mr. Vladeck and HCFA in trying to move us in that direction, and as well, the Committee. I believe Chairman Thomas has spoken very forcefully on provider-sponsored organizations and direct contracting where truly you can get enough of the premium dollar or the Medicare dollar, in this case, to then more appropriately spend it.

Mr. CHRISTENSEN. Mr. Lane.

Mr. LANE. I would express severe caution and reservation and it could be significantly disruptive in patient care. And dangerously reverse the incentive to move patients into the most cost-effective setting. It is noteworthy that in the private sector most payers do not premise payment for post-acute services on hospital reimbursement. That is because of three real issues. One that diagnoses is not a good predictor of post-acute services. Second, the hospital is, in fact, the highest cost model and you have a tendency to

medicalize services that may not necessarily need and have excess capacity. And the third is that, in many instances the hospital is not suited to deliver post-acute care.

So, I would realistically say to the Subcommittee that if we are going to focus on what can get done in a period of time to least disrupt care and yet bring appropriate service, to move forward with setting specific prospective payment system and see how that affects the system first.

Mr. CHRISTENSEN. Ms. Bailis.

Ms. BAILIS. The best way to really achieve a holistic model of care or an integrated delivery system is to pay all post-acute providers prospectively. And to introduce, in fee-for-service Medicare, some case management models of what assist in securing the best setting at the most efficient and high-quality result.

Managed Medicare already has essentially done that but clearly prospective payment system for all post-acute systems of care is the way to achieve that. I would suggest to you that the endless debating about how to do it, which has gone on for years, should at some point come to a halt and sometime or other we should just get on with it.

Mr. CHRISTENSEN. I want to thank this panel for their patience in waiting until the end of the day and thank you very much for your testimony.

This brings a close to this hearing.

The hearing is adjourned.

[Whereupon, at 5:33 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

**STATEMENT OF SHELDON L. GOLDBERG, PRESIDENT
AMERICAN ASSOCIATION OF HOMES AND
SERVICES FOR THE AGING**

INTRODUCTION

Mr. Chairman and Members of the Committee, I am Sheldon L. Goldberg, President of the American Association of Homes and Services for the Aging (AAHSA). I am grateful for the opportunity to submit testimony for the record of your hearing on Medicare Prospective Payment for Skilled Nursing Facilities and Home Health Agencies.

AAHSA represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly. Our membership consists of nearly 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community-based service organizations. With our broad range of facilities and services, AAHSA serves more than one million older persons daily. We have a long history and consequently, significant experience in meeting the needs of the elderly. We recognize the important role that the Medicare program has played in ensuring that the health care needs of older Americans are adequately met.

The future of the Medicare program will be affected by a rapidly growing population of elderly and individuals with disabilities, diminishing resources in the Hospital Insurance Trust Fund, and growing costs of providing medical care. This future presents many difficult problems that this Congress and the next must face, if the country is going to maintain its commitment to its seniors. We appreciate the competing and sometimes incompatible demands that you must reconcile in order to keep the Medicare program operating. We pledge to work with you in any way possible to control health care spending and reduce the national deficit while still preserving access to high quality skilled nursing, home health and other health care services for our nation's elderly.

Our members include not-for-profit home health agencies (HHAs) as well as skilled nursing facilities (SNFs) and my comments today generally apply to both types of providers, since many of the issues relating to prospective payment are similar. We will specify when referring to one type of service in particular.

LONG-RANGE VISION

Looking well into the future, we believe our members will be actively participating in managed care. They will be providing care and services financed by systems that coordinate care across time, place and provider. These systems will emphasize prevention, risk-sharing and

appropriate utilization of services based on consumer and community demand for maximum health and well-being at lower overall cost.

We see the beginnings of these systems now, as evidenced by the growth of managed care and Medicare beneficiaries' growing participation in Health Maintenance Organizations (HMOs). There is a greater use of cost-effective, post-acute services and fewer days spent in expensive, acute care hospitals by managed care enrollees. Managed care organizations already receive substantial cost savings from the use of sub-acute care services without a three day prior hospital stay and from the substitution of post-acute care for unnecessary hospital days. Unfortunately, the Medicare program can not reap the same savings from these trends.

MEDICARE SAVINGS PROPOSALS

We have two savings proposals for your consideration. First, the elimination of the three day prior hospitalization requirement for selected diagnoses and second, the recalibration of acute hospital prospective payment rates, based on current lengths of stay. These two changes would permit Medicare to accrue savings from the growing use of cost effective post-acute services instead of more expensive acute care hospitals.

A third opportunity for savings comes through the Program of All-inclusive Care for the Elderly (PACE) demonstration and some waivers for Medicare and Medicaid, such as the Minnesota Senior Health Options Project. These are innovative approaches to integrating funding and services to enhance the quality of care available for seniors and they have the potential for cost savings, as well. Facilitating the waiver process for states would permit greater experimentation and flexibility in the treatment of beneficiaries who are eligible for both programs. Lessons learned from these demonstrations also reveal opportunities for savings in the Medicare program.

Superficially, the proposal to bundle payment for all post-acute services with the prospective payment to the acute care hospital may seem to provide for that type of substitution and savings. However, in reality, it would create distortions in the marketplace and would shift control of patients back to the hospital. Hospitals would have an incentive to retain relatively lower cost patients in their own nursing units and to discharge relatively higher cost patients to free-standing facilities, but their incentives concerning payments would be to retain more money to cover their own higher cost nursing units and to contract with free-standing facilities at reduced rates. The trend towards integrated delivery systems, combining

primary, acute, post-acute and long-term care providers with case management and equitable sharing of risk, has a greater potential to improve the quality of care delivered to beneficiaries and to produce savings. This is mainly because there would be no bias towards the most expensive providers.

We recognize that, in the short-term, reform of the current retrospective, cost-based reimbursement system is inevitable and that some form of prospective payment is likely. The Medicare PPS for low-volume SNFs is a start that has been working fairly smoothly, but it is only a first step. A well designed PPS could promote management efficiencies and create some savings for the Medicare program. But a poorly designed PPS could mean unintended consequences that might not help the Medicare program, its beneficiaries, or the long-term care industry.

We have seen from the implementation of the hospital PPS that the health care industry is very complex and can react in unexpected ways to PPS incentives. For example, the reduced hospital length of stay was an anticipated and desired result of PPS implementation. With hindsight, the growth of subacute care based in hospitals seems a natural result, but it was not as clearly expected at the time of implementation.

We understand that health care providers cannot continue with a "business as usual" attitude. It is also important for Congress and the Administration to understand that, with current major cutbacks in state Medicaid programs and the growth of managed care, SNFs and HHAs will not have the flexibility to cross-subsidize unreimbursed costs for Medicare patients with revenue from private patients.

Our members are committed to providing the highest quality care and living environments for their residents and patients, often exceeding the federal standards and requirements and providing more than the minimum care and services. High quality, however, does not come cheaply. With strong community support and charitable contributions our members have been able to provide more care and at more affordable rates than would otherwise be the case. But there is a limit to how much of the gap can be filled by development activities. An adequate level of compensation for residents and clients financed by public programs is essential.

PROSPECTIVE PAYMENT GOALS

While the most immediate objective for initiating a prospective payment system (PPS) may be to produce program savings, it certainly is not the

only one. Following are some other goals that ought to be included when designing a new reimbursement system.

- Access to care: The PPS should facilitate the timely movement of Medicare patients from acute care to the appropriate post-acute care setting. Reimbursements should not be set so low that providers would be reluctant to accept patients with high acuity, needing relatively intense or lengthy courses of treatment.

- High quality care: Ideally the PPS should reward high quality care and focus on quality outcomes.

- Efficient use of resources: The PPS should encourage efficiencies while recognizing that circumstances will vary from one provider to another and will affect management choices. The choice of service setting or provider type as well as the specific mix of service to be offered to a beneficiary should be encouraged to reflect the efficient use of resources as well as medical necessity and patient choice.

- Ease of administration: The current system of cost reporting with retroactive adjustments, audits, and settlement delays is cumbersome and costly. Management of the program by Medicare and of the service by the provider should be greatly streamlined.

- Innovation: Given the current dynamism of the health care market, the PPS should not lock-in the status quo, rather it should permit and encourage innovation and change. It should also recognize the costs of compliance with any new federal requirements, such as changes in the minimum wage or OSHA.

UNDERLYING ASSUMPTIONS

Basic to the achievement of these goals are some important underlying assumptions.

- Skilled nursing facilities must rehabilitate Medicare beneficiaries in their care to the highest practicable physical, mental, and psycho-social well-being. This is federally mandated by OBRA '87.

- In general, Medicare payment for nursing care and home health services should approximate the reasonable costs of efficient providers. It does not matter how finely constructed are the incentives of the PPS, if there is not a realistic level of funding in the system.

- There are some legitimate differences, such as labor market wages, in factors affecting provider costs that are to be expected.

- Not all costs of producing services can be controlled directly by management.

- It must be recognized that the growing expenditures of the Medicare program result not only from provider actions that can be corrected by a PPS, but also from growing numbers of beneficiaries with greater needs for services.

ELEMENTS OF THE PPS

Case Mix Adjustment: Basic to the achievement of almost any of the goals mentioned above is the ability of the PPS to discriminate among patients requiring different levels and types of care and associating that with the resources used in treatment. In other words, residents or clients requiring more expensive and extensive courses of treatment should generate a payment amount greater than the average patient. Likewise, a relatively easy care patient should generate a payment less than the average. However, there should also be an incentive to rehabilitate the patient and move a high acuity patient to a higher functional level with a less intense level of service needed.

In the acute care hospital, prospective payment per case is set by diagnosis, but a classification by diagnosis for post-acute care is not a good predictor of resource use. Functional limitations are a better indicator of costs of care within a given post-acute care setting (SNF or HHA). HCFA has a Multistate Skilled Nursing Facility Medicare Case-Mix Demonstration currently underway. Soon, HCFA should be receiving data on case mix adjusted payments for SNF care that includes some ancillary costs along with routine costs. However, the project is very limited in the number and geographic spread of participating facilities as well as limited in the costs covered. The evaluation data will not be available in the near future. A case mix adjuster for HHA patients is also far from fully developed although the second phase of a demonstration project is in operation. There is not yet a case mix adjuster that explains a significant amount of the variation in costs per case. It is essential that case mix adjusters for both HHAs and SNFs be developed, refined and tested as quickly as possible.

Unit of Payment: The most commonly mentioned units of payment are: episode/case/stay and per diem/visit. While it is relatively straightforward to define a visit or day for payment purposes, defining a post-acute case

or episode of care or a SNF stay becomes more complex. Care of a Medicare beneficiary in a post-acute setting can be punctuated by an acute incident requiring temporary hospitalization and then a return to the same or a different SNF or HHA. Or, a resident may leave the SNF to return home, have a relapse or find it impossible to manage at home and then return to the SNF. Likewise, a HHA client might stop service for a period, either because of an acute or post-acute care admission or for lack of continuing need, but then return later to HHA care for the same diagnosis.

Defining and keeping track of a beneficiary's treatments during an episode of post-acute care requires very sophisticated and integrated information systems. Even with a clear definition of episode, it will be difficult determining norms for payment purposes. The appropriate, medically necessary post-acute care course of treatment can vary significantly, even for patients with the same diagnosis or functional level. In addition, the social and family supports and personal preferences of a beneficiary can affect the length of treatment and setting. Again, the case mix adjuster becomes crucial for differentiating between the amounts of care needed by beneficiaries and for defining the episode and payment level appropriately.

The choice of payment unit affects the incentives of the PPS. These incentives would need to be carefully balanced with an effective quality assurance/outcomes monitoring system. With a payment per episode there would be an incentive to reduce/eliminate unnecessary services. Similarly, it could provide an incentive for underservice or early discharge. For home health, in which Medicare's concern is with an increasing proportion of cases receiving long courses of treatment with many visits, a payment per episode would be appropriate. However, such a mechanism to control volume of services in the home health setting would need to be balanced by effective monitoring of quality and a payment process for exceptional cases.

The choice of a unit of payment is less obvious for SNFs. After observing the trend in hospitals over the past dozen years since implementation of a PPS based on episode, to discharge patients "quicker and sicker", we should approach that method with caution for SNFs. There is no evidence of an increase in the average length of stay of Medicare nursing home patients or of dramatic increases in the proportion of beneficiaries using SNFs. Medicare's concern with the growth in the number of therapies/ancillary services could be met with a per diem payment. In addition, the SNF Medicare benefit has a limit of 100 days (unlike the unlimited HHA benefit) and the copay of $92 per day after the 20th day may help deter unnecessary utilization. Methods of phasing in an

episodic payment or blending it with a per diem payment should be explored, given Medicare's lack of a sophisticated and accurate case mix adjuster and refined quality outcomes monitoring systems.

Covered Costs:

Ultimately, the PPS should include all costs related to caring for Medicare beneficiaries: routine, capital and ancillary costs for a SNF and visit, travel, and administration costs, etc. for a HHA. However, a phased-in approach, perhaps covering only routine costs initially, until complete data are available would make more sense at the start of a PPS. A comprehensive payment is more attractive administratively for the program and the provider, facilitates planning and permits flexibility of operations. However, an all-inclusive payment presumes a knowledge of all the components of care and associated costs that currently go into an episode or day of care and a norm of what volume of service ought to be included. That information and understanding is not yet available.

Even with the case mix demonstrations, HCFA will not have complete data on all the ancillary services and supplies and their costs that are currently associated with particular categories of cases. Treatment protocols and clinical pathways for common post-acute diagnoses are still under development. It will be difficult devising reasonable assumptions about length of stay/number of visits, and appropriate ancillary costs to cover in an all-inclusive payment. This again would argue for a phased-in approach.

Inflation Factor: Any PPS must recognize the impact of inflation on the provision of services. The "market basket" approach used for the Medicare low-volume SNF/PPS makes sense. However, the projections and updates should be made in a timely fashion to assure their accuracy and close proximity to reality, since a retroactive adjustment for inaccurate projections would be counter to the prospective philosophy.

Since the design of the PPS is predicated on the assumption of a realistic level of payments, it would be a gross distortion of the system to use the inflation factor as a mechanism for reducing the payment level to meet arbitrary congressional or administration budget constraints. The ease of abusing the inflation factor, for example, by setting it at market basket minus 2% shows a clear disregard for the goals of PPS and makes the industry leery of supporting any reimbursement change.

Other Adjustments: Geographic adjustments are important for recognizing variations in costs affected by place of service (urban/rural)

and costs of labor in different markets. Such adjustments are included in the low-volume Medicare SNF/PPS and the hospital PPS system and appropriate mechanisms should be included in any new PPS system.

In keeping with the goal of matching the payment amount to the acuity of the case and level of services needed, we recognize the need to eliminate the differential payment for hospital-based SNFs.

Outliers: Even with a sophisticated, fully tested case mix system, there will be a need for recognizing exceptional cases requiring substantially more services than the norm. With a crude system still under development and not fully tested, the exceptions process becomes even more important. This is particularly true with respect to home health, where the benefit is not time or visit limited.

Waiver of Liability: Given the complexity of Medicare's eligibility rules and definitions, providers of service need the reinstatement of the waiver of liability, whether the payment system is retroactive or prospective. This is necessary to protect innocent, careful providers who unintentionally and on rare occasion, make a coverage mistake and to ensure the timely availability of services to beneficiaries.

CONCLUSION

We recognize the need to move forward with a new and improved payment system to cover Medicare SNF and HHA patients. Well designed and implemented Prospective Payment Systems for all SNFs and HHAs could meet many of the needs of the program as well as of providers and beneficiaries. We are concerned, however, about imposing too rapidly any system that has been inadequately tested and is based on insufficient data. In conclusion, we recommend:

- The collection of necessary cost and utilization data and the evaluations of the demonstrations as quickly as possible,

- Any PPS be phased-in to permit smooth implementation and the avoidance of drastic and inappropriate changes. The PPS could cover gradually increasing categories of costs or could be a blended rate based on a provider's current payment and the new PPS rate.

- The full PPS include monitoring of program implementation to spot potential problems early. Also, it should include evaluation of the implementation phases and their impact on the health care industry broadly and on SNF and HHA providers, beneficiaries and their quality

of care and the quality of life, in addition to their impact on Medicare's budget. Changes and revision of the PPS should be expected based on the evaluation.

- The three-day prior hospitalization requirement be eliminated for selected diagnoses,
- The PPS payments to acute care hospitals be recalibrated to reflect more accurately current lengths of stay,
- The Waiver of Liability be reinstated, and
- Waivers for Medicare and Medicaid integration and programs such as PACE be facilitated.

We look forward to working with you in the months ahead to help develop a payment system that will work for Medicare, its beneficiaries, and the whole industry. Thank you for this opportunity to present the views of the not-for-profit nursing facilities and home health agencies who are members of the American Association of Homes and Services for the Aging.

Statement of
Dwight S. Cenac
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Submitted to the
The Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

On Issues Related To Home Health Agencies and Skilled Nursing Facilities

August 5, 1996

Mr. Chairman and members of the Subcommittee, on behalf of HCAA, I am pleased to have the opportunity to share our views concerning the critical issues related to Medicare payment policies for post-acute care services, especially home health care. I would like to begin by commending Chairman Thomas for convening the July 23, 1996 hearing to address the critical need to control the rate of growth in Medicare spending, while assuring that necessary services will be provided to the most vulnerable members of our society, our nation's elderly. HCAA applauds and embraces these attainable goals.

HCAA represents the voice of 300 freestanding home care agencies. I attended this important Subcommittee hearing on behalf of HCAA; listened to and read the testimonies and statements given; and heard the questions raised by members of the Subcommittee. Accompanying me was Scott Lara, HCAA's governmental liason-representative.

This submittal is divided into four sections: Section I - What This Subcommittee Can Do Now; Section II - Our Response to Questions Raised by Members of the Subcommittee, Which HCAA Feels Were Not Appropriately Addressed; Section III - A Comparison of HCAA's "Per-Visit" PPS Plan to "Per-Episode"; and Section IV - Other Issue.

Before beginning, HCAA would like to clarify that the "Revised Unified PPS (Home Care) Plan" presented to the Subcommittee **does not have the endorsement** of the only two national associations exclusively representing freestanding agencies; nor does it have the endorsement of our respective state chapters. Noticeably absent from their "Declaration of Support" are the signatures of both HCAA and the American Federation of Home Health Agencies, AFHHA (AFHHA, similar to HCAA, is the other national trade association representing an equally large number of freestanding agencies.). HCAA would like to be included, as a witness, in future meetings/hearings on home health care. We are concerned that, although freestanding agencies represent the largest group of providers, the list of "home health care" witnesses (excluding the AHA) testifying before the Subcomittee consisted of two VNAs and one chain--there was no home health care representation by freestanding proprietaries. While we support the right of other associations to have their voices heard, HCAA is compelled to ensure fair representation of our members' values and beliefs and of the rights of their patients. We believe that fair representation is also necessary in order for the goals of this Subcommittee to be effectively accomplished.

SECTION I - WHAT THE COMMITTEE CAN DO NOW

(a) Stop Fraud and Abuse Enforcement---How? Have Industry (Preferrably AHCA and HCAA) Representatives on ORT task force and place limits on ORT over-zealous surveyors.

(b) Stop Improper Hospital "Double-Dipping" (Once in their DRG "charge" based rates and then again in their SNF and Home Care

"cost" based rates). --- How? By eliminating the allowablity of Hospitals Administrative & General cost allocations to their Hospital-Owned SNFs and Home Care Facilities.

(c) **Stop Inappropriate Hospital "Self-Referrals" --- How? By requiring HCFA to enforce 42CFR 424.22 against Hospital-Owned agencies who are violating the Law.**

(d) **Stop Unjust Cost Caps (that currently propose home care skilled nursing and home health aide Cost Cap Limitations, for all agencies nationwide, at levels BELOW Pre-Freeze levels). ---How? Instruct HCFA that when such a condition exists, Cost Caps must be made equal to Freeze levels.**

SECTION II - ANSWERS TO COMMITTEE QUESTIONS

Conspicuously absent (and troublingly so) were critical home health care industry insights and responses to the Subcommittee questions on such key payment issues as: (a) fraud enforcement; (b) improper hospital "double-dipping," (c) inappropriate hospital self-referrals; (d) and the need to stop unjust 1996 cost cap limitations which are LOWER than the 1993 freeze levels.

(a) Fraud and Abuse Enforcement- ORT & Need For Industry Input

No one industry organization has shown more concern over fraud and abuse in home care than HCAA. In fact, HCAA's Chairman, Dwight Cenac, delivered a scathing report to HCFA on November 11, 1992 pinpointing abusive activities by both ABC (a $600-million, 400-office chain operation) and other mega agencies utilizing subcontracted staff at greatly inflated prices. In a subsequent telephone follow-up, Mr. Cenac queried HCFA's Mr. Eric Yospe, a HCFA official bearing some responsibility for the audits of home care expenditures nationwide, on dealing with these abusive issues, and provided him additional information on how a major abuser of subcontract services in Miami, Florida (Hospital Staffing Services, Inc. (HSS), a $90-million, multi-office chain) was improperly milking the Medicare program millions each month. For the most part, the activities reported by Mr. Cenac were discarded by HCFA--although, MUCH LATER, a great deal has been said to Congress about these activities; and no credit has been afforded to the freestanding agencies for our attempts to help police such mega felons. In fact, years before the OIG prosecuted these felons, HCFA's Yospe stated, in response to the allegations of impropriety raised by Mr. Cenac, that HCFA had no way of ascertaining the fair value of subcontracted services, and that there was nothing wrong with HSS 's exclusive utilization of subcontracted nurses--even after he was informed by Mr. Cenac that such subcontracts were from seperate corporation(s) *OWNED* by the referring physicians. What is greatly troubling to HCAA is HCFA's and the OIG's misrepresentations that freestanding proprietaries (who generally bill less than $10 million annually) are, somehow, similar to these mega chains and self-referring physcian practices; and, somehow, should be subjected to increased scrutiny--now under the umbrella of ORT--because of such felons. HCAA is not opposed to investigations of fraud and abuse. In fact, as stated above, HCAA has attempted to bring such issues of fraud and abuse into light--**years before they were brought to Congress, or for that matter, before the felons caught.** What HCAA is opposed to, however, are two issues: first, the unwarranted singling out of freestanding agencies--while, at the same time, the unwarranted selective exclusion of HMOs, hospital-owned agencies and chains from ORT's process, and second, the improper use of excessive force by ORT's inexperienced and overzealous surveyors aimed at expelling freestanding agencies from Medicare participation by improperly interpreting **guidelines that they are NOT similarly and simultaneously applying against hospitals and chains** It is in this **spirit of fair play** that HCAA appeals to this Subcommittee (1) to properly and uniformly channel the ORT task force; and (2) to request the incorporation of valid industry input, such as HCAA, into the selection and investigation of today's sophisticated health care thief. Although **Peg Cushman** testified on behalf of NAHC and the home care industry, she later

told HCAA that NAHC's legal counsel, **Mr. Bill Dombi**, failed to notify her of the ORT abuse hearing he attended on behalf of NAHC member CSM (a freestanding agency in California). HCAA was concerned regarding the failure, in the testimony given, to reference the real attrocities occuring against the freestanding agencies under the umbrella of ORT. CSM Home Health Services, Inc., is a 10-year-old Los Angeles agency, which has spent more than $60,000 on legal and consulting services to fight its improper Medicare decertification after an ORT survey. One independent home care news reporter stated that the CSM story is not new--in fact, "In California, 26 of 40 planned surveys were completed last month. Six agencies were decertified; three voluntarily withdrew from the Medicare program; and one filed for bankruptcy. Think that because you're not in one of Operation Restore Trust's five targeted states, you'll escape its increased scrutiny? Think again. The latest state to be snared by the fraud initiative is Tennessee." **The presiding judge over the CSM case, the Honorable John G. Davies (Case No. CV 96-4651-JGD),United States District Court -Central District of California, could find no legal grounds (this is precisely why this Subcommittee's intervention is needed) to grant CSM relief, although he definitlely wanted to. Judge Davies said of the ORT process, "I think the surveyors -- I think CSM Home Services has a case. The evidence that is before me that I have perused, read, considered, leads me to those conclusions. The Surveyors, I had the Impression, were not reticent to wear their power on their cuff and to manifest it and exercise it in ways that are undesirable in today's society. The bureaucracy overreacted once again. That is my view of this case. But, what relief can I give you?"** What follows is a portion of the sworn testimony of one of CSM's key employees. It is given this Subcommittee as a reference point of the type of agency being abused by the unbridled ORT process, as it currently operates. "I, Jean R. Murphy, R.N., have been a registered nurse for over twenty years, a portion of which was served as an officer and flight nurse in the United State Air Force. I have approximately thirteen years of experience in home health care as an administrator and/or consultant. I am currently administrator of CSM Home Health Services, Inc. I have held this position for four years. CSM has been serving Los Angeles' underserved minority communities since 1985. These communities include the Rampart District, South Central Los Angeles, Koreatown and other primarily minority communities. ***CSM's clerical and field staff are also primarily minority. CSM staff continued to serve their clients during the 1992 riots under security guards. During the Northridge earthquake, my staff forsook their families to rush to the aid of their patients. One black certified home health aide was present in a board and care facility during the earthquake; and placed several residents under mattresses to protect them as she, herself, braced and quieted their fears. The CSM Director of Nurses stood in water without power using her cellular phone to try to reach staff and patients to ensure their safety, despite the fact that she, herself, was in peril because the gas supply in her apartment had not been turned off and had been evacuated for fear of explosion. One of CSM's clinical supervisors was carjacked and robbed at gunpoint while she sat in her car solving a patient crisis on her mobile phone. Another registered nurse, whose husband had driven her to a patient's home after the riots, was shot as they sped away to avoid being carjacked or killed. CSM has undergone Medicare recertification surveys annually since its founding. These surveys have been conducted by the surveyors from the Department of Health Services, who have found only minor deficiencies with CSM's compliance with Medicare Conditions of Participation. CSM responded to these deficiencies with corrective action plans; and there have never been any termination actions initiated against CSM as a result of these minor deficiencies."***

HCAA asks the question: Does the Subcommittee believe that CSM is the type of agency at which ORT should be targeted?

For the record, below is a sampling of the ORT findings used against CSM, as the basis for booting CSM out of Medicare (None of the findings were related to patient care--odd isn't it?):

G104 - Standard: Exercise of Rights and Respect for Property and Person. The surveyors alleged first that there was a conflict between CSM's admission consent form and CSM's patients right form. CSM believes that it was in full compliance with this standard at the time of the survey, since the general consent form simply authorizes the agency to begin treatment; and the patient rights form gives the patient the right to refuse any specific treatment at any time. However, CSM amended both of these forms to comply with the surveyors' expectations. The

Surveyors also alleged that CSM had deficiencies in informing patients of the State home health hotline number, because some of the patients could not explain to the surveyors the purpose of the hotline. However, the regulation requires only that the hotline information be provided to the patients in writing. Upon admission, CSM provided (verbally and in writing) all of the information regarding the hotline number to each of the surveyed patients.

G108 - Standard: Right to be Informed and Participate. The surveyors alleged that CSM was not in compliance with this standard because one patient claimed that he was not informed of his patient rights and was not included in the plan of care. However, CSM had documentation that this patients had signed a patient's rights statement; and, therefore, was informed of his rights. Surveyors also alleged that one patient was told by a physician that he wanted the patient to be referred to CSM. CSM did not condone or request this action by the physician; and, therefore (I believe) cannot be held responsible for the physician's actions. Further, this alleged problem does not appear to be covered by this regulation; and, therefore, CSM was not out of compliance with this Standard.

Other issues cited by the ORT surveyors were similar AND were not patient care issues

HCAA is not alone in its concerns and observations regarding the need to oversee such ORT policies. *Testimony given by Susan Bailis, AHCA, states that the Subcommittee should "carefully monitor the implementation of the 1995 Survey, Certification and Enforcement rules to ensure they are cost-effective, and are not abused by over-zealous inspectors and are enforced fairly and evenly."*

The final comparison I would like to make, to what is happening in the ORT process, was best stated by Ann Chadwell, Knight-Tribune News Service. Ann states that, *"Behavior that is high-handed and harsh from people in control toward people economically beholden and unable to fight back is cheap."* Ann shared a story to make her point: "There's a great story about passengers mobbing the reservation counter after a cancelled flight. Airline personnel were doing their best to rebook passengers quickly. A demanding passenger pushed to the front of the line, pounded on the counter and shouted repeatedly, ' You have to get me on this plane.' The reservationist remained accommodating and unrattled. The passenger's tirade became even more incensed and insulting. 'Do you know who you're talking to?' he shouted. 'do you know who I am?' The reservationist calmly took the microphone and announced over the intercom, 'We have a passenger who doesn't know who he is. Will someone who knows this passenger please come identify him?' That caused the other passengers to erupt in applause." **This fine example was given to me by my thirteen-year-old son, Dwight Cenac II.** I believe that **America would cheer** a Subcommittee which properly brought back into-line an out-of-order bureaucracy which has lost touch with the issues.

(b) Hospital "Double-Dipping" - Overcharging Medicare Billions (for HHA and & SNF Covered Services)

One committee member repeatedly asked the NAHC and PPS Work Group home care representaives about the impact of hospital "double-dipping" and self referrals (See section (c), below, for our separate concerns on self-referrals.) upon the home health care industry and upon their PPS "per-episode" proposal. I believe most agencies would be shocked to hear that the only response given was by Mr. Hoffman (one of the two spokespersons for the PPS work group), who stated, "I have never given it any thought " This is a most incredible response, given the massive amount of adverse publicity this activity has received in Texas (Mr. Hoffman's state of residence). HCAA does not concur with such unreliable testimony. Today's flawed reimbursement to hospital-owned agencies (and SNFs) essentially allows hospitals to commit legalized fraud/abuse by "double dipping" Medicare funds. Today, hospitals are rapidly jumping into home health care and unethically blocking referrals to freestanding agencies because they've discovered a reimbursement loop-hole that allows hospitals to get paid twice. They are able to do this **once** with their Medicare DRG rate, which includes their administrative costs, **and then** by allocating this very same administrative cost to their hospital-owned agency. In fact, hospitals are even purchasing agencies whose owners have been convicted of fraud (such as Health Masters).

Hospital Medicare reimbursement needs to be changed to stop hospital administrative "double-dipping," falsely called "cost shifting." A "cost shift" means just that! It means **shifting** a cost **to another location**. It does **not** mean **"duplicating"** the cost somewhere else! Patients were supposed to be guaranteed a choice of health care providers! HCAA findings can best be compared to the testimony given by Susan S. Bailis, representing 11,000 freestanding SNF's who are members of the American Health Care Association (AHCA). Ms. Bailis shared in her testimony the need to stop rewarding inefficient hospitals through Medicare's failure to recalibrate DRG's (improperly allowing hospitals to double-dip Medicare in the SNF market as well). HCAA shares Ms. Bailis's concerns about HCFA's unwarranted "desire to continue to subsidize less-efficient and more-costly hospital-based care." Identical to HCAA's concerns, Ms Bailis testified as to "incentives for hospitals to allocate labor, administrative, and general costs over to PPS-exempt SNF units (one Executive identified $50,000 per bed as a common figure); and the ability of hospitals to receive a cost-based payment higher than a freestanding SNF, in addition to the full DRG payment." AHCA proposed, and HCAA agrees, that hospital "DRGs be examined and recalibrated according to severity of illness and length of stay." Although most experts (including testimony by Ms. Bailis and testimony by Joseph P. Newhouse Ph.D., Chairman of ProPAC) agree that the recalibration of DRGs is needed, they seem to be at a loss with regard to how to get it done. HCAA proposes, therefore, that the only other appropriate interim solution is to simply STOP the hospital's double-dip allocation (to Medicare), of its administrative costs (already included in its charge-based DRG), to cost-reimbursed home health care or SNF care rendered in facilities owned by the hospitals. HCAA has calculated that Medicare could save $1.2 Billion annually (in the home health care market, alone) by stopping this double dip. AHCA calculates that Medicare could save "$9 Billion per year (in the SNF market)!"

(c) Improper Hospital Self-Referrals

Again, HCAA is concerned over the lack of response, given by the home health care representatives who testified, to Subcommittee members who questioned the guerilla-like self-referral tactics hospitals are, allegedly, utilizing to pirate referrals **away from** freestanding agencies **into** their hospital-owned home care facilities. The issue of self-referrals should be of keen interest to this Subcommittee for the following four key reasons:

(1) Self-referrals cost Medicare significantly more.

This subcommittee has already received testimony to the effect that home care, provided by hospitals, costs more. Evidential testimony was given to this effect by HCFA, ProPAC, AHCA (similar SNF substantive testimony), and even the AHA which (unbelievably) petitioned to keep such overcharges legal.

(2) Self-referrals create inappropriate market dominance and deny patient choice.

The best response was made by AHCA, which testified that such inappropriate rules are "directly attacking our ability to compete in the sub-acute Medicare marketplace."

(3) Self-referrals (from physicians) have already been legislated as Non-Allowable (But HCFA refuses to enforce this Regulation when it applies to hospitals.).

Unfortunately, HCFA has chosen to unfairly **not enforce** 42 CFR 424.22 in a even-handed manner against hospitals which violate this significant policy. Specifically, 42 CFR 424.22 prohibits Medicare (HCFA) from paying claims to hospitals (and all other home health care agency types as well) for any home care referrals received from physicans compensated more than $25,000 annually.

(4) Self-referrals create overutilization (and hence costs) of home care services .

Surprisingly, no one testified before this Subcommittee on ProPAC's finding of hospital

overutilzation of home care services WHEN they own the home care agency they self-refer to. **The June 1, 1996 "Report To Congress" submitted by Joseph P. Newhouse, who testified before this Subcommittee, stated that, "Hospital-based providers also were likelier than free-standing ones to treat beneficiaries who had been in the hospital."**

The vital issue of abusive hospital self-referrals is not as prominant in SNFs as it is in home care. We believe this is so because patients are normally familiar with the differences between a freestanding SNF and the hospital's; whereas such familiarity is not known for home health care. The primary reason that self-referrals is such a critical issue in home health care is because hospitalized elderly patients are victimized, by hospital staffers, into believing: first,that the hospital is the only provider; and second, that only the hospital-owned agency is capable of giving them the specialized care they need once they are discharged to their homesetting. The issue compounds itself because hospitals are purchasing physician practices and then mandating the physicians to self-refer to the hospital's owned agency. This "purchased" physician self-referral practice is **supposed to result in denial of claims**, based upon 42 CFR 424.22. Enforcement of 42 CFR 424.22 clearly falls into the jurisdiction of HCFA as it is a claim-denial issue, not a fraud issue--**and on June 18, 1996, the OIG brought this to HCFA's attention!** Specifically, the Chief Counsel to the Inspector General, D. McCarry Thornton, "copied" HCFA's Thomas E. Hoyer stating, "HCFA has the responsibility for enforcement of these regulations." *Eli's Home Health Care Report* stated that after the Thornton letter, HCFA itself will not issue further clarification on the issue. "They're going to adhere to their current interpretation (meaning hospitals are not permitted to self-refer) and their current 'enforcement' (which means no enforcement of the Law against hospitals), one source says." Another, notes that "*HCFA will now let the courts decide* the extent to which 42 CFR should be enforced (even though HCFA has made NO disallowances against violating hospitals) and whether or not hospital-based agencies should be granted a moratorium, as they have requested. 'Whether HCFA is going to do anything more than it has in the past, such as disallowing these claims, I don't know,' adds Pyles." HCAA has asked for a meeting with HCFA's chief, Dr. Bruce Vladeck, who testified before the Subcommittee, to uncover the truth as to why his office will not enforce 42 CFR 424.22 in an even-handed manner. However, Vladeck privately told HCAA that he **will not meet on this matter. HCAA feels it is imperative that this Subcommittee require HCFA to even-handedly enforce the regulation (42 CFR 424.22) against violating hospitals; and then, if necessary, let the courts decide. To be fair to the hospital industry, HCAA would request that the Subcommittee require HCFA to first, and immediately, instruct its Contractors and Intermediaries to notify hospitals about this potential liabilty; and then, make disallowances for referrals from physicians whom they compensate, directly or indirectly, over $25,000 per year.** HCAA wishes the Subcommittee to know that this vital issue (self-referral) is not one evolving from the interest of hospitals in patient care, as there were few hospitals rendering home health care before DRGs. **The issue is clearly one created by the hospital's ability to be paid twice (see (b), above, on the "double-dip") and to get paid "twice as much" by (improperly) monopolizing referrals.** Specifically, there are two well-known industry suits recently filed (in Texas) against Columbia/HCA on the very issue of hospital improper self-referrals. One suit is a "whistle-blower" action filed by Dr. James Thompson, a family practitioner in Corpus Christi, Texas, contending, according to a November 11, 1995 Associated Press story, that "Columbia-HCA Healthcare Corp., the nation's biggest hospital chain, paid doctors illegal kickbacks (including cash, free vacations and cheap office rentals) in exchange for patient referrals". The second is a class-action suit filed on January 17, 1996, again, against Columbia-HCA, by a freestanding proprietary agency (CHS of El Paso,Inc - El Paso, Texas) alleging that Columbia-HCA owns four hospitals in El Paso and is employing monopolistic practices by having "pressured physicians with staff privileges" and "profit incentives" if they'll stop referring patients to CHS companies. These instances of impropriety are far from alone. Some further examples of such hostile self-referral hospital tactics are recounted here as quoted form the June 3,1996 issue of *Eli's Home Health Care Report*: " *'As we continue to see more hospitals get involved in the home health side of the business, outside the confinement of the hospital, our referrals continue to dry up,'* notes Glen H. Beussink, Executive Director of Cape Girardeau, MO-based home care provider Health Data Services, Inc Marilyn LeVasseur, MS, RN, Administrator of Family Nurse Care in Brighton, MI, also says that her revenues have been hurt by a local hospital's getting into home care business. *' In April of this year, the only hospital in the county became affiliated with a multi-hospital organization, and our referrals decreased*

30 percent,' LeVasseur says. According to Beussink, *'many of the physicians are pressured ever so slightly to use the hospital services. '* The American Federation of Home Health Agencies (AFHHA) also notes that *'we have received many reports that physicians have refused to sign home care orders unless the patient agrees to use the hospital-based home health agency.'* The National Home Infusion Association (NHIA) agrees, noting that *'our organization routinely receives calls from both outpatient providers and physicians indicating that hospitals are increasingly pressuring physicians and patients, both directly and indirectly, to utilize the hospitals' own services. '* Phyllis W. Fredland, RN, Director of Nursing for Health Personnel Incorporated in McKee's Rocks, PA, also observes that *'here in Pittsburgh, if doctors refer to another entity outside the hospital, the hospital can revoke their privileges. 'In our area, they are nothing less than predatory.'* According to Robert J. Brock, vice-president of At Home Health Care in Redwood City, CA, *hospitals 'discard literature we deliver to the hospital."* HCAA uncovered another contemptible tactic used effectively by hospitals to prey on their medical staff employees. In a misleading letter to home care agencies in its California community, Scipps Memorial Hospitals, in San Diego, California, stated, "It is the intention of Scripps to give to our patients reasonable choice in their selection of healthcare providers." The real truth of its intentions is shown, however, in its February 16, 1996 secretive internal memo written to its Medical Staff (as a basis for restricting freestanding home care agencies from receiving referrals). It read, "We believe it is critically important to keep patients within the Scripps health system whenever possible. This enables Scripps to deliver its premier quality care while assuring continuity of patient care throughout the system. When patients leave the system and are enrolled in other home care agencies, we lose jobs for Scripps employees, dollars for the Scripps system, and risk adverse patient outcomes as a result of care that may be less than the Scripps standard." Caught red-handed in its deceit, Script gave this arrogant, and yet weak, defense for its actions: alleging that, somehow, **care given by others is not up to its premier standards (forget Medicare's)**; "patients are encouraged to use Scripps' facilities because the recommending personnel have first-hand knowledge of the quality of those services."

d) Stop Unjust 1996 Cost Caps Lower Than 1993 FREEZE Levels

In his closing testimony, HCFA's Bruce Vladeck told the Subcommittee, "Let me end the home health discussion with a note of agreement. Both the Congress and the Administration wisely proposed to permanently extend the savings from the OBRA-1993 freeze on home health cost limits by not allowing for the inflation that occurred during the freeze. In the absence of this legislation, spending reverts to pre-freeze levels." However, Mr. Vladeck and others who testified failed to address the actual horrifying new Cost Limitations as published for comment in the Federal Register dated Monday, July 1, 1996. When directed by Subcommittee member, Jim McCrery (R.-La.) on whether he (Vladeck) understood that the Subcommittee's intentions were to control the growth rate of Medicare Expenditures, and not to "cut" Medicare expenditures to home care, Mr. Vladeck stated that he understood. What he failed to point out to the Subcommittee was that HCFA's currently-proposed skilled nursing and home health aide Cost Limitations, for all agencies nationwide, were SIGNIFICANTLY BELOW Freeze levels (thereby, representing a "cut" in home care expenditures and not a control on the rate of growth). Clearly, the proposed Cost Limitations do not meet the stated goals of the Subcommittee; and are unduly harsh and punitive, given these astonishing post-freeze results of HCFA's proposal. Whether HCFA's July 1, Cost Limitation findings are in compliance with statutory directives cannot be HCFA's shielded response when HCFA's results are so improper when compared to Congress' intention--as stated in this Subcommittee, and as agreed to be fully understood by HCFA's chief, Bruce Vladeck. The new rebased cost limitations proposed by HCFA at levels lower than the freeze period defy all logic-irrespective of any rhetoric made to defend them. Specifically, proving the new REDUCED Cost limitations defy all reasonable logic, we offer the following three points: First, the Freeze level cost caps were determined, according to the Federal Register dated February 14, 1995, "from settled Medicare cost reports, for cost reporting periods ending on or after June 30, 1989 and before May 31,1991" (the published average agency cost per visit, from HCFA, Office of the Actuary, for this time period was : 1989-$57.18, 1990-$54.85, and 1991- $56.19) ; Second, the newly published REDUCED "Post-Freeze" level cost caps were determined, according to the Federal Register dated July 1, 1996, "from settled Medicare cost reports, for cost reporting periods ending on or after June 1, 1991 and settled by October 1,1995"

(the published average agency cost per visit, from HCFA, Office of the Actuary, for this time period was : 1991-$56.19, 1992-$57.23, 1993-$60.26, 1994- $61.66 and 1995- $63.79); and Third, Table 11 in the July 1, 1996 Federal Register (entiled "HHAs Exceeding the Cost Limits) brazingly states that under these new limits 34.5% of all agencies are projected to EXCEED these new Reduced "Post-Freeze" Cost Cap Limitations. **Given these important facts, we ask that the Subcommittee instruct HCFA that the NEW Cost Cap Limitations, as published on July 1, 1996, be modified to state that where cost caps are found to be lower than the 1993 freeze levels, they be modified to equal freeze levels, plus a cost of living increase.**

SECTION III - A COMPARISON OF PPS PLANS

(A COMPARISON OF THE PPS "PER-VISIT" PLAN TO THE "PER-EPISODE")

WHY A "PER-VISIT" PPS PLAN WILL WORK

ANY PROSPECTIVE PAYMENT (PPS) PLAN SHOULD GUARANTEE FIVE THINGS:

1. **That we pay for what patients receive (Not for what they don't).** There should be incentives to provide needed care, not incentives to deny it when our elderly need it most.
2. **That the Government has the opportunity to share in savings.**
3. **That Medicare expenditures are "truly" contained.**
4. **That Medicare fraud/abuses are curtailed.**
5. **That a Medicare Review Program is in place to ensure quality care is being given.**

HCAA'S PPS "PER VISIT" PLAN GUARANTEES SAVINGS AND QUALITY CARE:

At the very core of HCAA's proposed PPS Plan, is our guarantee to provide care to the nation's elderly at an agreed-upon national cap for home care expenditures; thereby, controlling cost increases, and realizing a savings for the Medicare program. Let's not repeat the **tragic premature implementation of PPS** in home health care that occurred in 1983 for hospitals, by implementing an untested "per-episode" DRG PPS plan, resulting in today's four-fold cost increase. HCAA proposes a PPS plan that is based on per-visit (thus, guaranteeing the incentive is on **providing** care, **not** on **denying** care). Our plan also promised the opportunity for the government to share in savings (unlike a per-episode method wherein the payment becomes the ceiling and the government is thereby denied any opportunity for savings). **To guarantee that the rate of growth for home care Medicare expenditures is truly contained, HCAA proposes that there be a national cap on home care expenditures, adjusted only for two factors**: First, an annual cost of living increase; and Second, an annual adjustment based on the actual percentage growth in the beneficiary population. HCAA's "per visit" plan calls for a payment method that is both fair (eliminates the inducements to self-refer) and offers providers incentives and abilities to self-police, and expose today's sophisticated health care abusers. Congress has already received testimony that a flat, "per-episode" pay rate (similar to HMOs/DRGs) does not have the controls and safeguards in place to ensure necessary care is given, whereas HCAA's "per-visit" reimbursement rate, based on care actually provided, already has a quality assurance program in place within the current Medicare Intermediary system.

HOW TO IMPLEMENT HCAA'S PPS "PER-VISIT" PLAN:

* *HCAAs Plan is the Only Plan With a Fail-Safe National Cap:*
Statistics are readily available for current home care expenditures nationally, by state, and by local geographic area. HCAA proposes that these be used to establish a fail-safe cap and that this would be the only manageable basis to truly establish the control on the growth in Medicare expenditures. This fail-safe national cap would be modified only for the two adjustments described above: one, a cost of living increase; and two, beneficiary growth. For management purposes, the fail-safe national cap is to be further divided by state, and then by area. To manage (and curtail) fraud/abuse HCAA recommends that, FOR THE FIRST TIME, agencies be given authority to appoint representatives to monitor monthly area claim expenditures made by intermediaries, thus forming a "WE" team between government and providers. Abuses and unnecessary services can be more readily monitored by including the providers in the enforcement process. In the event of demographic population changes, an adjustment could be made between these smaller, manageable components - without altering the national cap.

* *HCAAs Plan is based on a "Per-Visit" PPS Rate - Thus Guaranteeing Care ("Per-Visit" is similar to the "Per-Diem" method HCFA endorses for the SNF industry)*

The current visit rates are already known. A geographic phase-in can be made, similar to the DRG phase-in with the exception that a mileage factor be included, in addition to a labor factor. Additionally, to stop hospital inducements to deny patient choice, payments to hospitals need to be "lowered" to reflect administrative costs already covered in their existing hospital DRG inpatient rates. Also, three further restrictions are necessary: First, a hospital cannot be entitled to receive more than 30 percent of its own referrals and should be prohibited from receiving referrals from other community sources. Second, there can be no more than a minimal amount of independent contractors for nursing or aide services (we recommend a 10 percent ceiling on such contracts). Third, physicians may not participate in home care remunerations. There is only one exception the "sole" community provider. Also, during the phase-in period, agencies must be permitted to market their services in the community, similar to the marketing used by HMOs and other health care providers in their area (with, of course, cost caps remaining during the phase-in).

WHY A "PER-EPISODE" PPS PLAN WILL FAIL

Any PPS method based on a "Per-Episode" payment will not succeed in either reducing current Medicare costs or insuring that care is provided to the elderly. Why? Here are the reasons:

1. **"HCFA SAYS "Per-Episode" Payment is a Bad Choice.**

   On page 20 of Bruce Vladeck's July 23 testimony, he hammers out why a per-episode payment is a poor choice as a PPS plan for SNFs. His same reasoning (on page 14 of his testimony) is exactly applicable to home care; and makes one wonder why he would even consider a per-episode PPS plan for home care, except that he stated that his plan for home care would not begin to transition to PPS until 1999 (at which time more data *could* be available on case-mix adjusters, etc). Mr. Vladeck stated, ***"There is no comparable information for per-episode prospective payment system. Not only do we not have sufficient information to determine the appropriate level of payment, no research has been conducted on the effects of a per-episode payment system on patient outcomes, quality, or access to care. The incentive under a per- episode prospective payment system could be for facilities to discharge patients as quickly as possible, as facilities receive the same payment irrespective of how many days the beneficiary remains in the SNF. Earlier discharge may result in poor quality care and increased overall program costs, as beneficiaries still needing services may return to the hospital or initiate home health visits. Furthermore, in the absence of an accurate case-mix adjuster (which currently does not exist to predict per-episode costs), SNFs would have an incentive to avoid more resource-intensive patients; and access to SNF care for the beneficiaries that need it the most would be reduced."*** Every reason given here by Mr. Vladeck is identical to the problems in implementing a per-episode payment for home care.

2. **"Per-Episode" Payment** is, by definition, a flat payment based upon characterization (similar to DRGs and/or HMOs).

3. **Overwhelming evidence** shows that a PPS "Per-Episode" method will fail to:

   A. Reduce Costs
   (Both DRGs and HMOs have not saved one cent. In fact, they have proven to cost more.)

   B. Provide care
   (Both DRGs and HMOs have proven to deny care).

4. **"Per-Episode"** will result in payment for what patients don't get--not a wise decision!

5. **Caution** - ***Adopt A PPS Plan That Pays Per-Visit, Not Per-Episode***

   The most important issue that everyone agrees on is that the rate of growth of health care "costs" should be controlled; but no one feels that "services" should be denied. HCAA

implores you to reject the imposition of any PPS plan for home health care, such as per-episode payment, which is based on denying care and has no true cost control measures inherent in its design! As two bipartisan members of the subcomittee pointed out in the hearing, a per-episode method has the same inherent payment problems of HMO and hospital DRGs: denial of care and failure to control costs. It was also pointed out by the honorable Chairman that although the industry representatives testifying may like the per-episode method, there is no proof that it is a better method of controlling costs. Allow the current PPS demonstration project to be completed for home care; and consider the results. Seek home care industry input from freestanding proprietaries before PPS is implemented.

BEN FRANKLIN'S ACID TEST RESULTS

Equal a Decided NO to PPS Per-Episode and YES to PPS Per-Visit

Ben Franklin's method was to list the advantages and disadvantages in order to reach a proper decision.

THE ACID TEST	PER-VISIT (with a National Cap)	PER-EPISODE
1. Does it pay for what patients receive?	YES	NO
2. Will the government share in savings?	YES	NO
3. Will Medicare expenditures be contained as a result?	YES	NO
4. Will Medicare fraud/abuse be curtailed?	YES	NO
5. Is a medical review program in place to ensure quality care?	YES	NO

SECTION IV - OTHER ISSUE

1. STOP HMOs FROM OVERBILLING MEDICARE BILLIONS!

HCAA recommends HMO legislation to save the desired 6 percent (over $16 billion) in Medicare dollars annually, by requiring HMO Medicare reimbursements to incorporate a "case-mix" capitation adjustment. Currently, HMOs are paid an average of $4,500 per Medicare beneficiary, which was falsely computed based upon the naive assumption that HMOs would enroll a case-mix of both healthy and sick Medicare beneficiaries. Because it has now been proven that HMOs target the healthy elderly, and because these healthy enrollees cost Medicare less than $500 a year (Consumers' Research, 7/95), HMOs are costing (not saving) Medicare the billions of dollars that, alone, would keep the program solvent. For example, a "case-mix" capitation adjustment factor (i.e., payment of only $500 for healthy elderly enrollees, versus the current $4,500), would guarantee that HMOs would be paid only what it costs to provide quality care, plus a fair reimbursement for administration and profit. On Nov. 11, 1995, the GAO delivered its fourth HMO report to Congress with this statement, fully supporting HCAA's conclusion: "HMO Rate-Setting Methodology Thwarts Medicare's Efforts to Realize Savings." In fact, an NBC News expose documented that a full 90 percent of all Medicare beneficiaries cost an average of only $1,900 per year under traditional Medicare. HMOs currently overcharge Medicare $16 BILLION Annually.

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to the Prompt Implementation of Medicare Prospective Payment for Home Care

August 6, 1996

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515-6348

Re: Supplement for the Record in the Hearing on Issues Related to Home Health Agencies and Skilled Nursing Facilities

Dear Chairman Thomas:

The following information is provided on behalf of the Home Health PPS Work Group and is intended to supplement the testimony presented by Stephen W. Holt and Phillip I. Hoffman at the hearing on Issues Related to Home Health Agencies and Skilled Nursing Facilities held on July 23, 1996.

This information is provided in response to comments and questions raised at the hearing by some members of the Subcommittee concerning the wisdom of imposing copayments on home health services covered by Medicare. Also included are some additional comments on the testimony presented at the July 23, 1996 hearing by HCFA Administrator Bruce Vladeck.

Copayments Are Bad Public Policy And Should Not Be Adopted.

The imposition of copayments on home health services covered by Medicare will not result in more cost effective health care and is less effective than prospective payment in controlling the growth rate in home health expenditures for the following reasons:

1. **Like the Part B shift, copayments create no incentives for cost effectiveness.**

   Just as with the Part B shift proposed by the Administration, copayments do not address the underlying problem which has produced the unacceptable rate of growth in Medicare expenditures for home health services. Copayments do not alter the incentives under the current antiquated cost reimbursement system for home health agencies to incur higher costs per visit, provide more visits per patient, and keep patients on service for longer periods of time. Just as with the Part B shift, copayments offer an illusory solution which obscures, rather than addresses, the defects in the current reimbursement system.

2. **Unlike PPS, copayments are a cut in the current Medicare benefit.**

   Copayments constitute a cut in the current Medicare benefit, while the unified prospective payment proposal achieves savings by reducing the rate of expenditure growth. Just as with the Part B shift, copayments also cheapen the value of the Medicare Part A benefit while not reducing the payroll taxes used to pay for that benefit.

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3. Copayments are cruel and/or ineffective in reducing expenditures.

The most often cited rationale for copayments is that they will instill "responsibility" in the patients by showing them that the care is not "free." In other words, access to home care will be reduced by inflicting economic pain. The effectiveness of that barrier to access, however, will depend on the patient's liability and ability to pay the copayment amount. Thus, a copayment will be most effective in reducing access to care for those who are poor and/or on fixed incomes.

Copayments apply only to services that have been determined, under Medicare coverage guidelines, to be covered and "medically necessary" to treat an illness or injury. Therefore, if copayments have the intended effect, they will principally deprive the poor and frail elderly of medically necessary services.

On the other hand, if copayments are covered for many of these patients by Medicaid or Medigap policies, then the patient will suffer little or no economic pain for the use of the service, and the deterrent effect of the copayments will be lost. In the case where a copayment is picked up by Medicaid an unfunded mandate would be imposed on the states. If the cost of the copayment is covered by a Medigap policy, then the cost is merely shifted to private insurance, which is often provided by a former employer as part of retirement benefits.

In fact, in its 1993 review of the landmark Rand Health Insurance Experiment, the Congressional Office of Technology Assessment confirmed that once patients entered treatment, the amount and cost of their care was largely unaffected by cost sharing and apparently was determined principally by their physician.

It has been suggested that a three-day prior hospitalization requirement, as well as copayments, might be adopted to control the increased utilization of home health services. Written testimony submitted at the hearing by ProPAC, however, showed that Medicare payments for skilled nursing facility services have been growing at a far greater rate (33% annually) than payments for home health services and that SNF services are already subject to a three-day prior hospitalization requirement and a substantial copayment after the 20th day.

It cannot be ignored that patients receiving home health services are already shouldering the bulk of the cost of the care. They are responsible for the building, the furnishings, the heat, the light, and the water, and they often furnish staff assistance through family and friends who assist with the care. All of these costs would have to be borne by Medicare if the services were furnished in a hospital or nursing facility.

In addition, copayments on home health would further compound the economic burden which home health patients are already required to sustain in the form of costs for physicians' services, medical supplies, medications, unskilled personal care, and special diets.

It is also likely that imposing a barrier to home health services through a copayment will encourage patients to remain in the hospital for longer periods, because there is no cost sharing for the first 60 days of covered hospital inpatient services. In addition, patients are more likely to be hospitalized if they forego medically necessary home health services.

4. **Copayments will have a disproportionate adverse effect on certain providers and patients.**

Copayments imposed on a prospective payment system would have an arbitrary and disproportionate adverse effect on certain groups of providers and patients. Percentage-based copayments would be difficult to administer as they would vary by MSA and non-MSA under the revised unified PPS plan, because per visit rates will vary by region. "Fixed amount" copayments would arbitrarily penalize providers in regions where the per visit rates are lower, because the copayments would constitute a larger percentage of payments.

In a cost-based system, percentage-based copayments would disadvantage agencies with higher costs per visit (such as the hospital-based agencies). A fixed amount copayment would disadvantage lower cost agencies by failing to reimburse a higher percentage of their costs.

5. **Copayments increase administrative costs without improving services.**

Copayments would require an additional billing system to be established for Medicare patients, and providers would incur substantial losses due to bad debt. Because there are millions of relatively small claims filed for home health services, the added administrative costs would be extremely high. Those costs would not be significantly lower if the copayment were "nominal," since the cost of dunning patients for payment or determining other coverage remains roughly constant regardless of the amount of the copayment.

One PPS Work Group member in Michigan has estimated that it would cost an additional $8.40 for each copayment claim paid within 30 days of submission. Non-payment of the invoice would add an additional $16.70, not counting the bad debt write-off. These costs would be legitimate and necessary expenses of providing Medicare services and would have to be included in either the cost reimbursement system or a prospective payment system. The cost of home care would thereby be driven up with no improvement in the quality or cost effectiveness of the care.

Moreover, Medicare reimbursement for copayment bad debt would erode any potential savings to the program from shifting costs to beneficiaries.

6. **Copayments increase the opportunities and incentives for fraud and abuse.**

Copayments present an incentive and opportunity for some providers to waive or fail to make a sincere effort to collect the amount billed to the patient in order to induce the patient to select their agency or obtain more services from that agency. Although providers are expected to make a good faith effort to collect copayments under Medicare (generally recognized as three dunning letters), there is no effective way to ensure that a sincere collection effort is made.

Imposition of copayments would be poor public policy for several important reasons. The unified and revised unified PPS plans were developed by the home health industry in response to Congress' challenge to develop and propose a preferable alternative to copayments. The revised unified plan, which was submitted as an attachment to Mr. Holt's testimony, is the product of 18 months of intensive work, negotiation, and compromise among numerous factions within the home health industry.

Adoption of the revised unified PPS plan as an alternative to copayments has the support of virtually the entire home health industry, including nonprofit, proprietary, hospital-based, and freestanding agencies in every state. It is unlikely that this consensus could be maintained if Congress were to renege its part of the challenge.

The revised unified PPS plan achieves the twin objectives of controlling the growth in home health expenditures while preserving access to medically necessary services. Copayments fail to achieve either objective.

Comments on Mr. Vladeck's Testimony

Several statements made by HCFA Administrator Bruce Vladeck, in our view, need clarification so that they do not lead to inappropriate policy decisions.

First, **home health services covered under Part A of the Medicare program are not "post-acute care services."** Mr. Vladeck's testimony implies that acute care services are essentially hospital inpatient services, which were intended to be covered under Part A of Medicare, and that all other services are essentially chronic or long-term care services that were intended to be covered under Part B. Test. at 5-6. These mistaken assumptions lead to the conclusion that home health services should be covered under Part A only to the extent that they follow a three-day hospitalization and that the bulk of the benefit should be shifted to Part B. Test. at 17.

In fact, these assumptions do not accurately reflect the structure of the Medicare program or the manner in which home health services are furnished today. Part A of the Medicare program only covers home health services to the extent that they are "acute care services" -- that is, services which are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." See §§ 1812(a)(3), 1814(a)(2)(C), and 1862(a)(1)(A). This is precisely the same coverage standard for hospital inpatient services. By contrast, neither Medicare Part A nor Part B cover long-term or chronic care services (with the possible exception of hospice services). See § 1862(a)(9). Thus, home health services and hospital inpatient services are both acute care services under the Medicare coverage criteria, and both are appropriately covered under Part A.

Moreover, Part B of Medicare has never been a program designed to cover long term or chronic care. Thus, transferring the bulk of the home health benefit to Part B would not be a rational policy decision even if home health were "post-acute care."

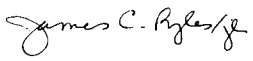
Finally, Mr. Vladeck's testimony ignores the fact that, with the discharge of sicker patients to home care (Test. at 4), home health agencies have increasingly provided **covered acute care services on a longer term basis.**

Second, neither the PPS plan in the Conference Agreement nor the industry's revised proposal "relies wholly on an untested, unreliable new payment methodology that uses an inappropriate case-mix adjuster." Test. at 15-16. Both plans are based largely on Phase II of the National Home Health Agency Prospective Demonstration Project, which was approved by HCFA and has been in operation for more than one year. Test. at 12. Thus, both the payment methodology and the design of the case mix adjuster have been approved and are being tested by HCFA. HCFA obviously believes they have merit, because it is proceeding with the next two years of the project. Test. at 12.

By contrast, the Administration has not proposed a specific prospective payment methodology and has just issued a 30-month contract for a research project to determine **whether** a better case mix adjuster can be developed. Clearly, there would be no time to test whatever plan might be developed before the October 1, 1999 effective date set forth in the Administration's proposal. HCFA is undoubtedly at least as prepared to implement prospective payment for home health services as it was to implement prospective payment for inpatient hospital services in 1983.

The PPS Work Group looks forward to working with Congress and the Administration to implement prospective payment for home health services in 1997.

Sincerely,



James C. Pyles

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SUPPLEMENTAL STATEMENT FOR THE RECORD

WAYS AND MEANS HEALTH SUBCOMMITTEE

HEARING ON PROSPECTIVE PAYMENT FOR HOME CARE

August 5, 1996

The National Association for Home Care (NAHC) is the nation's largest association representing home health care providers, home care aide organizations, and hospices. Our membership includes hospital-based, freestanding, voluntary, and proprietary home health agencies. NAHC strongly opposes the imposition of copays on Medicare home care services.

Home care performs an important role in the American health care system. Home care patients tend to be older and poorer than the average Medicare beneficiary, and in great need of care. Copays would penalize the most vulnerable Medicare beneficiaries because of their illnesses.

Copays are regressive and tax the sick.

The average Medicare home care patient is female, white and 75 years of age or older. Poverty rates are higher for this group than for the general population. In 1993, the median income for elderly women in this age group was $8,365, bringing the poverty rate to nearly 20 percent. Health Care Financing Administration researchers Mauser and Miller have said, "we would expect [copays to result in] decreased use of home health by low-income, non-Medicaid beneficiaries because they tend not to have medigap policies and would not be able to afford the increased cost." (Mauser and Miller, "A Profile of Home Care Users in 1992," p. 30.)

A Medicare home care copay would substantially increase the proportion the poor and near poor elderly spend on health care. For example, nearly 30 percent of all elderly Medicare beneficiaries had annual incomes of less than $10,000 in 1993, and the average Medicare home care patient received 66 home care visits in 1994. A copay of $10 per visit would add 6 percent to the 24 percent of income already spent by elderly with annual incomes below $11,000, bringing out-of-pocket spending levels to 30 percent of total income for low-income seniors.

Long-stay patients are particularly at risk because they receive the most visits and would pay the most in copays. Long-stay Medicare home care patients tend to be older, more functionally impaired, and have multiple acute and chronic illnesses. A Medicare home care copay would be a "sick tax" on this group, requiring those with the most medical needs to pay the most.

The elderly already pay high out-of-pocket health care costs, despite Medicare and Medicaid coverage.

On average, elderly households spent nearly 20 percent of their income on health care in 1994. For elderly individuals with disabilities, out-of-pocket spending for home care can be an extremely heavy burden. The Medicare home care benefit does not cover all their needs, and many seniors spend out-of-pocket for the additional care they require. In fact, elderly home care patients paid more than one-third of their home care expenses out-of-pocket in 1992.

Seniors living on fixed incomes, especially those needing intensive visits following a hospitalization, may not be able to afford home care copays. These individuals have just paid the $736 Medicare Part A hospital deductible, may have had $184 per day in charges if their hospital stay was over 60 days, and have many new prescription costs that are uncovered by Medicare, in addition to the $100 Medicare Part B deductible and 20 percent copays for doctor services and equipment. Added home care copays would be prohibitive.

Patients who cannot afford home care copays may refuse all services, or choose some of the ordered services and refuse others. For example, a stroke patient who wants to be able to communicate better and needs assistance with personal care may accept speech therapy and some home health aide services, but refuse nursing, physical therapy, and occupational therapy services, which would have taught him how to care for himself and manage his disease independently. Requiring home care patients to make these kinds of choices will not result in the best health outcomes and may prove costlier to the Medicare program.

Copays -- An unfunded mandate

About 40 percent of long-stay home care users and 24 percent of all home care users are Medicaid eligible. Copays may have the unintended effect of increasing Medicaid outlays, not only for the 20 percent of currently eligible persons, but by adding more people to Medicaid roles based on spend downs resulting from these copays. In addition, home care patients eligible for both Medicare and Medicaid may be entitled to have Medicaid cover their Medicare home care copays.

Medicaid may not protect low income home care patients.

Some states with Medicaid payment rates below the Medicare rate have refused to cover the cost of Medicare copays. Medicaid eligible home care patients in these states may not be sheltered from the additional costs of copays.

Copays would be another federal administrative burden on providers.

Home health agencies would need to develop new accounting and billing procedures, and create new software packages, as well as hire staff to send bills, post accounts receivable, and rebill.

The majority of computerized billing systems for home care are not sophisticated. Currently, home health agencies do not have data mailer capabilities, the least costly and most efficient method of billing. Without this capability, agencies will need to hire additional staff to manually prepare, stuff, and mail copay bills, in addition to posting receipts, which can cost as much as $15 per bill.

Presently, agencies can post receivables from Medicare as one lump sum for each patient when billed services are paid in full. With copays, posting home care receipts will be much more complicated. Every visit would need to be posted separately in order to provide patients with itemized statements showing dates of different copays by type (e.g. nursing, therapy, home health aide). Reimbursement specialists would be required to post these complicated multiple line items.

Data mailers, while much more efficient, will also add significant new administrative costs to home care. Data mailers would cost home health agencies 75 cents for mailing, postage, and handling of each mailer. A typical agency has 6,600 admissions per year, 75 percent of which (4950 patients) are Medicare. Most patients will receive an average of 4.5 mailers. Therefore, 22,275 mailers at 75 cents each would cost a typical agency approximately $16,700 annually to mail bills for copays for the Medicare patients.

Personnel costs for mailing, opening, posting payment, and rebilling, increase these costs by 25 cents per bill, or about $1.10 per patient admitted. At an average of 4.5 bills per patient and 25 cents per bill, annual billing costs could easily hit $27,500 for a typical agency.

In addition, federal law requires health care providers to send three statements before declaring a bill uncollectible. The national average for collecting health care copays from patients under any insurance requirement is about 60 percent; 40 percent are uncollectible. Before Congress eliminated home care copays under Medicare B, a majority of those copays, too, had to be written off to bad debt. There is also an increasing trend by patients to declare bankruptcy in response to overwhelming medical bills.

Home care patients and their families already contribute to the cost of their care.

Proponents of copayments fail to recognize the in-kind contributions home care patients and their families already make to the cost of care. With hospital and nursing home care, Medicare pays for room, board, and extensive custodial services. At home, these services are provided by family members or paid for out-of-pocket by patients without family support.

Patients and their families are already doing their part; copayments would only add to their considerable burdens. Family members often put in enormous amounts of time and energy caring for home care patients, work that would have to be done by hospital or nursing home staff. Family members frequently leave jobs so they can stay at home and provide care.

In many cases, family members are trained by home care providers to render semi-skilled support services for home care patients, such as changing dressings, giving injections, bathing and transferring patients, tube feeding, catheter care, and IVs. Medicare would have to pay for these services in hospital and nursing home settings.

Elderly Americans who received both unpaid and paid home care services in 1993 received an average of 31 hours of unpaid care from their families and friends, and 16 hours of paid assistance. Those who received some Medicare home health services in 1993 paid 28 percent of their home care expenses out-of-pocket for an average cost of $2,377.

Conclusion

The National Association for Home Care has offered Congress a proposal to enact a prospective payment system (PPS) for Medicare home care services as an alternative to home care copays. Copays would inappropriately require patients to assess their care needs based on their financial ability to pay for care. PPS for home care will place the burden on the provider, giving home care providers incentives to achieve high quality home care outcomes as efficiently as possible.

We strongly urge Congress to enact PPS for home care as an important and meaningful alternative to copays.

Revised Unified Proposal for a
Prospective Payment System for Medicare Home Health Services

March 28, 1996

Attached is the Industry's Unified Plan for 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 as an alternative to Congressional movement to impose copays on Medicare home care services or 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 any of our organizations at the numbers listed below.

National Association for Home Care
Dayle Berke/Lucia DiVenere 202-547-7424

PPS Work Group
Jim Pyles 202-466-6550

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, culminating in an episodic prospective payment system plan that should:

- o be developed cooperatively by HHS, the industry, and Congress
- o be acceptable to the industry
- o include extended care
- o be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation
- o be approved by Congress
- o include adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o 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 and 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 developed and implemented. The data base must be able to link case mix data with cost (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

Effective date: 60 days after enactment

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

- o 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 month 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

- o amounts in excess of the per visit rate, up to a limit as defined below, may be paid if:
  1) an HHA can demonstrate costs above the payment rate, and
  2) quarterly reports demonstrate that total payments will not exceed the agency aggregate limit

- o 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

- o base year for payment rates and cost limits – 1994 (using settled cost reports)

Agency annual aggregate per patient payment limit

- o base year for aggregate payment limit – 1995 utilization data for each agency

- o 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 for 12 months following implementation of Phase I, then 50% agency data & 50% census region data

- o 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

- o 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, Mountain, 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.

- o 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

- o continue per visit payment as in Phase I
- o 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
- o 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)
- o the 18 category Phase II case mix adjustor is applied to the first 120 days, or a more accurate one if available
- o 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
- o 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
- o the region for the episode limit – MSA/nonMSA area
- o 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
- o 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
- o the current certification and coverage guidelines continue

Sharing Savings

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

- o developed cooperatively by HHS, the industry, and Congress
- o acceptable to the industry
- o includes extended care
- o must be submitted to Congress one year in advance of implementation and within 4 years of enactment of legislation
- o approved by Congress
- o adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o 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 where 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 for such exceptions. Methods should be developed to allow for additional home care 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 which emphasizes patient satisfaction and successful outcomes.

   Home health 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)

HOME HEALTH INDUSTRY'S REVISED UNIFIED PPS PLAN (MARCH 1996) • CONGRESSIONAL, DEMOCRATIC, AND UNIFIED PLANS COMPARED

Page 1 of 2	Current Law	Congressionally-Passed Plan (H.R. 2491)	Democratic/Administration Alternatives (H.R. 2530)	Revised Unified PPS Plan
1. Core Concept	Per visit cost-based reimbursement, subject to cost per visit limits.	PPS with per visit payment subject to aggregate per episode limit.	Per visit cost reimbursement with lower cost limits and annual aggregate per beneficiary limit until FY 2000, per episode PPS (to be developed) thereafter.	PPS with per visit payment subject to annual aggregate per patient limit; after 18–24 months change to aggregate per episode limits on payments for first 120 days of care; episodic PPS after 5 years.
2. Implementation Date	Currently in effect.	October 1, 1996.	New cost limits effective 10/1/96, per episode PPS effective 10/1/99.	Beginning six months after enactment, phased in over 24 months.
3. Payment System	Cost-based reimbursement, subject to cost per visit limits.	PPS based on a flat per visit payment rate (by discipline) subject to an agency aggregate episode limit (as described in #8 and #9 below).	Interim payment system based on reasonable cost per visit payments subject to an aggregate per patient annual limit until 10/1/99 then switch to a pure per episode PPS.	Interim PPS based on a flat per visit payment rate (by discipline) subject to agency aggregate limits; in Phase I: aggregate annual per patient limit; in Phase II: aggregate episode limit for 0-120 days and aggregate annual per patient post 120 day limit.
4. Converts to per episode PPS	N/A	No conversion to pure per episode PPS.	Pure per episode PPS to be developed and implemented by 10/1/99.	Converted to episodic PPS approximately 5 years after enactment based on HCFA/industry design.
5. Payments to HHAs	Per visit cost reimbursement, subject to retroactive cost disallowance.	National per visit rates regionally adjusted. Flat rate equal to the national average amount paid per visit for each discipline with labor portion adjusted for MSA/non MSA area.	Reasonable cost per visit up to a cost limit and annual aggregate per beneficiary limit until 10/1/99, with payments based on per episode PPS thereafter.	National per visit rates, regionally adjusted. Flat rate equal to the national average amount paid per visit for each discipline with labor portion adjusted for MSA/non MSA area; payment up to a limit when certain conditions met.
6. Limits on Payments	Per visit cost limits, excluding hospital-based data. Per visit cost limits equal to 112% of the mean. Applied in the aggregate.	Aggregate per episode limit for first 165 days, no limit thereafter.	Per visit cost limits of 112% of mean with labor portion adjusted for MSA/non MSA area (the Administration proposed 105% of median) and annual aggregate per beneficiary cap until 10/1/99, then per episode payments.	Annual aggregate per patient limit for all payments during first 18–24 months; in Phase II, aggregate per episode limit on payments for services 0-120 days and per patient limit post 120 days; Phase III, per episode payments.
7. Episode Definition	N/A	120 days preceded by 60 days without home health services.	Time limited episode not used; the per patient limit is an annual limit (if a patient continues on service into a new fiscal year another per patient limit is allocated).	In Phase II episode defined as 120 days preceded by 45 days without Medicare-covered home care services. In Phase III to be determined.
8. Episode Limit	N/A	Determined for each case-mix category in an MSA/non MSA area and is equal to the mean number of visits for each type of service furnished in an episode in FY94 adjusted by the case-mix adjustment factor and multiplied by the per visit payment rate for each type of visit; if an area has an insufficient number of agencies the Secretary can designate another area.	Starting 3 months after implementation the per patient annual limit is changed from agency specific to a blended limit based 75% on the agency specific reasonable cost per patient per year and 25% on the census region (or national) reasonable cost per patient.	Phase I: annual per patient limit based 75% on agency data and 25% on census region data for 12 mos., then 50%-50% blend; Phase II: 1) episode limit based on number of visits in and episode by case-mix category in the MSA/non MSA region multiplied by the payment per visit: 2) post 120 day annual per patient limit based on a 50%-50% blend of agency and census region data.
9. Calculation of Aggregate Limit	N/A	Aggregate episode limit is the sum of the products of the number of episodes for each case-mix category multiplied by the per episode limit for such category.	Annual aggregate per patient limit equals the product of the per patient limit multiplied by the unduplicated census count of Medicare patients.	Annual aggregate per patient limit and post 120 day per patient limit calculated by multiplying the number of unduplicated Medicare patients by the per patient limit; aggregate episode limit is the sum of the products of the number of episodes for each case-mix category multiplied by the per episode limit for such category.
10. Application of Visits to the Limits	N/A	Visits after the first 120 days are paid per visit; however, visits on days 121-165 are applied to the aggregate episode limit which is based on the average cost for 120 days; after day 165, visits are not applied to the limit.	Aggregate limit based on average reasonable cost per patient per year for all visits including services beyond 120 days.	The time periods for applying visits to limits are the same as the time periods on which the limits are calculated (no gaps).
11. Base Year	N/A	1994: visit rate based on data from most recent 12 month cost reporting periods ending on or before 6/30/94 (not updated to 10/1/96); episode limits based on the mean number of visits per episode in FY94.	1994: per patient limit calculated from 12 month cost reporting periods ending on or after 1/1/94 and on or before 12/31/94 (updated by the market basket index to 10/1/96).	1994 for cost per visit (updated by market basket index to implementation date); 1995 for utilization.

Draft: July 23, 1996

Page 2 of 2	Current Law	Congressionally-Passed Plan (H.R. 2491)	Democratic/Administration Alternatives (H.R. 2530)	Revised Unified PPS Plan
12. Updates	Cost limits updated annually.	Per visit payment rates and per episode limits are updated annually by *home health market basket minus 2 percentage points.*	Per patient limit updated annually by the market basket index; per visit payment rates based on reasonable cost up to the cost limits; cost limits calculated annually.	Per visit payment rates, per visit payment limits, and per patient/episode limits updated annually by the home health market basket index.
13. Rebasing	N/A	Rebase per visit payment rates and episode limits in 1999, then every 5 years.	In the interim system, no rebasing of per patient annual limits; cost limits are calculated annually; the payment rates are reduced by 15% with the implementation of per episode PPS 10/1/99, unspecified thereafter.	No rebasing.
14. Incentives for Cost Effectiveness	None	50% of the difference between total visit payments and the aggregate limit up to maximum of 5% of total payments.	50% of the difference between reasonable costs and the aggregate limit up to a maximum of 5% of total reasonable cost, if the agency cost/utilization experience is below 125% of the mean cost/utilization experience per patient in the census region (or nationally).	50% of savings up to a maximum of 10% of total per visit payments; same limitation (125% of census region mean) in *Phase I and post 120 day* in Phase II as in HR2530.
15. Case Mix Adjustment	N/A	18-category case-mix adjuster from home health PPS demonstration project.	Interim system does not use a case-mix adjuster—agency specific costs used to account for each agency's case mix; case-mix adjuster implemented in 10/99 with per episode PPS.	*Phase I:* same as HR 2530; Phase II: first 120 days same as HR 2491; post 120 days as in HR 2530; Phase III: new case-mix adjuster based on research.
16. Tracking Patients	N/A	Track home health patients that switch agencies and adjust payments to ensure that aggregate payments do not exceed what would be paid to a single agency.	If services provided by *more than one agency, per patient limit pro*-rated among the agencies.	Track home health patients that switch agencies and adjust payments to ensure that aggregate payments do not exceed what would be paid to a single agency.
17. Payments for Non-Routine Supplies	Reimbursed on a cost basis.	Not specified.	Included in average cost per patient.	Allowable costs for nonroutine supplies included in the database to develop payment rates and limits.
18. Certification	On admission, and every 62 days thereafter.	Recertification by intermediaries at 60 and 165 days.	Same as current law.	Same as current law.
19. Exceptions/Exemptions	Unlimited exceptions allowed for reasonable costs beyond the agency's control.	Limited to 1994 amounts increased by the home health market basket percentage increase for the fiscal year involved.	Not included.	Exceptions allowed for circumstances beyond the agency's control. Total amount limited to funding from non-agency share of savings.
20. Low Cost Cases	N/A	Develop a system to adjust payments to an agency for an increase in percentage of low cost cases.	Not included.	Monitor significant changes in distribution of both low and high cost cases.
21. Case Mix Adjustment Factor	N/A	Case-mix adjustment factor to assure that aggregate home health payments do not exceed previous year's payments as a result of changes in the number and type of visits within categories for 1997-2000; for subsequent years, a factor determined by the Secretary necessary to remove the effects of case-mix increases due to reporting improvements instead of real changes in resource usage.	Not included.	Not included.
22. Fail-safe	N/A	Contains mechanism to trigger an automatic across-the-board cut in home health care payment rates *if total deficit reduction targets are not met.* Mechanism cuts approximately $2.1 billion from home health expenditures over 7 years in addition to PPS savings. (CBO, Nov. 22, 1995).	No fail-safe.	No fail-safe.
23. PPS Scored Savings	None	$14.2 billion over 7 years. (CBO, Nov. 16, 1995).	$8.7 billion over 7 years. (CBO, Dec. 15, 1995)	Comparable to HR2530 and Administration's plan.
24. A to B Shift	Full coverage under Part A.	Full coverage under Part A.	2530: Part A covers up to 150 days during any spell of illness. Part B covers thereafter. Admin: Part A covers up to 100 visits following 3-day hospital stay. Part B covers all other visits.	Full coverage under Part A.

Draft: July 23, 1996

Declaration of Support

* * *

Declaration of Support for Implementation of a Prospective Payment System for Medicare Home Health Services

July 17, 1996

Whereas the health care industry is facing rapid and significant changes both in the delivery of services and its relationships with payors;

Whereas the health care delivery system is increasingly relying on some form of managed care to encourage providers to achieve patient centered, favorable outcomes in the most cost effective manner possible;

Whereas the current structure of cost reimbursement for Medicare home health services is counter productive to the goals of delivery high quality, cost effective, and medically necessary services;

Whereas the home health industry must move to a Prospective Pay system to operate more consistently with non-Medicare reimbursement systems;

Whereas the Congress and the Administration have indicated that the rate of expenditure growth in the Medicare home health benefit, combined with the overall financial state of the Medicare program, requires the adoption of some measure to reduce the growth rate in Medicare home health expenditures per patient in future years;

Whereas the home health industry considers copayments, at any level, an unacceptable and improper burden on the infirm elderly and disabled who receive Medicare home health services given the significant contributions made by these individuals and their families make as primary caregivers in the home setting;

Whereas the home health industry considers proposals to "bundle" home health payment with other Medicare payment, such as hospital services, to be inappropriate and counterproductive in achieving the goal of providing care in the most cost effective setting possible;

Whereas the Congress has requested the home health industry to offer a substitute for copayments and bundling that provides incentives for reducing the rate of expenditure growth while preserving access to medically necessary home health services;

Whereas the home health industry considers the implementation of a Prospective Pay system to be the appropriate mechanism to address the needs and concerns of patients, the Medicare program, and the home health industry;

Be It Resolved that the following organizations, comprised of the National and State Associations representing the interests of Medicare certified home health agencies, and the patients they service, nationwide commit their support for the enactment and implementation of a Prospective Payment system which is entitled "The Revised Unified Plan", as attached hereto.

Signed,

Home Health Services and Staffing Association

National Association for Home Care

Visiting Nurse Associations of America

Alabama Association of Home Health Agencies

Alaska Home Care Association

Arizona Association for Home Care

Home Care Association of Arkansas

Home Care Association of Colorado

Connecticut Association for Home Care, Inc.

Delaware Association for Home and Community Care

Capital Home Health Association

Associated Home Health Industries of Florida, Inc.

Georgia Association of Home Health Agencies, Inc.

Georgia Association of Community Care Providers

Hawaii Association for Home Care

Idaho Association of Home Health Agencies

Illinois Home Care Council

Indiana Association for Home Care, Inc.

Iowa Association for Home Care

Kansas Home Care Association

Kentucky Home Health Association

Homecare Association of Louisiana

Home Care Alliance of Maine

Maryland Association for Home Care, Inc.

Home & Health Care Association of Massachusetts

Massachusetts Council for Home Care Aide Services

Michigan Home Health Association

Minnesota HomeCare Association

Mississippi Association for Home Care

Missouri Alliance for Home Care

Montana Association of Home Health Agencies

Nebraska Association of Home and Community Health Agencies

Home Health Care Association of Nevada

Home Care Association of New Hampshire

Home Care Council of New Jersey

Home Health Services and Staffing Association of New Jersey

New Mexico Association for Home Care

Home Care Association of New York State, Inc.

New York State Association of Health Care Providers, Inc.

North Carolina Association for Home Care, Inc.

North Dakota Association of Home Health Services

Ohio Council for Home Care

Oklahoma Association for Home Care

Oregon Association for Home Care

Pennsylvania Association of Home Health Agencies

Puerto Rico Home Health Agencies

Rhode Island Partnership for Home Care, Inc.

South Carolina Home Care Association

Tennessee Association for Home Care, Inc.

Texas Association for Home Care

Utah Association of Home Health Agencies

Vermont Assembly of Home Health Agencies

Virginia Association for Home Care

West Virginia Council of Home Health Agencies, Inc.

Wisconsin Home Care Organization

Home Health Care Alliance of Wyoming

Approval Pending:

South Dakota Home Health Association

Home Care Association of Washington

Testimony of
James L. Scott
President, Premier Institute
Premier, Inc.
400 N. Capitol Street, NW, Suite 590, Washington, DC 20001-1511

Submitted to the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
on Medicare Payment Policies for Home Health and Skilled Nursing Facility Care
July 23, 1996

Mr. Chairman and Members of the Subcommittee, on behalf of Premier, Inc., which represents major integrated delivery systems across the country and one-third of the community hospital beds in the nation, I am pleased to have the opportunity to share our views about Medicare payment policies relating to postacute care services, especially home health and skilled nursing facility (SNF) care. I would like to begin by commending Chairman Thomas for convening this important hearing and for according attention to needed reforms in Medicare payment for home health and SNF services. As this Subcommittee well knows, Medicare expenditures for these services have been rising much more rapidly than outlays for most other facets of the program. Moreover, the proportion of Medicare patients receiving home health and SNF care, and the average amount of such care per patient, are rising.

For nearly fifteen years, Medicare has paid for inpatient hospital care on a prospective, per-case basis, using a diagnosis-related classification system. In contrast, Medicare continues to pay for home health and SNF services using a cost-based methodology. While the Health Care Financing Administration (HCFA) has supported a great deal of research and undertaken several demonstration projects in the hope of devising separate, prospective payment policies for home health and SNF care, we are concerned that they have given insufficient attention to a much more promising approach, i.e., rebundling payments for postacute care into the existing hospital prospective payment system (PPS). Given Congressional interest in increasing the use of capitated arrangements for Medicare beneficiaries in a wide range of integrated care organizations, it would seem that the bundling of home health and SNF services into the existing PPS is preferable to investing considerable resources in separate, fee-for-service payment methodologies for these services, especially methodologies that result in payment on a per-diem or per-visit basis, rather than on a more global basis (e.g., per case). At the very least, it would seem prudent for Congress to direct that the same level of resources be devoted to developing a rebundling policy as in devising other alternatives.

Obviously, third party payors (including Medicare) are interested in bundled payment arrangements because they guard against overuse of services, especially where the individual bundles capture a large range of services provided over a long period. And payors are likely to want the simplest (and most comprehensive) bundling arrangement possible, rather than many, relatively small service bundles each provided by a different entity (and requiring a separate contract or other business arrangement).

Under a rebundling approach, a hospital could receive a single payment for both the costs of an inpatient stay and necessary postacute services (e.g., SNF, home health and rehabilitation) and would be responsible for ensuring that the patient received all necessary care. Of course, the bundling of SNF care into Medicare's hospital PPS would make the ongoing nursing home prospective payment demonstrations largely irrelevant since a prior three-day hospital stay is a prerequisite for Medicare coverage of SNF services and, thus, all Medicare-covered SNF services would be rebundled into PPS. It would also lessen the importance of the ongoing home health prospective payment demonstrations, since a large proportion of the Medicare beneficiaries receiving home health services have had a preceding hospital admission and these services would also be rebundled into PPS. For example, in 1992, about two-thirds of Medicare home health users began their episodes of care within 30 days of being discharged from a hospital. Finally, rebundling would obviate the need for other

planned refinements in SNF and home health payment policies, including the adoption of revised salary equivalency guidelines for rehabilitation services provided under arrangements to SNF patients.

In designing an appropriate postacute care rebundling methodology, four key tasks would need to be accomplished: (1) defining the bundle of services to be covered; (2) identifying an appropriate patient classification system for payment purposes; (3) developing a method for determining the appropriate payment amounts and settling a variety of related issues (e.g., the need for exceptions or outlier payments, and the method for adjusting payments for geographic considerations); and (4) settling the question of which entity or entities should receive payment for the bundled postacute services. With respect to patient classification, the system of diagnosis-related groups (DRGs) already in use appears to provide a ready-made solution. Over time, it may be necessary to further refine the DRG classification system to account for differences in the postacute care needs--and costs--of patients now classified in the same DRG. However, such refinements would be no different that the many other changes in the classification schema that have already been made for a variety of reasons.

Of course, the rebundling of postacute care undoubtedly would raise questions about the impact on quality of care, treatment outcomes, and utilization of services. Moreover, consideration should be given to the need for changes in existing Medicare statutory and regulatory requirements, and appropriate beneficiary coinsurance and copayment obligations for the rebundled postacute care services would need to be devised.

If payment for postacute care were bundled into the hospital inpatient PPS, the result would be a single responsible entity (the hospital), which would no longer see its obligations to the patient end at the time of discharge. Such rebundling would also give hospitals more flexibility in deciding how best to meet a patient's needs, and in what setting.

In short, while we recognize that rebundling postacute care into PPS raises a number of issues, such an approach appears to present clear advantages over continued reliance on per-diem, per-visit or other relatively fragmented payment methodologies, where multiple providers share responsibility and where it is conceivably easier for an individual patient to "fall between the cracks," or for one provider to shift a care burden to other providers, perhaps in response to the incentives provided by Medicare payment policy. Moreover, the long-term plan for Medicare envisions an expansion of private health plan options for beneficiaries, including provider-sponsored networks, with payment made to a single responsible party on a purely capitated basis for *all* Medicare-covered services. In light of this, rebundling postacute care into PPS certainly appears to be a move in the appropriate direction. Congress should consider mandating such a change by directing HCFA to test the concept in both urban and rural settings.

JOINT STATEMENT OF
RAYMOND N. ALTIERI, BURGESS A. HARRISON,
DAVID S. COLE, AND JOHN P. CLARK, ESQ
ON BEHALF OF STATCHEK

STATEMENT OF SUBMISSION NO. HL-21

August 5, 1996

INTRODUCTION

The prospect of PPS as the Medicare reimbursement system for homecare will clearly have a major impact on the homecare industry. Accordingly, many private sector firms are positioned, or are beginning to position themselves to help the industry to implement the changes necessary for successful implementation of PPS.

Homecare has clearly proven its value as an alternative to institutionalized care. It has provided a means by which acute care centers can discharge patients to less costly intermittent care much sooner than previously possible. Virtually all referrals of patients to homecare come from acute care centers. Therefore, expansion in the percentage of the total Medicare Part A expenditures for homecare, from 4% in 1989 to 13% in 1995 must be viewed in terms of the corresponding savings realized in acute care costs. Accordingly, this increase is a positive move by acute care centers that can reduce the in-patient and therefore overall Medicare costs for an episode of care. The recent trend towards earlier discharges from acute care centers to homecare agencies may be more closely related to current reimbursement policies than concern over patients' cost of care. However, the result is still the same, a less costly episode of care for Medicare.

Homecare is more than just a cost effective way of minimizing acute care stays. It allows patients to recover in the most comfortable and familiar surroundings, limits reimbursed care to clinical necessities and further offsets acute care costs by involving the patient's family in the recovery.

THE PROBLEMS

Stronger care management is necessary, and clearly the focus on minimizing acute care stays must and should continue. However, to be effective any new reimbursement system must address three critical issues.

First, and most importantly, prospective pay shifts the burden of "rationing" care to the provider agency. PPS must account for this and assure that provider agencies continue to provide the quality, quantity and frequency of visits necessary for patients to achieve the desired outcome. If the new system results in an increase in recidivism rates, the result of the entire program could be substantial increases in the net cost to Medicare for patient recovery.

Second, the system must return factual, objective data to Medicare, from which it can manage the system from a quality assurance perspective. It is critical in the administration of any managed care system to have truly objective data in order to know if the target reimbursement rates for the various diagnostic codes are accurate. That means that Medicare must know how many visits of what type and duration are really necessary to bring a patient from acute care discharge through homecare to the desired outcome level. Without this information, perspective pay can be no more effective than the current "fee for service" system.

Third, PPS has been designed to place "reasonable" financial limits on the costs of services which provider agencies deliver to patients. To assure these providers can continue to service patients and deliver an adequate level of care under the new system, the providers must become more efficient. Efficiency is not easily obtained and will require cooperation between Medicare and provider agencies to be achieved.

One of the major problems in homecare is the inefficiency inherent in providers' operation and management of their agencies. As a company experienced in working with agencies throughout the nation of all types, from hospital based to government based, from VNAs to privately owned agencies, and from sizes ranging from less than 10,000 visits per year to those delivering in excess of 1,000,000 visits per year, we possess knowledge which rises from our experience with many different levels of provider efficiency. We find that most agencies do not benefit from an economy of scale. Rather, they maintain a direct relationship between the number of field staff and the number of office/support personnel. While most agencies are in the range of four to seven field workers per office/ support staff person, the paradigm ranges from 1:2 in the worst cases to 1:20 in the best. This ten-fold difference in efficiency translates to potentially huge savings when extrapolated throughout the industry.

Inefficiency in homecare agency operation can be directly linked to the nearly unmanageable myriad of paperwork and requirements established by the various federal, state local and private pay sources. PPS must address these areas as well.

ANALYSIS

The first two issues, quality assurance and accuracy in determination of reimbursement rates, must be centered and based upon objective data to work successfully. The third issue, efficiency, can also be somewhat addressed through the collection and analyses of objective data. The problems then that must be solved are: how to collect the data, centrally, accurately and timely, while also reducing the reporting and record-keeping burden, all while helping provider agencies improve their efficiency. If PPS fails to achieve any one of these goals it cannot succeed.

There are solutions that exist today that can assure data is collected quickly and accurately, directly from the point of care. Some of these solutions also address the other issues of quality assurance, efficiency and reduced administrative overhead.

Implementation of PPS in and of itself will not solve the issue of escalating volume and utilization within SNF benefits as covered under Medicare. What is needed is a true public/private partnership as PPS is implemented within the industry. It is our position that the partnership should seek to outline, develop and deploy the tools necessary to assure PPS achieves its goals in a practical manner. Fixing the cost for each diagnostic code, as the plan in essence does, only serves to push down the reimbursement and shift the "rationing" of care to the provider without regard for how services are delivered and the subsequent outcome or quality of care.

PPS assumes that if costs are capped providers will focus on the quality of service and outcome. yet recidivism to acute care facilities could easily become the preferred outcome (or the only financial viable alternative) under PPS.

Certain implementation and execution tools are needed that would coincide with the introduction of PPS. These tools would work in tandem with other quality improvement efforts in place or planned such as OASIS, Medicare's outcome measurement system.

Numerous discussion, research and hearings have been held regarding imbedded waste, fraud, abuse and inefficiencies within the system PPS, won't stop the inefficiencies. The public sector, through HHS and HCFA, can support provider efforts to increase efficiencies within their organizations. For example, a stronger emphasis on the Paperwork Reduction Act would be a good first step. Tools and systems already exist within the industry to achieve some of the goals of the act. The government

should help providers through incentives for those willing to implement fraud-free data collection systems versus traditional, paper-based, manual processes.

One key component of the proposed PPS is the development of rate limits determined by a national average and adjusted for regional differentials in overhead and labor costs. Although this method recognizes that differences exist between various areas of the country, it does not go far enough. National and regional benchmarking of home health agencies should include components that are gathered independent of the agency in order to put labor cost data into perspective. This additional data will help provide another dimension to the determination of rate limits so that inefficiency isn't rewarded through higher rate limits. Additionally, agencies should benefit from the ability to compare key performance indicators with peer agencies in their region and with best practices on a nationwide basis. Independently collected data that is confidential and verifiable is key to the validity of this process.

RECOMMENDATIONS

From the private sector, firms already have entered the market with systems that automate homecare providers' data collection. Government agencies and legislators should seek to support these efforts and assist providers in their implementation of such systems. They should also work cooperatively with these firms and providers to exchange ideas and plans as they relate to PPS and other initiatives.

It is recommended that the following areas be addressed in any PPS scenario and be included in the overall PPS planning and implementation process:

- automated, third party, independent verification of service delivery;
- reliable, accurate and automated capture of objective data from field workers, directly from the point of care;
- automated recording and capture of outcome event data from the point of care;
- timely provision of all data to HCFA;
- greater ability for home health care agencies to track and predict their actual costs on a "per diagnostic code" basis;
- methods for determination of worker utilization and performance measures in order to pro-actively address substandard care delivery during, rather than after the conclusion of an episode of care.

CONCLUSION

It is in our nation's best interest for government and private industry to work together on the overall improvement in cost, productivity, quality and efficiency of home health agencies. These factors must be addressed concurrently in order to have any chance of long term success. There is little value in changing the system if the result forces homecare agencies to deliver the cheapest, lowest quality services. As in private industry, manufacturers often work hand in hand with their suppliers in a team effort to reduce overall production costs. To truly obtain cost benefits these cooperative efforts also incorporate quality circles or other quality improvement programs, since industry knows very well that lower costs are usually derived only with higher quality production system and products.

STATCHEK, INC.

The aforementioned recommendations are not presented in the absence of a solution. In fact a number of home health care agencies across America have begun to move through an evolutionary path towards complete automation of their operations with services from StatChek, Inc. of New Haven, Connecticut.

For over three years, StatChek has provided information management solutions exclusively to the homecare industry through its HomeKey Service. Using a unique combination of software, telecommunications and interactive voice response, StatChek has forged an innovative solution to age old industry issues. The problems solved include: assuring visits were actually delivered as claimed, determination of actual starting and ending times and duration of visits, elimination of paperwork through verified and automated capture of visit data directly from patients' homes, benchmarking provider agencies and their workers, and the application of technology to reduce administrative overhead.

Homecare agencies in over 12 states so far, are moving down a path of automation that best meets their individual and unique needs. Now that a process such as HomeKey has been designed, tested and market proven under real conditions, the nation has an opportunity to equip all homecare agencies with similar cost efficiency tools.

The Company has participated in numerous industry events and is a member of the National Association for Home Care and the Home Care Association of America. Company principals have been published in industry trade journals and spoken at industry-wide meetings. This industry involvement coupled with continuous input from clients has served to develop and shape the Company's HomeKey Service to meet the specific needs of the home health industry.

A number of agencies already receive the benefits described within this written submission. However, the full benefit of this service, to the country and the industry can only be realized when providers can use the service to exchange visit information directly with the Medicare system.

Other software companies are providing various types of automation solutions to the industry as well. HCFA needs to recognize that American ingenuity is at work and should take advantage of those efforts that exist or are in planning within the industry to help it achieve its objectives of being the most efficient, effective and well managed care delivery system in the world.

As a company dedicated to serving the information management needs of the homecare industry, StatChek stands committed to working with HCFA and other governmental agencies as PPS is implemented.

H.R. 2976, THE "PATIENT RIGHT TO KNOW ACT OF 1996"

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

JULY 30, 1996

Serial 104–93

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104TH CONGRESS
2D SESSION

H. R. 2976

To prohibit health plans from interfering with health care provider communications with their patients.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 27, 1996

Mr. GANSKE (for himself, Mr. MARKEY, Mr. BARR of Georgia, Mr. BOUCHER, Mr. COBURN, Mr. DURBIN, Mr. GENE GREEN of Texas, Mr. JOHNSTON of Florida, Mr. KENNEDY of Massachusetts, Mr. KLECZKA, Ms. LOFGREN, Mr. MCDERMOTT, Mrs. MEEK of Florida, Mr. MORAN, Mr. NADLER, Mr. SANDERS, Mr. SERRANO, Mrs. SMITH of Washington, Mr. STARK, Mr. STUDDS, Mr. TRAFICANT, Mr. WAXMAN, Mr. WHITFIELD, and Mr. WISE) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, Economic and Educational Opportunities, and Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To prohibit health plans from interfering with health care provider communications with their patients.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Right To Know Act of 1996".

(b) FINDINGS.—Congress finds the following:

(1) Patients cannot make appropriate health care decisions without access to all relevant information relating to those decisions.

(2) Restrictions on the ability of physicians and other health care providers to provide full disclosure of all relevant information to patients making health care decisions violate the principles of informed consent and the ethical standards of the health care professions.

(3) Serious concerns have been raised about the use by health plans of contractual clauses or policies that interfere with communications between physicians and other health care providers and their patients and the impact of such clauses and policies on the quality of care received by those patients.

(4) The offering and operation of health plans affects commerce among the States, health care providers located in one State serve patients who reside in other States as well as that State, and, in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in one State as well as those operating among the several States.

SEC. 2. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) IN GENERAL.—

(1) PROHIBITION OF CONTRACTUAL PROVISION.—An entity offering a health plan (as defined in subsection (d)(2)) may not provide, as part of any contract or agreement with a health care provider, any restriction on or interference with any medical communication, as defined in subsection (b).

(2) PROHIBITION OF ADVERSE ACTION.—An entity offering a health plan may not take any of the following actions against a health care provider on the basis of a medical communication:

(A) Refusal to contract with the health care provider.

(B) Termination or refusal to renew a contract with the health care provider.

(C) Refusal to refer patients to or allow others to refer patients to the health care provider.

(D) Refusal to compensate the health care provider for covered services.

(E) Any other retaliatory action against the health care provider.

(3) NULLIFICATION.—Any provision that is prohibited under paragraph (1) is null and void.

(b) MEDICAL COMMUNICATION DEFINED.—In this section, the term "medical communication"—

(1) means any communication, other than a knowing and willful misrepresentation, made by the health care provider—

(A) regarding the mental or physical health care needs or treatment of a patient and the provisions, terms, or requirements of the health plan or another health plan relating to such needs or treatment, and

(B) between—

(i) the provider and a current, former, or prospective patient (or the guardian or legal representative of a patient),

(ii) the provider and any employee or representative of the entity offering such plan, or

(iii) the provider and any employee or representative of any State or Federal authority with responsibility for the licensing or oversight with respect to such entity or plan; and

(2) includes communications concerning—

(A) any tests, consultations, and treatment options,

(B) any risks or benefits associated with such tests, consultations, and options,

(C) variation among any health care providers and any institutions providing such services in experience, quality, or outcomes,

(D) the basis or standard for the decision of an entity offering a health plan to authorize or deny health care services or benefits,

(E) the process used by such an entity to determine whether to authorize or deny health care services or benefits, and

(F) any financial incentives or disincentives provided by such an entity to a health care provider that are based on service utilization.

(c) ENFORCEMENT THROUGH IMPOSITION OF CIVIL MONEY PENALTY.—

(1) IN GENERAL.—Any entity that violates paragraph (1) or (2) of subsection (a) shall be subject to a civil money penalty of—

(A) up to $25,000 for each violation, or

(B) up to $100,000 for each violation if the Secretary determines that the entity has engaged, within the 5 years immediately preceding such violation, in a pattern of such violations.

(2) PROCEDURES.—The provisions of subsections (c) through (l) of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) shall apply to civil money penalties under this paragraph in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(d) DEFINITIONS.—For purposes of this section:

(1) HEALTH CARE PROVIDER.—The term "health care provider" means anyone licensed under State law to provide health care services.

(2) HEALTH PLAN.—The term "health plan" means any public or private health plan or arrangement (including an employee welfare benefit plan) which provides, or pays the cost of, health benefits, and includes an organization of health care providers that furnishes health services under a contract or agreement with such a plan.

(3) SECRETARY.—The term "Secretary" means Secretary of Health and Human Services.

(4) COVERAGE OF THIRD PARTY ADMINISTRATORS.—In the case of a health plan that is an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974), any third party administrator or other person with responsibility for contracts with health

care providers under the plan shall be considered, for purposes of this section, to be an entity offering such health plan.

(e) NON-PREEMPTION OF STATE LAW.—A State may establish or enforce requirements with respect to the subject matter of this section, but only if such requirements are more protective of medical communications than the requirements established under this section.

(f) CONSTRUCTION.—Nothing in this section shall be construed as—

(1) as requiring an entity offering a health plan to enter into or renew a contract or agreement with any willing health care provider, or

(2) preventing an entity from acting on information relating to treatment actually provided to a patient or the failure of a health care provider to comply with legal standards relating to the provision of care.

(g) EFFECTIVE DATES.—

(1) CONTRACTS.—Subsection (a)(1) shall apply to contracts or agreements entered into or renewed on or after the date of the enactment of this Act, and to contracts and agreements entered into before such date as of 30 days after the date of the enactment of this Act.

(2) RETALIATORY ACTIONS.—Subsection (a)(2) shall apply to actions taken on or after the date of the enactment of this Act, regardless of when the communication on which the action is based occurred.

(3) NULLIFICATION.—Subsection (a)(3) shall apply to provisions as of the date of the enactment of this Act.

O

H.R. 2976, THE "PATIENT RIGHT TO KNOW ACT OF 1996"

TUESDAY, JULY 30, 1996

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

The Subcommittee met, pursuant to notice, at 1:10 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
July 23, 1996
No. HL-22

CONTACT: (202) 225-3943

Thomas Announces Hearings on H.R. 2976, the "Patient Right to Know Act of 1996"

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 H.R. 2976, the "Patient Right to Know Act of 1996." **The hearing will take place on Tuesday, July 30, 1996, in room 1310 of the Longworth House Office Building, beginning at 1:00 p.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 and for inclusion in the printed record of the hearing.

BACKGROUND:

On June 27, 1996, the Subcommittee on Health and Environment of the Committee on Commerce unanimously approved H.R. 2976. As reported by the Subcommittee, the bill would prohibit health plans from restricting medical communications between physicians and patients in their provider contracts. The introduced version of H.R. 2976 would have also prohibited plans from using standard contract language pertaining to physician compensation and incentives and non-disparagement clauses.

The rules regarding any limits on physician-patient communications by health plans, which are raised by the consideration of H.R. 2976, fall into three categories: those that restrain disclosure of treatment options; those that restrain disclosure of payment and financial incentive arrangements; and nondisparagement clauses. These limits or restraints are commonly referred to as "gag rules." Many physicians argue that contract provisions exist between health plans and providers that allegedly prohibit providers from disclosing all treatment options with patients. H.R. 2976 would prohibit such clauses. This term is being used to describe a variety of standard contract provisions including provisions protecting proprietary compensation arrangements and nondisparagement clauses. Proponents of legislation to end these rules contend that financial arrangements with individual physicians should remain proprietary, while financial incentives and compensation arrangements should be revealed at the plan level, because they argue, such arrangements can sometimes contribute to "inappropriate restraints on care." The health plans argue that provisions such as proprietary compensation arrangements and nondisparagement clauses are necessary to protect competition and prevent providers from steering patients to better paying plans.

Many States are moving forward with their own legislation in this area. Twelve States have passed some form of patient disclosure or specific rules. Other States have legislation pending and two States have defeated patient disclosure legislation.

FOCUS OF THE HEARING:

The hearing will focus on legal contracting issues involving managed health care contracts between health plans and their physicians. Key issues include: what types of provisions are contained in a managed care contract; what is the actual intent of particular provisions such as nondisparagement clauses contained in such a contract; and what practices and contract language constitute limits on physician-patient communications by health plans.

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, August 13, 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 on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/' or over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. The Subcommittee will come to order.

Today's hearing focuses on H.R. 2976, as amended, that was approved by the Commerce Committee last week. This legislation would prohibit health plan contracts with providers from restricting medical communications between physicians as well as other providers and their patients.

Proponents of legislation to prohibit the use of such alleged gag clauses—and I am looking for a much better term than that and we will take nominees today—contend that these clauses undermine a physician's ability to provide his or her patients with the best possible care. Others, health plans included, argue that provisions such as proprietary compensation arrangements and nondisparagement clauses are necessary to protect competition and prevent providers from steering patients to plans simply because of their reimbursement policies.

We are going to examine this issue, hopefully, from all angles, this afternoon. Witnesses including a panel of legal experts and consultants who will shed light on what goes on in the real world regarding the drafting of managed care contracts, include what types of provisions are contained in such contracts and what practices and contract language constitute limits on physician-patient communications by health plans.

We will also hear from the NAIC on its model regulation on provider contracting and get a brief overview on what is going on in the States with regard to legislation restricting the use of certain contract language.

Finally, we will hear testimony from interested parties including representatives for health care plans, physicians, patients, and employers.

To start it off, it seemed appropriate to hear from the authors of the legislation itself, but prior to recognizing our colleagues, I ask the gentleman from California if he has any opening comments.

Mr. STARK. Thank you, Mr. Chairman. Thank you for holding this hearing. I hope that it is the first in a series on the need for consumer protections in the managed care field.

The press tells us that Dr. Ganske was promised a vote on his antigag rule bill under suspension, but I understand we may mark up the bill later. So, at least, there could be a chance for some amendments, many of which we might adopt.

There is a tremendous demand for consumer protections to stop the horror stories, anecdotal as they may be, that have accompanied this rapid growth in managed care. For example, I believe we should consider adopting utilization review reforms, timely access to care provisions, nondiscrimination laws that protect patients with serious health problems, a ban on hold-harmless clauses so that the health plans could be held accountable for their actions, join in the fun with the physicians for lawsuits and disclosure of physician financial incentives and other planned statistics, prudent layperson laws that guarantee emergency coverage, a ban on drive-through deliveries, and so forth.

If the managed care industry were wise, it would embrace these types of amendments as a way to give the public some faith and confidence in this rapidly evolving product. It is, however, kind of disappointing to see the AARP's testimony today where they seem

on one page to deny that a doctor would have the best interests of a patient at heart. And on another page, they want to keep the financial incentives to preserve a competitive advantage. They treat the patient as if he or she is not capable of understanding the financial data, while earlier in the testimony, they say the patient can understand technical medical options.

Now, managed care is sort of like the stock market crash in 1929. There are some old line blue chips like Kaiser and then there are a lot of snake oil producers. The industry could use a SEC-type system, I suppose, of consumer protections that might give patients more confidence that they are entrusting their health and lives to reputable groups that meet some minimum standards of decency. Antigag legislation is just the first step in building those protections.

As for today's hearing, Mr. Chairman, I am still inclined to support the original Ganske-Markey bill. I think it is important for patients to understand the financial pressures plans place on their doctors and I would like to hear from witnesses why we should not go back to the original bill, rather than what I consider a somewhat watered-down version.

I look forward to hearing the testimony today and inquiring with our witnesses.

Chairman THOMAS. I thank the gentleman.

If you will allow me, the reasons these televisions are here—and I do not know how your time constraint is, but I will tell the gentleman from Iowa and the gentleman from Massachusetts that, after you make your opening statements, however you may wish to inform the Subcommittee, I have an excerpt from one of those Fred Friendly seminars that we did last fall, lasting about 2½ hours. The title was "Your Money and Your Life: America's Managed Care Revolution."

There is one approximately 5-minute segment in which an exchange among Dr. Gail Povar who is a general internist at George Washington University Medical Center, the moderator, Arthur Miller and others, framed the question about as well as I have seen it. So, if you folks would make your opening statements, we will then show the approximate 5-minute video. Then we can enter into a dialog either using something from the videotape as reinforcement or as a counterpoint, as you see fit.

Perhaps, in your opening statement, you might anticipate addressing briefly the gentleman from California, Mr. Stark's comment about the original bill versus the bill that has been referred to us on sequential jurisdiction from the Commerce Committee, since it was marked up and amended in Committee.

So, with that, Hon. Dr. Ganske.

STATEMENT OF HON. GREG GANSKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. GANSKE. Thank you, Mr. Chairman, for the opportunity to be here this afternoon. I am looking forward to viewing this videotape and, if I may suggest to the Chairman, I also have a videotape. It is from "NBC Nightly News." It addresses this issue specifically and has some patients in it that appeared before the Com-

merce Committee. It is not very long and maybe we could view that also.

Mr. Chairman, there is significant evidence that some managed care plans are gagging their health care providers, thereby keeping patients from full and complete access to information they need to make critical decisions. These gags, whether spelled out in a contract, a written policy statement, a letter, or communicated orally, eat like a cancer at the trust between a doctor and a patient.

Earlier this year, Mr. Markey and I introduced the Patient Right To Know Act, which would prohibit the enforcement of gag rules in health care contracts. The Commerce Subcommittee on Health held a lengthy hearing in May. We explored these issues with patients, physicians, and managed care plans. The Subcommittee marked up the bill last month and I worked very hard with Members and other interested parties to address concerns about possible unintended consequences of the bill and the need for health plans to protect proprietary data from disclosure.

The result was an amendment that was approved by the Subcommittee 22 to 0 and by the Full Commerce Committee by unanimous voice vote 6 days ago. It is supported by groups like AARP, the Center for Patient Advocacy, Citizen Action, Consumer Federation of America, Consumer Union, the American Academy of Family Physicians, the American College of Surgeons, the American Dental Association, the American Nurses Association, the AMA, the American Physical Therapy Association, Podiatric Medicare, and a host of organizations. It has over 130 bipartisan supporters, including many Members of this Subcommittee.

Mr. Chairman, I want to be very clear on one point. No written contract accurately describes all the functions of a complex business enterprise. Much more occurs through policy manuals, informal practice, and oral statements. While the language of the contract can be partly instructive, the Subcommittee should directly focus, on three issues. First, how the contract language is used.

For example, a nondisparagement clause is not automatically objectionable if it is used to prevent bad-mouthing of the plan. We added into the substitute that passed something specifically to address this issue. A physician could not use this bill as a way to financially improve his situation. But, the clause is a problem if it is used to keep a doctor from telling his patient that he needs a treatment the plan is refusing to pay for.

A Tulsa neurologist was reprimanded for "disparaging the plan" when he advised a patient that she needed a test the plan was not willing to pay for.

Second, plans generally include in their contracts a provision requiring the provider to follow manuals and policy bulletins. Consider this letter from the south Florida Office of the Prudential Health Care System to participating doctors. The plan's medical director wrote: "If you believe a member may require transplantation or other sophisticated and experimental care, we request that before discussing treatment options with the member, you call us to discuss the member's eligibility for the treatment and to discuss the appropriate institution. Failure to do so may result in treatments that are not covered by benefits and, therefore, unhappy members."

What about a bulletin issued by Humana stating that: "Effective immediately, all Humana participating providers must telephone the preadmission review department before an admission occurs and before conveying the possibility of an admission to a plan member," before conveying the possibility of an admission for a plan member. It is my understanding that public scrutiny led to a change in this policy, but I think the dangers are real.

These policies restrict communications between patients and their providers, but if Congress' focus is only on the actual terms of the contract, we would be blind to these problems.

Third, oral communications. Plans often communicate orally what they do not want to put on paper, whether to retain flexibility, because it is impossible to codify everything, or perhaps because they are attempting to enforce policies they do not want to put into print.

Consider the case of Christy DeMeurers. She was diagnosed with breast cancer and eventually sought care at UCLA, where the doctor who examined her swore under oath that she was an excellent candidate for a bone marrow transplant. When her health plan discovered this, they threatened to terminate UCLA's lucrative contract as a center of excellence unless the doctor reversed his opinion about her fitness for the procedure. Faced with this tremendous economic coercion, Christy DeMeurers' doctor wrote out a deposition recommending against surgery, just 11 days after stating under oath that, "She is a candidate who may receive superior results."

Christy DeMeurers is no longer alive.

I think the ban on oral gags is particularly important. If Congress acts to ban restrictions on written medical communications only, it will ignore a significant part of the problem motivating this bill and will tacitly encourage other plans to follow the example of HealthNet. The bill passed by the Commerce Committee contained a reasonable compromise on this issue.

To prevent plans from being subjected to a "he-said, she-said" battle over alleged oral statements, the bill requires that proof of a single incident to an oral gag be made by a "preponderance of evidence," a higher legal standard than the substantial evidence test sometimes used in civil money penalty cases. This was a key component of the amendment approved by the Commerce Committee and will give health plans greater defense against spurious charges that are not backed up by any corroborating evidence.

Finally, let me be clear about what this bill will not do. It does not empower the Secretary of Health and Human Services to scrutinize every contract or to place an inspector in every doctor's office. Instead, the legislation gives the Secretary the authority to examine cases of alleged gags when they are brought to his or her attention. This is an appropriate balance that safeguards patients against efforts to limit their access to critical information.

Mr. Chairman, as passed by the Commerce Committee, the Patient Right To Know Act is a balanced bill that addresses a real problem in the health care market. I look forward to working with you and other members of the panel on this important issue and thank you very much.

[The opening statement follows:]

Statement of Rep. Greg Ganske
Hearing on Managed Care "Gag Rules"
Committee on Ways and Means
Subcommittee on Health
July 30, 1996

Mr. Chairman, thank you for the opportunity to appear before you this afternoon.

There is significant evidence that some managed care plans are "gagging" their health care providers, thereby keeping patients from full and complete access to the information they need to make critical decisions. These gags--whether spelled out in a contract, a written policy statement or letter, or communicated orally--eat like a cancer at the trust between a doctor and a patient.

Earlier this year, Congressman Ed Markey and I introduced H.R.2976, the Patient Right to Know Act, which would prohibit the enforcement of gag rules in health care contracts. The Commerce Committee Subcommittee on Health held a lengthy hearing in May which explored these issues. The panel heard testimony that gags exist and pose very real dangers.

Before the Subcommittee marked-up the bill last month, I worked very hard with Members and other interested parties to address concerns about possible unintended consequences of the bill and the need for health plans to protect proprietary data from disclosure. The result was an amendment that was approved by the Subcommittee 22-0 and by the Full Commerce Committee by unanimous voice vote six days ago.

The version of the bill adopted by the Commerce Committee represents a compromise which fairly balances the interests of patients, providers, and health plans.

Mr. Chairman, I want to be very clear on one point. No written contract accurately describes all the functions of a complex business enterprise. Much more occurs through policy manuals, informal practice, and oral statements. While the language of the contract can be partly instructive, the Committee should more directly focus on three issues:

First. How the contract language is used. For example, a non-disparagement clause is not automatically objectionable if it is used to prevent public bad-mouthing of the plan. But it is problematic if it is used to keep a doctor from telling his patient that she needs a treatment the plan is refusing to pay for. A Tulsa neurologist was reprimended for "disparaging" the plan when he advised a patient that she required a test the plan was not willing to pay for.

Second. Letters and policy bulletins. Plans generally include in their contracts a provision requiring the provider to follow manuals and policy bulletins. Consider this letter from the South Florida office of the Prudential Health Care System to participating doctors. The plan's medical director wrote, "If you believe a member may require transplantation or other very sophisticated and possibly experimental care, we request that BEFORE DISCUSSING TREATMENT OPTIONS WITH THE MEMBER, you call us to discuss the member's eligibility for that treatment and to discuss the appropriate institution. Failure to do so may result in treatments that are not covered by benefits, and therefore unhappy members."

Or what about a bulletin issued by Humana stating that, "Effective immediately, all Humana participating providers must telephone the Preadmission Review Department. . . before an admission occurs and before conveying the possibility of admission to the plan member." It is my understanding that public scrutiny led to a change in this policy, but I think the dangers are very clear.

These policies restrict communications between patients and their providers. But if Congress focusses only on the actual terms of the contract, we would not view this as a problem.

Third. Oral communications. Plans often communicate orally things that they do not want to put on paper--whether to retain flexibility, because it is impossible to codify on paper a multi-billion dollar industry, or perhaps because they are attempting to enforce policies they don't want to put in print.

Consider the case of Christy DeMeurers. She was diagnosed with breast cancer and eventually sought care at UCLA, where the doctor who examined her swore under oath that she was an excellent candidate for a bone marrow transplant. When her health plan discovered this, they threatened to terminate UCLA's lucrative contract as a Center of Excellence unless the doctor reversed his opinion about her fitness for the procedure. Faced with this tremendous economic coercion, Christy DeMeurers' doctor swore out a deposition recommending against the surgery--just eleven days after stating under oath that "she is a candidate who may receive superior results."

I think the ban on oral gags is particularly important. If Congress acts to ban restrictions on written medical communications only, it will turn a blind eye to a significant part of the problem motivating this bill and will tacitly encourage other plans to follow the example of HealthNet in its treatment of Christy DeMeurers.

The bill passed by the Commerce Committee contained a reasonable compromise on this issue. To prevent plans from being subjected to a "he said, she said" battle over alleged oral statements, the bill requires that proof of a single incidence of an oral gag be made by a "preponderance of the evidence," a higher legal standard than the "substantial evidence" test sometimes used in civil money penalty cases. This was a key component of the amendment approved by the Commerce Committee and will give health plans a greater defense against spurious charges which are not backed up with any corroborating evidence.

Finally, let's be clear about what this bill will not do. It <u>does not</u> empower the Secretary of Health and Human Services to scrutinize every contract or place an inspector in every doctor's office. Instead, the legislation gives the Secretary the authority to examine cases of alleged gags <u>when they are brought to his or her attention</u>. This is an appropriate balance that safeguards patients against efforts to limit their access to critical information.

Mr. Chairman, as passed by the Commerce Committee, the Patient Right to Know Act is a balanced bill that addresses a real problem in the health care market. I look forward to working with you and the other Members of this panel on this important issue.

Thank you. I would be pleased to answer any questions that Members may have.

Chairman THOMAS. Thank you very much. If I did not say so, obviously without objection, any written statement that either of you have will be made a part of the record.

The gentleman from Massachusetts, Mr. Markey.

STATEMENT OF HON. EDWARD J. MARKEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. MARKEY. Thank you, Mr. Chairman, and I thank you for holding today's hearing on this important legislation.

Gag rules restricting medical communications between doctors and their patients enforce a code of silence on doctors that makes informed consent impossible. Such an attack on this most basic patient protection simply cannot be tolerated in a free society. When you are a patient, what you do not know can hurt you. That is why Dr. Ganske and I joined forces last February to introduce the Patient Right To Know Act of 1996, which protects medical communication between health care providers and their patients by banning the use of gag rules by health plans.

That is why the House must pass this bill this year and we must send it to the President's desk before the end of the session.

Our bipartisan proposal has over 140 cosponsors from both sides of the aisle and every part of the political spectrum. It is supported by a wide range of health care and consumer groups, including the American Medical Association, the American Nurses Association, the Consumer Federation of America, and the Consumers' Union. The American Association of Retired Persons and the American Heart Association both have written letters to us expressing their support for the bill as well.

Incidentally, contrary to the implication of an advertisement which ran in one of the local newspapers last week, the National Governors' Association has not taken a position on the Ganske/Markey bill. That ad, which was paid for by the managed care industry, reflected the managed care industry's view of H.R. 2976, not the position of the National Governors' Association on our bill.

My mother always told me to consider the source when I hear something I am not sure about. In this case, I would strongly urge my colleagues to do the same.

During the recent markup of this bill by the Commerce Committee, my friend from Iowa offered a substitute amendment that addressed several of the main concerns about the bill that had been raised by the managed care industry. Specifically, it protects proprietary data from disclosure, eliminates the second higher tier of civil penalties imposed by the original bill, and delays the effective date by 60 days to give plans adequate time to comply.

In addition, the substitute includes a provision explicitly stating that the bill does not protect communications made by doctors to their patients that are made solely for the doctor's own financial gain. This provision should silence once and for all those who oppose the bill for other reasons, but seek to undermine it by claiming that it is a provider protection bill rather than a patient protection bill.

I want to touch on one more point before I close. Some who have looked at this issue have focused their attention exclusively on what is written in the doctor's contract. If a clear gag clause cannot

be found there, they assume the doctor is free to speak. I would urge this Subcommittee to look deeper into this issue before drawing such a conclusion.

Dr. Rosabel Young, a Texas neurologist, was reprimanded by her HMO employer, CIGNA, for recommending a muscle biopsy to one of her patients even though it was not covered by the plan. She was told that, "It was a mistake to tell the patient about a procedure before checking to see whether it was covered." "It was as if I were a store vendor," she said "and was only supposed to advertise the products that we offered" as part of their own brand label. Clearly, CIGNA was trying to keep Dr. Young from giving her best medical advice to her patients, to gag her, not by invoking a specific provision in her contract, but by enforcing an oral policy against discussing treatment options not covered by the plan with those patients.

The Patient Right To Know Act was approved by the Commerce Committee last week by a voice vote. I am very pleased, Mr. Chairman, that you have been willing to have this hearing in such a timely fashion. Silence is not always golden. No doctor can practice good medicine in a muzzle. We must ungag the doctors and give patients confidence that nothing is preventing their doctors from telling them the truth, the whole truth, and nothing but the truth about the health of that individual or their family member. America's patients deserve no less.

I thank you, Mr. Chairman and, I look forward to the rest of the hearing.

[The prepared statement follows:]

STATEMENT OF REP. ED MARKEY
ON HR 2976, THE PATIENT RIGHT TO KNOW ACT
BEFORE THE COMMITTEE ON WAYS AND MEANS

July 30, 1996

Mr. Chairman, I want to begin by thanking you for holding today's hearing on this important legislation.

"Gag rules" restricting medical communications between doctors and their patients enforce a code of silence on doctors that makes informed consent impossible. Such an attack on this most basic patient protection simply cannot be tolerated in a free society.

When you're a patient, what you don't know can hurt you. That's why Rep. Ganske and I joined forces last February to introduce the "Patient Right to Know Act of 1996," which protects medical communications between health care providers and their patients by banning the use of "gag rules" by health plans. That's why the House must pass this bill, this year, and we must send it to the President's desk before the end of the session.

Our bipartisan proposal has over 130 co-sponsors from both sides of the aisle and every part of the political spectrum. It is supported by a wide range of health care and consumer groups, including the American Medical Association, the American Nurses Association, the Consumer Federation of America, and Consumers Union. The American Association of Retired Persons and the American Heart Association have both written letters to us expressing their support for our effort.

Incidentally, contrary to the implication of an advertisement which ran in Washington Times last week, the National Governors Association has not taken a position on the Ganske-Markey bill. That ad, which was paid for by the managed care industry, reflected the managed care industry's view of HR 2976, not the position of NGA on our bill. My mother always told me to "consider the source" when I hear something I'm not sure about -- in this case, I would strongly urge my colleagues to do the same.

During the recent mark-up of this bill by the Commerce Committee, my friend from Iowa offered a substitute amendment that addressed several of the main concerns about the bill that had been raised by the managed care industry: specifically, it protects proprietary data from disclosure, eliminates the second, higher tier of civil penalties imposed in the original bill, and delays the effective date by 60 days to give plans adequate time to comply.

In addition, the substitute includes a provision explicitly stating that the bill does not protect communications made by doctors to their patients that are made solely for the doctor's own financial gain. This provision should silence, once and for all, those who oppose the bill for other reasons but seek to undermine it by claiming that it is a "provider-protection" bill, rather than a "patient-protection" bill.

I want to touch on one more point before I close. Some who have looked at this issue have focused their attention exclusively on what's written in the doctor's contract. If a clear gag clause can't be found there, they assume the doctor is free to speak. I would urge this Committee to look deeper into this issue before

drawing such a conclusion. Dr. Rosabel Young, a Texas neurologist, was reprimanded by her HMO-employer, CIGNA, for recommending a muscle biopsy to one of her patients even though it wasn't covered by the plan. She was told that "it was a mistake to tell the patient about a procedure before checking to see if it was covered." "It was as if I was a store vendor and was only supposed to advertise the products we offered," she recalled. Clearly, CIGNA was trying to keep Dr. Young from giving her best medical advice to her patients, to gag her, not by invoking a specific provision in her contract but by enforcing an oral policy against discussing treatment options not covered by the plan with those patients.

The Patient Right to Know Act was approved by the Commerce Committee last week by a voice vote. I am pleased that the Ways & Means Committee has now turned its attention to HR 2976, and I am hopeful, Mr. Chairman, that you will schedule action on it as soon as possible.

Mr. Chairman, silence isn't always golden. No doctor can practice good medicine in a muzzle. We must ungag the doctors, and give patients confidence that nothing is preventing their doctors from telling them the truth, the whole truth and nothing but the truth. America's patients deserve nothing less.

Thank you and I yield back the balance of my time.

Chairman THOMAS. I thank the gentlemen, both gentlemen, for their comments.

As was indicated on the floor, with the legislation going to the Committees of jurisdiction, we would not in any way inhibit it. I think it is fairly evident that we are complying with that with the hearing today. It is the Chairman's intent that, although we are going out this week, the first week, no later than the second week when we come back, we would move to a markup if, in fact, there seems to be a general feeling that perhaps some language might be able to improve the legislation.

Prior to going to questions from Members, as we indicated, with your tape added, Greg, let's show—about how long is it?

Mr. MARKEY. Three or four minutes.

Chairman THOMAS. Run that tape and then run the excerpts from the "Friendly" program.

I tell everyone present, this is our small step forward in moving toward the cyber-Congress. We thought we would go high technology. [Laughter]

Obviously, Tom Brokaw does not understand the importance of mentioning sponsors of the legislation. [Laughter.]

Mark, I thought you would have that covered.

Mr. MARKEY. We have to have a gag rule at the networks on that. [Laughter.]

Chairman THOMAS. That is right.

The second tape is an excerpt from, as I said, one of those "Fred Friendly" seminars, in which Arthur Miller roams around with all the hypothetical questions—hold it. Thanks.

I need to set the setting so that, as you look at this piece, you will understand what is going on. We had in the room around the table myself and Henry Waxman, as politicians, Califano, a number of doctors, others representing hospitals, as is usually the case. He roams around, as I said, with hypotheticals.

This scenario is about a woman who was in the process of determining, under an open enrollment season, what health care option to take. She decided to take the managed care option, although there is a long discussion about the options between the managed care and the fee-for-service, about the adverse risk selection, portability, preexisting medical conditions. She makes a choice to go with the managed care option.

So, in this scenario, Miller is playing the woman who chose the managed care plan and is carrying out a discussion with the doctor. The doctor is Dr. Gail Povar, general internist at George Washington University Medical Center, as I said.

Obviously, if all of the doctors were as aggressive in terms of supporting the patients as Dr. Gail Povar seems to be, regardless of what contracts you may have signed, we would have less concern about this.

So, you get the contrast between the two tapes and I am pleased that you brought the NBC one, Greg.

Let me ask you a couple of questions which will hopefully frame it for some of us, because if you are going to be dealing with Federal regulations governing private contracts, we are all very sensitive about when and how the Federal Government is going to in-

tervene to either provide an advantage in a negotiating arrangement with one side or the other.

In addition to that, a number of States are beginning to move in this area and the legislation says no State can do legislation that is less restrictive than what we have in the bill. So, notwithstanding the agreement and the comfort level in the State, this Federal legislation may disrupt those relationships as well. So, we are very sensitive about it.

To what extent is it fair to say that contracts—you can pick some of the most egregious examples that you might in terms of what you call a gag rule—if signed by a doctor would require them to hesitate based upon their Hippocratic Oath? Are we dealing with contracts that doctors would feel, in fact, violate what they believe to be their commitment to the Hippocratic Oath?

Mr. GANSKE. I believe that you are going to get testimony that physicians in general would feel that these kinds of contracts are unethical. The situation, depending on whether a physician signs a contract with these in them or not, is something that I cannot defend. The fact is, we have ample evidence that the contracts exist and that they are affecting a patient's ability to get the information they want.

I should emphasize, Mr. Chairman, that this——

Chairman THOMAS. I guess I was trying to drive you to the most extreme position I could think of, not that it might interfere, not that it might be inconvenient, but that you would be forced to make decisions that would be inconsistent with your professional judgment as it is determined in the Hippocratic Oath.

Mr. GANSKE. I will answer that, but let me just first say, I firmly believe the primary purpose of this is not for physicians, but it is for patients. That is why groups like Citizen Action and the American Heart Association and the American Lung Association, AARP, Consumer Union have all come out endorsing this bill.

Are there situations where the economic forces in the market could place an exceedingly heavy load on a physician to sign one of those contracts? I think that there are. There are situations developing where consolidation has occurred in the managed care industry where a few players have a very large share of the market. It may mean whether a physician can stay in that locale, as to whether they sign a contract or not.

So, there definitely can exist a very significant conflict of interests, both in terms of fulfilling your Hippocratic Oath, but also in terms of whether you are going to practice in that community where your kids are going to school and where you may have set down roots 20 years ago.

Chairman THOMAS. On the NBC tape and the Fred Friendly tape, it was primarily focused on physicians. Your comments are focused on physicians and quite rightly the end result is informing the patient, as you indicate with the findings. The very first finding you have in the bill is the patient's right to know.

But in the bill, you define health care provider—the term health care provider means anyone licensed under State law to provide health care services. The scope of that definition is obviously, I think we all agree, far broader than physicians. It would extend to not only physicians' assistants, but nurses, nurse practitioners,

nurse midwives, therapists, dieticians, dental hygienist, social workers, certain medical records employees, and so forth, who would come under a number of States' definition of health care provider.

Do you believe it is essential to have it as broad as that?

Mr. GANSKE. I do. I have had personal communications from members of the nursing and physical therapy professions that they are experiencing the same types of problems with these types of gag clauses.

Chairman THOMAS. OK. Then when you have medical communication defined in the amended bill—in this section, the term medical communication means a communication made by a health care provider with a patient of the provider, with respect to the patient's physical or mental condition or treatment options—it does not indicate that the health care provider show any expertise by virtue of the license they receive in the State or knowledge about the area in which they could make comments—it could be physical, mental or treatment options.

How do you deal with a ophthalmologist making a statement to a patient about the mental health aspect of the provision or a dietician making a comment about some physical treatment aspect? Do you see what I am talking about? Given the broad definition and the fact that you do not restrict the comment to the expertise, either by licensure or employment, contract employment, of the individual making the statement, that you provide blanket protection for anybody to make any comment about any aspect of the plan, whether they have expertise or not.

Mr. GANSKE. Well, the matter of expertise, I think, is adequately handled by the State licensing boards. If individuals are making recommendations outside of their area of expertise, they are going to be subject to the usual sanctions.

Chairman THOMAS. Well, no, not making recommendations, making comments about the health plan's provisions. They are criticizing the health plan's provisions in areas in which they have no expertise. They are making comments about it. They are protected under this bill in the communications with the patient or with the people who are provided with the plan and they are making "a medical communication." They could be commenting about any of the physical or mental provisions or treatment options in the plan and it could be anybody, including one of the medical records employees.

Mr. GANSKE. I would just say that if a treating surgeon who is a licensed physician has a concern about a patient's severe depression and recommends to the patient that they obtain a consultation from a psychiatrist, I think they are operating within the bounds of what would traditionally be seen as a pertinent part of their treatment of that medical condition. I think the——

Chairman THOMAS. I obviously have little or no quarrel with the example that you gave. Do you see how I could provide you with an example based upon how you define health provider under the law and the provision in which they could make a comment on the plan, that I could provide a number of extreme examples in which people could clearly be seen to be meddling or making disparaging remarks about a plan with no clear intent to assist the patient in

their right to know on the basis of physical or mental condition or treatment options.

This is just an area that you need to look at and think about. As we move toward the potential markup, I would like to have some conversations in terms of the scope and the extent to which folk who I believe probably have no professional expertise could make comments and be protected under the very broad umbrella. I understand you need to create a broad umbrella. I am just questioning, perhaps, maybe it is broader than it needs to be.

Mr. GANSKE. Mr. Chairman, I worked with Congressman Burr, and also worked with various interested parties on this legislation. We came to an understanding of sorts and had a colloquy on this. I think this would be an appropriate issue for report language, especially in terms of just exactly what a medical communication is. I believe that it is basically any test, consultation or treatment option, any risks or benefits associated with them in any variation and quality among health care providers or institutions providing such services, as an example of, I think, the type of language that I would be happy to work with you on.

Chairman THOMAS. I appreciate that. I am currently representing an interest group of one on this issue. It may or may not extend beyond that, but that is the group I am looking out for right now.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. I have been trying to sort out the differences between the original bill and the bill before us. I guess the easiest way would be to ask the witnesses if they could just give me a quick summary of what was dropped from the original bill and if there was any reason other than political expediency to get a bill passed. If there was a technical reasons for dropping it, maybe you could tell us. Maybe there was no reason other than votes, that is a pretty good reason.

Could you run through quickly and give us an idea——

Mr. MARKEY. I can, if you want, just summarize——

Mr. STARK. Yes.

Mr. MARKEY [continuing]. The changes that were made. The most significant change was the deletion of language in the base bill that listed a series of adverse actions that are prohibited. Instead the——

Mr. STARK. The doctor, the termination to renew a—a refusal to renew a contract, that section?

Mr. MARKEY. Right, exactly.

Mr. STARK. OK.

Mr. MARKEY. Instead, the substitute does make clear that plans may not gag their providers. Plans that attempt to impede free communications between providers and patients would still be punished even if they have taken no retaliatory actions. The substitute contains a more focused definition of protected medical communications, deleting a long list of terms that appeared in the base bill.

The substitute includes a provision that makes clear that providers may not use the protections of this bill solely for the purpose of steering patients into a competing health plan which pays them better. That is based on language from the gag clause ban which passed the Assembly of California by a 72 to 0 vote.

Finally, the substitute narrows the focus of the bill to the core patient protections. The substitute protects only medical communications between providers and patients. This represents a change from the base bill which also protected statements made by providers directly to the health plan and to State or Federal regulators. Significant questions were raised about possible unintended consequences of these provisions and the substitute deletes them. As Dr. Ganske mentioned in his statement, we changed the test from substantial to a preponderance of the evidence as well.

Finally, we wanted to get a bill passed, too. That was also one of the reasons.

Mr. STARK. The part that addresses making statements by providers to the health plan or to the State or Federal regulators, we have a couple of lawsuits in California now where plans are refusing to give information to the State as required by State law. These changes would affect that kind of restriction, so the physicians would not be able to discuss this with State regulators. Is that one of the things that was dropped out?

Mr. GANSKE. I think that providers under an inquiry from a State or a Federal regulator, if the Secretary made an inquiry, would still be able to provide information as it relates to the gag clauses. I mean, this specifically deals with banning gag clauses.

Mr. STARK. In other words, the State would have to get the information from the plan? They could not get it from one of the physicians working in the plan, in effect? Your original bill would have allowed them to do that and, as I see it, this newer version is silent on that.

Thank you. Thank you, Mr. Chairman.

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

Mr. CHRISTENSEN. No.

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

Mr. MCDERMOTT. Yes, thank you, Mr. Chairman. I have a question. Why do you think you need a Federal law to do this? Why don't you let the insurance commissioners do it in the 50 States?

Mr. GANSKE. Well, if I may answer that, I think we need a Federal law because about 50 to 60 percent of people with employee provided insurance are not covered by State law. We are talking primarily about ERISA plans. I do feel that managed care is a legitimate option for people to have. I think that the ERISA law was set up to provide uniform standards for certain reasons. Health was folded into those pension issues. There should be a minimal, I believe, level playingfield.

I would argue, quite frankly, that the established HMO plans may find themselves at a disadvantage to a more entrepreneurial type of managed care plan which has these types of restrictions in it, because you can increase your profit line basically by decreasing the care. These gag clauses can function to do that. So, quite frankly, it is very similar to, I think, legislation we passed in the Commerce Subcommittee on telecommunications.

I think there is a role for some minimal level of regulation, particularly when you run into some egregious examples like we have

seen. So, the short answer is, because the State insurance plans do not regulate a lot of the plans.

Mr. MCDERMOTT. Well, let me just walk you through an example. One day, I was flying home to Seattle and I was sitting next to a woman who was the manager of an office for a neurologist out in Vienna, Virginia. I asked her if she had anything to do with these managed care contracts and she said, Oh yes, we have signed 70 of them. I said, Well, you have signed them, have you read them all? Do you know all the provisions that are in them? She said, Are you crazy? I could not possibly do that. She said, We have to sign all of these so that we can get paid.

Now, suppose she were to find that there was a clause or the doctor was to find that there was a clause in one of those contracts that was restrictive, a gag clause, and they wanted to deal with this. Under your bill, what would be the mechanism by which that individual neurologist could go after the particular company he had signed this contract with? Would all managed care contracts have to be reviewed by the Justice Department before they could be used by insurance companies or——

Mr. GANSKE. No.

Mr. MCDERMOTT [continuing]. Would the doctor have an individual cause of action against the insurance company because they have an illegal provision in their contract? Explain to me how that would work. I would like to know, as a physician, when I am back out there practicing after this election. What steps do I have to take under the provisions of this bill to deal with this kind of stuff?

Mr. GANSKE. Well, I do not know whether you will be back practicing after this election. [Laughter.]

The way that I would see this working is, the bill, if it is signed into law, outlaws or bans those gag clauses. Upon information of them, the Secretary of HHS could levy a $25,000 fine.

Now, let us say that you are a practicing provider, whether you are a nurse practitioner, a physical therapist, or whatever. You get a communication from the medical director of the plan. It says, "You have recommended a treatment that we are not covering. I would remind you that you have in your contract a clause that says you may not discuss treatment options unless you first get an OK from us. If this behavior persists, we will take you off our plan."

That raises some concern for that practitioner so the practitioner, I think, would then initiate a complaint and point out to the management that, under the Patient Right To Know Act, this restriction is not legal and if you persist in enforcing it, then I could bring this to the attention to the Secretary of HHS. It does not mean that the Secretary is going to look at every contract around the country. It simply provides a mechanism whereby these would be limited.

Mr. MCDERMOTT. So, it would be the general counsel of HHS who would get these cases as they came from individual practitioners, who have received a communication that they are going to be dropped because there is a clause that limits them?

Mr. GANSKE. That would be how I would envision it.

Mr. MCDERMOTT. Mr. Markey.

Mr. MARKEY. The regional HHS office, yes.

Mr. MCDERMOTT. OK.

I was listening to your answer to the Chairman about the issue of breadth of the bill versus narrowness. I think I would have answered that question a little differently or a little bit more emphatically, that you want a broad bill if you are on the side of the patient. If you are on the side of the HMO industry, you want a narrow bill. So, only psychiatrists can make referrals about psychiatric issues and only belly surgeons can talk about belly issues and neurologists only about nerves. Nobody can stray out of their very narrow constraints.

The problem, it seems to me, in trying to write any definition that gets narrow is going to be that, you have nurse practitioners and you have physicians' assistants who are operating in broad areas as well as, physicians who operate in broad areas. I think if you try to narrow this, I would be very careful in any kind of negotiations you make in terms of narrowing, because you will always take away information from the patient that they do not know about.

Even if it is a physical therapist who says, Well, I saw a case like this once and I thought this worked. Then the patient goes to the plan and says, Well, why cannot they do this. I think this might make my back feel better or whatever.

That information that comes from whatever level of practitioner is for the patients—at least gives the patient a little bit more understanding of what is going on. I would be—in your negotiations the Chairman is talking about, I would be wary of narrowing the definition.

Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes, just a very quick question.

Gentlemen, it is great to see you. Thanks very much for being here and pushing this bill.

New York has just passed a bill, just about a week or so ago, doing the same thing, prohibiting gag clauses. I am not quite sure of two things, one, how your bill will fit into that. Maybe you do not know what the bill is. The other thing is, Is there a difference between written and oral communications here?

Mr. GANSKE. Well, let me answer that. I think that this bill is needed, because even if New York passes this law, about 50 percent of the residents in New York with health insurance will not be covered, because they are covered by ERISA plans that would be exempted from State regulation.

I believe that it is very important to leave oral communications in this bill, because we had ample testimony that it is not just the written contract that is a problem. It is a phone call from the medical director not recorded on paper that says, "If you keep making these referrals for this type of treatment, you are off the panel."

Picture your wife with a breast cancer and she has a lump in her breast and she goes in to her physician and he has signed one of these contracts with these gag clauses. He does her history and physical exam and there are four commonly accepted treatments. He says, Excuse me, and he leaves the room and gets on the phone and says, Can I tell the patient about these four types of treatment for this breast lump? That is what we are talking about in this bill.

Your wife or your loved one needs to know what their options are in order to make informed consent in order to get the best treatment.

Now, if that plan has in their contracts that they are not going to cover a type of treatment, let's say, bone marrow transplants, that is fine. The patient should know whether a bone marrow transplant is an option for them and then they can take up the issue of whether this is authorized or not with the company.

Chairman THOMAS. In the legal advice provided by the gentleman from Washington and your negotiations on the legislation, all of the examples that were used were fairly obvious in terms of types of doctors being able to make broad-based recommendations. Even in the example of the therapist, I think it makes some sense. I just think when you use the definition—and I am trying to explore all of the folks who are covered by that very expansive definition—you reach a point where you are in the chair with a dental hygienist cleaning your teeth and they are talking about something they read in People Magazine. It seems to me, that is a bit far afield in terms of what would be protected in this kind of legislation, based upon the gentlemen's concerns and the continued, repeated examples, including the one that he just gave.

In fact, I found it interesting. In my preparation for this, I read a number of booklets that are now being prepared to advise doctors on how to deal with contracts with managed care organizations or MCOs, as this one book called them, the "Legal Analysis of Managed Care Contracts." I do want to underscore, because I believe, Dr. Ganske, you said in your opening comments that you do not intend for this legislation to cover someone who might make disparaging remarks.

For example, in this document, "Legal Analysis of Managed Care Contracts," on page 11, they talk about marketing issues. They talk about how some contracts include provisions that prohibit you from encouraging any member to disenroll and from making disparaging remarks about any physician participants in the plan or the plan itself. "I would recommend that you get an MRI, but your health care plan is too cheap to pay for it." Then in offset type it says—this is the contract language. "Provider shall not make and shall not use his best efforts to insure that no employer of the provider or subcontractor of the provider makes any derogatory remarks regarding HMO to any member."

That is not your intent as I understand the provisions in your bill; is that correct?

Mr. GANSKE. Mr. Chairman, that is specifically the issue of a conflict of interests in terms of a provider bad-mouthing a plan in order to move a patient into a plan where their fee schedule may be better. It is a valid concern and that is why we added language to the bill that specifically preempts that.

Chairman THOMAS. I wanted to get that on the record.

Then on page 12, they go on in advice to doctors in——

Mr. GANSKE. Mr. Chairman, what are you referring to?

Chairman THOMAS. This is a Legal Analysis of Managed Care Contracts, Managed Care 2000, from Astro Merck [phonetic], a series of family practice management monographs developed through an educational grant from Astra Merck. It is sponsored by the

Family Practice Management. I looked at a number of these booklets that outline do's and don'ts.

For example, read the contract is the first thing that they say. Understand that there are supportive documents to the contract; read those, too. When you look at words, do not assume you know what they mean. If they are capitalized, you need to understand the definition. It is that kind of advice that they are giving. They then give examples, in fact, they have a sample contract.

I was just trying to understand what level of information was being provided to doctors on do's and don'ts. I found on page 12 of this particular document a recommendation from the attorneys that doctors do not sign any contract requiring you to provide the highest quality or best care. It says, "Do not sign any contract requiring you to provide the highest quality or best care." Perhaps, we need to, at a different time, spend some time finding out why folks are so concerned about making sure that the Patient Right To Know Act covers the physician or the medical provider's ability to communicate to the patient but that all of the documents in fairly bold language say do not sign a contract requiring the doctor to provide the highest quality or best care available. I need to know and understand that provision.

Have you had a chance to look at the bill that Mr. Markey referred to in his comment to the gentleman from Washington, the legislation that has passed both the assembly and the Senate and is on Governor Wilson's desk? It is recommended that he sign it. I wanted to call your attention to section D, which I believe, in reading this section—and on line 16, the last word there is peer, peer review. I believe if your legislation became law, this would not be allowed to go into effect in California.

I would like your reaction, either in terms of why it would weaken your legislation or why you would recommend that it not be included in your legislation since it passed both the assembly and the Senate in California and probably will go into effect in California if Governor Wilson signs the bill.

Mr. GANSKE. Well, Mr. Chairman, I have just briefly looked this over.

Chairman THOMAS. I understand.

Mr. GANSKE. I need to review it in more detail. It appears to me that this is not a prohibition against economic credentialing, and that is also protected in my bill. It also appears to allow sanctions of providers who fail to follow legal standards. That is also consistent with H.R. 2976.

Chairman THOMAS. Well then, I would very much like to sit down, with some more time available to us and, review this California legislation to see where it is in conflict or would be less stringent in protecting, as you would say, the patient's right to know so that we could use that as an example. My information is, the Governor is about ready to sign it.

Does the gentleman from California wish to——

Mr. STARK. Yes, thank you, Mr. Chairman. I want to go back, Mr. Markey and Hon. Dr. Ganske, here for 1 minute. Mr. Markey, in the statement you made about the major changes, the original bill protected statements made by providers directly to State or Federal regulators. I am picking the words out there.

Now, in an Los Angeles Times article, it says here that there is a court case with Pacific Care Health Systems with 11,000 complaints. Pacific Care is resisting a demand by the State Department of Corporations to access the internal records of their health plan. The department, the State's regulator of health HMOs says it sought the records after the enrollees complained.

Now, in your bill, the original bill, you talk about protecting communications—and I am jumping—but it says, with any State or Federal authority who is responsible for licensing or oversight. What I guess is, by taking that out, what you are saying is, any doctor, let's say, who talked to a State regulator or a Federal regulator could be fired. Ought they not to be protected?

I suppose a State could go in and subpoena them under a criminal action, but we are trying to get away from that. We are trying to get some interim control both at the State level and at the Federal level where you do not have to go for a criminal action to put somebody under subpoena.

Would it not be a good idea to free up the physician's ability to communicate with regulators?

Mr. GANSKE. Well, Mr. Stark, if I may address this. When we dropped a couple of those provisions, first, I think there were some concerns about communications back and forth between a provider and the health plan and it was not essential for the bill. The second part which was about whether there could be communications between Federal and State regulators was—well, we did not have any examples of plans trying to prevent that. So, if you have information on that, I would be interested in knowing about it. Since we had not really seen that as a problem, we just decided to delete the language and simplify the bill.

Mr. STARK. I guess, and I do not know if we want to get into the State issue, but it would seem to me that if there is going to be future—if we are going to look at this both through Medicare, Medicaid or through the insurance regulations, we would not want to provide a screen behind which a plan administrator could say to all of the physicians, shut up or you will get fired. Then you have to go through a whole legal routine to get testimony from them. It is something we can discuss later.

If that was not a particular issue you were concerned about in changing the bill, I would suggest that maybe we revisit that.

Thanks very much.

Mr. MARKEY. If I may——

Mr. STARK. Yes.

Mr. MARKEY. In the same way that the gentleman from California is raising issues as the gentleman from Washington and you, this is not the Magna Carta yet. [Laughter.]

Mr. STARK. That is an oak tree you are sitting under.

Mr. MARKEY. We will have the next 5 weeks at least to walk through. If you have a real life example where you think that, for example, there is a significant harm that would be created by our inability to be able to extend this law into areas where we have not, then I clearly would like to hear it. At the same time, we are not withholding any protections that already exist. We have expanded, we think, at this point as far as we could go realistically in our Subcommittee at this time.

However, we are not at all—I am, at least, not adverse to moving it on further if you want to give additional communications protections. Understand, we did it in the context of the Commerce Committee as it existed circa 1996. We think that this is a very good bill in terms of at least giving the patient the ability in their conversations with their doctor to be able to have their rights fully protected. If I could go further, of course, I would have gone further. That is a limitation. I accepted it.

Mr. STARK. I appreciate the answer from both of you.

Thank you very much, Mr. Chairman.

Chairman THOMAS. The gentleman from Washington.

Mr. MCDERMOTT. Mr. Chairman, I have always believed that everything good or bad starts in California. [Laughter.]

So, when you bring me an assembly bill, I would call to your attention——

Chairman THOMAS. We are pleased that water runs downhill and we really do look forward to Washington's water.

Mr. MCDERMOTT. So far, the Columbia has not.

In the bill from the assembly, they use the term "the ability of a physician, surgeon, or other licensed health care provider." I think the breadth of that is basically the breadth that is used in this bill. I think that is primarily because most States have a licensure law under which you have about one hundred things licensed these days.

Chairman THOMAS. I understand that. Even pulling out specific titles from the general health care provider, I think, does give an emphasis that we may want to talk about, notwithstanding the list both being universal. The way in which they describe it at least places an emphasis in terms of importance of role, perhaps. It is an area to discuss.

I want to thank both of you. Normally, as you know, members come, make a statement and there is almost a silent understanding that you would not subject them to any questions about their own legislation. We feel fairly comfortable in doing that, one, because obviously the gentleman is not only knowledgeable from a theoretical point of view, but he is also very knowledgeable from a realistic point of view. The gentleman from Massachusetts has been involved in this area for some time.

In addition to that, if we are going to go with sequential referral and the bill originated in your Committee, given the shared jurisdiction that we have, I think it is extremely important and valuable for us to talk with each other from the two Committees in a way in which we can inquire of a substantive nature.

So, I want to thank both of you, not only for making the historically usual visit, but also for allowing us to ask you some questions, which I think will help us in framing how we may approach the bill from our Subcommittee's jurisdiction.

Mr. MARKEY. May I say, Mr. Chairman, I understand and appreciate the fact that congressional expert is an oxymoron, if we are describing a Congressman. The next panel is one of real experts and I have just had the good fortune, however, of testifying with someone who happens to also have the benefit of being an expert and a Congressman at the same time on this subject.

Chairman THOMAS. We thank both of you for your contribution.

Mr. GANSKE. Thank you, Mr. Chairman.

Chairman THOMAS. The next panel is described as a panel of legal experts, Dr. Peter Kongstvedt, who is partner and national practice director of the Managed Care Strategy and Medical Management Section of the Managed Care Group of Ernst and Young; Joel Stocker from Greenberg Traurig, Miami, Florida; and Mark Rust, a partner in Kamensky and Rubinstein law firm in Chicago.

I would tell each of you that your written testimony will be made a part of the record. You may proceed to inform the Subcommittee in any manner you see fit in the timeframe that you have available. We will begin with Dr. Kongstvedt and move to the rest of the panelists.

Doctor.

STATEMENT OF PETER R. KONGSTVEDT, M.D., PARTNER AND NATIONAL PRACTICE DIRECTOR, MANAGED CARE STRATEGY AND MEDICAL MANAGEMENT SECTION, MANAGED CARE GROUP, ERNST AND YOUNG, LLP

Dr. KONGSTVEDT. Thank you, Mr. Chairman. My name is Peter Kongstvedt. I am a board-certified physician of internal medicine and a fellow in the American College of Physicians. I appreciate your introduction.

On behalf of Ernst and Young, LLP, I would like to thank you for inviting me to testify.

In the popular press, the issue at hand has been labeled the gag rule or the gag clause. Many groups charge that HMOs and PPOs have sought to restrict or gag what a contracting provider may or may not discuss with a health plan member, including discussions related to the provision of patient care and to the health plan's business secrets.

Using the technique of orchestrated outrage, the issue has been brought to the public's attention, using such examples as the cover of a widely circulated news magazine featuring the photo of a model wearing surgical scrubs and mask, ostensibly to represent a gag physician. Using another technique known as the identifiable victim, others have used anecdotes to describe the issue in terms of a misfortune that has occurred to an individual, ascribing that misfortune to the provision in the contract between the health plan and the physician.

In Ernst and Young's dealings with a broad representation of the health care industry, predominantly on the provider's side, we have not actually seen evidence of the gag rule being an issue. The issue at hand does appear to be somewhat difficult to surface. In all honesty, I can say that I have not personally seen such a gag clause in its most restrictive format, but it is possible that such a contract does exist, because I certainly cannot claim to have seen every contract in existence.

At the same time, there are indeed clauses in these contracts that serve to control certain aspects of communication between physicians and members of health plans, as illustrated in the attachment to my testimony. The three common forms of such clauses include those related to business secrets, those related to the plan's market position and those related to compliance with the plan's medical management program. It is common in contracts

between physicians and health plans to require the physicians to respect and maintain the confidentiality of the business secrets of the health plans, the most common example being fee schedules and capitation schedules and, in some cases, also secrets of third-party vendors.

Clauses related to the health plans's market position are designed to prevent a contracting physician from taking actions or making statements that would harm the business interests of the health plan. The most common example are restrictions on a physician from encouraging patients to join a competing plan for whatever reasons, but primarily because the other plan pays better.

The clause also encompasses the possibility that the health plan terminates its contract with the physician. The physician then encourages patients to switch to a plan that does continue to cover the services of that physician. Both of these positions are very easily understood and obviously easy to defend, but they are primarily economic. The health plan wishes to maintain its membership base. The physician wishes to maintain his or her patient base. It is difficult to state which party in any given event may have the better economic case.

Contracts between health plans and physicians commonly contain language contractually requiring physicians to comply with the medical management program. Such medical management programs, which are the hallmark of managed care, usually focus on utilization management and quality management. Problems may arise when the physician and the health plan disagree about a course of treatment or when the physician or health plan want to use a particular provider or hospital but the health plan does not use that provider or hospital.

I personally know of no health plans that deliberately and/or systematically deny medically necessary services to members, although the ongoing debate about the definition and, therefore, coverage of experimental investigational medical services makes this issue an ever changing one. It is not in the best business interests, to say nothing about the moral, ethical and legal interests of either a health plan or the physicians that it contracts with to deny truly needed care. If care is truly needed and not provided, the patient gets sicker and is likely to become more expensive to treat in the future.

In addition, if either the plan or the providers engage in such systematic or deliberate behavior, the effect on the market and sales would ultimately be very detrimental.

Health plans usually have contract clauses that expressly state that the health plan is not in the practice of medicine and the physician is obligated to undertake the proper clinical course of action. Health plans routinely include such clauses for several reasons, not the least of which is to lower their exposure under joint and several responsibility or respondeat superior. A gag clause would undermine the risk management aspect of that clause in the contract.

The conflict between providers and health plans may not be legal or contractual, but rather lie in the implementation of those contractual terms. I will be the first to acknowledge that it is more than possible that some health plans and some medical directors are inept at carrying out their functions, whatever the actual policy

and the position of the health plan is. In those cases, it is possible that an incompetent medical director could communicate an adverse coverage ruling in such a way as to make the network provider perceive a threat or, worse yet, actually threaten the provider with termination from the plan, despite having no sound contractual or policy grounds for such a threat.

Likewise, it is possible that there are some who are using this issue to resolve by legislative means the problems that they cannot resolve in the marketplace. It is always a risk, when Congress contemplates legislative action, that there will be unintended consequences, particularly when there is a high talk to reality ratio. Some examples, which have been discussed, include increasing litigation based on creative interpretation of the law, lobbying patients under the guise of medical communications about health plan movement for reasons that may be detrimental to the competitive process and the creation of a precedent that, when business disputes arise between physicians and health plans, the Congress will be required to pass ever more detailed laws controlling the management of health plans and physicians.

Mr. Chairman, to answer some of the questions surrounding these issues, Ernst and Young, LLP does have a proposal to submit for your consideration. We would consider undertaking an examination of a representative sampling of nongroup, nonstaff model HMOs to validate the process in the contractual relationship between providers and health plans to determine this relationship's impact on physician-patient communications. This would encompass various aspects and, Mr. Chairman, if you will allow me 30 more seconds, I will conclude.

Including the legal aspects, does the health plan have clauses in place in their provider contracts which constitute the commonly accepted definition of the gag clause, that is, restrictions and discussions by a contracting provider with the health plan member regarding the full range of treatment options available, regardless of what is covered and behavior? Does the plan exclusively promote through its legal and QA processes open full communications between providers and patients? If such communications are indeed hindered, is the problem surrounding the gag issue at the plan systemic or individual in nature?

We are pleased to offer our services on a pro bono basis with the cooperation of the providers and the health plan industry.

Mr. Chairman, thank you again for the opportunity to testify.

[The prepared statement and attachments follow:]

STATEMENT OF
PETER R. KONGSTVEDT, M.D., FACP, PARTNER
ERNST & YOUNG LLP

Introduction

My name is Peter R. Kongstvedt, M.D., F.A.C.P. I am a board-certified physician of Internal Medicine and a Fellow of the American College of Physicians. I am a partner in the Washington, DC office of Ernst & Young LLP, where I serve as the National Practice Leader for Managed Care Strategy and Medical Management for the firm's Managed Care Group. Professionally, I lead and assist in the development of health care quality and cost-containment strategies for a variety of health care clients, including providers, integrated delivery systems, and health plans. I also serve as one of Ernst & Young's leaders in the research and development of issues impacting managed care systems. I am the editor and principal author of *The Managed Health Care Handbook, 3rd Edition*, published by Aspen Publishers. This text, and its companion text, *The Essentials of Managed Health Care*, are the leading texts on managed care in the country today and are in use in a large number of graduate programs in health care administration.

Mr. Chairman, on behalf of Ernst & Young LLP, I would like to thank you for allowing me the opportunity to share with this committee our observations and experiences regarding the nature of physician/health plan contracting and how this relationship impacts patient care.

The Issue

There are largely two issues before the committee today: the physician/health plan relationship and what communications, if any, should be considered to be "protected medical communication" between a contracting physician and a health plan member. By their very nature, contractual arrangements between providers and health plans are complex. These arrangements encompass numerous issues, including compensation, plan protocols, and the provision of medical care. As is apparent in Attachment 1 (reprinted with permission from *The Managed Health Care Handbook, 3rd Edition)*, there are a great many contractual terms in most legal agreements between physicians and health plans. In the popular press, this issue has been labeled the "gag rule" or "gag clause." Some groups have charged that health plans, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs), have sought to restrict, or "gag," what a contracting provider may and may not discuss with a health plan member, including discussions related to the provision of patient care and to the health plan's business secrets. To remedy these alleged restrictions, some groups are advancing legislation, including H.R. 2976, "The Patient Right to Know Act," sponsored by Representatives Greg Ganske (R-Iowa) and Edward Markey (D-Mass.), which would define what physician/patient communications may be considered to be protected medical communications and provide penalties for health plans who violate these protections. Using the technique of Orchestrated Outrage, this issue has been brought to the public's attention using such examples as the cover of a widely circulated news magazine featuring a photo of a model wearing surgical scrubs and a surgical mask, ostensibly to represent a "gagged" physician. Using another technique known as The Identifiable Victim, others have used anecdotes to describe this issue in terms of a misfortune that has occurred to an individual, ascribing that misfortune to this alleged "gag" provision in the contract between the health plan and the physician.

The Reality

Quite frankly, in Ernst & Young's dealings with a broad representation of the health care industry, we have not seen evidence of the "gag rule" being an issue. The issue at hand appears to be the Sasquatch of managed care: it is large, ugly, hairy, and scary, however, producing the actual thing has proven to be quite difficult. Despite the public discussion, there have been few concrete examples of unedited contracts that support the claim that such inappropriate "gag" rules actually exist. In all honesty, I can say that I have never seen such a clause, despite having reviewed personally several hundred such contracts in the course of my career. Nonetheless, health plans appear to be sensitive to even the perception that they "gag" their physicians. In at least one well publicized case, a health plan was accused of having a "gag clause." While the plan denied that it was their intent to "gag" providers, they changed the clause anyway.

At the same time, there are indeed clauses in these contracts that serve to control certain aspects of communication between physicians and members of health plans. As illustrated in Attachment 1, there are three common forms of such clauses:

- those related to business secrets
- those related to the plan's market position, and
- those related to compliance with a health plan's medical management program

Business Secrets

It is common in contracts between physicians and health plans to require the physician to respect and maintain the confidentiality of the business secrets of the health plan. In some cases, these business secrets are the property of the health plan; the most common example of such secrets are fee schedules or capitation schedules (i.e., the financial terms or payment terms between the health plan and the physician). In other cases, the business secrets are the property of a third party vendor with which the health plan has contracted. A common example of such an arrangement would be clinical management protocols licensed from a medical management or disease management organization. These business secrets are generally considered to be proprietary because they foster competition between health plans -- competition which has been found in many surveys both to lower overall health care costs and maintain or improve the quality of care provided.

The Health Plan's Market Position

Clauses related to a health plan's market position are designed to prevent a contracting physician from taking actions or making statements that would harm the business interests of the health plan. These clauses have no bearing on the provision of care. A common example of these clauses would be a plan restricting a physician from encouraging patients to join a competing health plan ostensibly for reasons of quality, but in fact because the competing health plan pays better.[1]

This clause also encompasses another possibility: in the uncommon event a health plan terminates its contract with a physician, the physician may then encourage patients covered by that health plan to change coverage to another plan that will continue to cover services of that physician. Both positions are quite understandable: the health plan wishes to protect its membership base, while the physician wishes to protect her or his patient base. In both cases, the reasons for doing this are primarily economic and it is thus harder to clearly state which party is more deserving economically.

[1] In the case of sophisticated providers with equity positions or other forms of incentives, this might include encouraging only healthy patients/members to switch plans, leaving the sick ones behind. This is generally referred to as Adverse Selection.

Compliance With Medical Management Programs

Contracts between health plans and physicians commonly contain language contractually requiring the physician to comply with the plan's medical management program. Such medical management programs, which are the hallmark of managed care, usually focus on utilization management and on quality management. It is perhaps in this area that much of the confusion by both physicians and health plans occurs.

This clause (or section of the contract) may be broadly defined, leaving the specifics of the medical management program to an appendix or a policy and procedure manual. The clause may be specific, such as requiring a physician to contact the health plan prior to authorizing a referral or an admission. In a similar fashion, the contract may be specific with regards to requirements under the quality management program such as credentialing criteria or allowing the health plan to have access to clinical records for peer review.

Where problems may arise is when a physician and a health plan disagree about a course of treatment, or when a physician or patient want to use a particular provider or hospital, but the health plan does not use that provider or hospital. In those cases, the physician is most likely to tell the patient that the health plan has not approved a particular provider or hospital (for payment only, of course; the health plan cannot control what the patient actually does, only for what the health plan will pay). Most well-run health plans have rapid dispute resolution policies to resolve these disagreements in a timely manner, but it is possible and likely that some health plans do not carry out that activity with alacrity.

I personally know of no health plans that deliberately and/or systematically deny medically necessary services to members, although the ongoing debate about the definition (and therefore coverage) of experimental and investigational medical services makes this issue an ever-changing one. It is not in the best business interests – to say nothing about the moral, ethical, and legal interests -- of either a health plan or the physicians it places "at risk" to deny needed care: if care is truly needed and not provided, the patient gets sicker and is likely to become more expensive to treat in the future. Additionally, if either the plan or its providers engage in such systematic or deliberate behavior, the effect on their marketing and sales would be quite detrimental – something that managed care plans can ill-afford in this current environment of intense market competition. Many employers have used managed care to reduce their exposure to spiraling health care cost increases. These employers are holding health plans accountable for the quality of the services they provide. Indeed, many employers require health plans to adhere to strict quality guidelines, such as those developed by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization which credentials HMOs. With respect to "gag clauses," the NCQA Accreditation Standards specifically prohibit managed care organizations from placing any "restrictions on the clinical dialogue between practitioner and patient."[2]

Health plans, as illustrated in Attachment 1, usually have contract clauses that expressly state that the health plan is not in the practice of medicine, and that the physician is obligated to undertake the proper clinical course of action. In other words, if a dispute cannot be resolved, the physician must take appropriate clinical action. The physician and health plan can argue the financial issues later without involving the patient. Health plans routinely include such clauses for several reasons, not the least of which is to lower their exposure under Joint and Several Responsibility and/or Respondeat Superior. A "gag clause" would undermine that risk-management aspect of the contract.

Moreover, the conflict between provider and health plan may not be legal or contractual, but rather lie in the *implementation* of mutually agreed upon contractual terms. I would be the first to acknowledge that it is more than possible that some health plans and some medical directors could be inept at carrying out their functions, whatever the actual policy and position of the healthplan is. In those cases, it is possible that an incompetent medical director could communicate an adverse coverage ruling in such a way as to make a network provider perceive a threat to their status as a contracting provider, or worse yet, actually threaten a provider with termination from the plan despite having no contractual or policy grounds for such a threat.

Likewise, it is more than possible that there are some physicians who are using this issue to try and solve via legislative means what they cannot solve in the marketplace. There are certainly some physicians who do not like managed care in any form, and who do not wish to see any organization involved in changing the way they practice medicine – even if the care they provide is not appropriate treatment, is not performed in the right setting, is of questionable quality, and is ultimately unaffordable. It is also possible that there are some physicians who are hearing what is *not* being said about managed care or who are very worried about the emergence of managed care, even if they have not actually experienced it themselves.

Lastly, the health care marketplace is witnessing the rapid growth of provider-based integrated delivery systems. These organizations seek not only to provide medical care, but to manage the financial aspects of that care as well. In these systems, this very same issue of "gag clauses" and provider/patient communications arises. However, it is not the health plan that is managing the communications, it is the providers themselves. These systems have the very same needs for compliance with medical management programs, protection of business secrets, and protection of their market share. The needs of these provider-sponsored systems will create these same issues being discussed here today. In fact, one increasingly popular approach for many large and sophisticated health plans is to capitate globally integrated delivery and financing systems, and have those systems manage these aspects of the plan.

Unintended Consequences

There is always risk when Congress contemplates legislative action, especially when that action is taken to deal with something that has a high talk-to-reality ratio. Global responses to discreet and scattered problems raise the possibility of unintended consequences. I respectfully caution Members of this committee that the potential for these unintended consequences is both *real* and *genuine*. Examples germane to this discussion could include (depending on the type of legislation being considered):

- Increased litigation by physicians, members, and others based on a "creative" interpretation of the law;
- Physicians may "lobby" patients under the guise of "medical communications" about health plan selection for reasons that may be self-serving to the physician, and detrimental to the health plan;
- A reduction or removal of incentives for physicians to comply with medical management policies of health plans;
- Physicians who have been terminated from the health plan (which is not common, but clearly does occur; not every one of the over 650,000 physicians in the U.S. is going to be a good physician or be able to practice in a managed care
- environment) would be permitted to claim that the only basis for termination was communications -- a claim that could easily be created by the physician simply talking at great length to their patients about the physician's complaints;

[2] 1996 NCQA Review Guidelines, *Members Rights and Responsibilities* standard 1.1.3.

- Provider Sponsored Organizations (envisioned under many Medicare Reform initiatives, and actively sought by most provider organizations) would find it more difficult to carry out effectively medical management activities for the same reasons that would apply to health plans; and

- The creation of precedent that when business disputes arise between physicians and health plans, Congress will be required to pass ever-more detailed laws controlling the management of health plans and physicians – a direction with which the nation as a whole is not comfortable.

A Proposal

As the health care marketplace continues to evolve, pressures to provide accountable, high-quality, and cost-effective health care based upon the best medical practices and outcomes will only increase. As a condition of enrolling in a health plan, many employers are moving to seek comparative "report cards" and other standardized quality information about health plans. Additionally, government actions may also change the health care landscape. In the coming years, these market and government pressures will only intensify.

Against this backdrop, the controversy surrounding "gag" clauses is being debated. It is my understanding that this hearing is being held to address many questions, including:

- What *is* the problem surrounding the perception by providers that they are being "gagged?"

- If there is indeed a problem, what is the scope of the problem? Is it system-wide or does it rest largely with a few "bad apples" in the managed care industry?

- How can an assessment be made of the issues surrounding physician/health plan contracting and physician/patient communication?

- What systemic processes do health plans have in place that balances the concerns of providers and health plans and the patients they serve? If a health plan does not have a system *in* place, should that absence be taken as a measure of the plan's overall quality?

Mr. Chairman, to answer many of the questions surrounding these concerns, Ernst & Young LLP would like to submit for your consideration the following:

Ernst & Young LLP would consider undertaking an examination of a representative sampling of non-group and non-staff model HMOs to validate the process begetting the contractual relationship between providers and health plans and to determine this relationship's impact on physician-patient communication.
This examination would encompass the various aspects of the physician/health plan relationship and its impact on patient care, including:

- ***Legal.*** **Does the health plan have clauses in place in their provider contracts which constitute the commonly accepted definition of "gag clause" – that is, restrictions on discussions by a contracting provider with a health plan member regarding the full range of treatment options available to the member, regardless of whether is it covered by the plan?**

- ***Behavior.*** **Does the plan explicitly promote, through both its legal and QA processes, open and full communication between providers and their patients? *If such communications are indeed hindered* is the problem surrounding the "gag" issue at the plan systemic or individual in nature?**

Mr. Chairman, Ernst & Young LLP is pleased to offer our services on a *pro bono* basis and would collaborate with industry associations and plans. We would develop a survey technique that would allow the plan to demonstrate its management practices with regard to this issue.

Mr. Chairman, thank you again for the opportunity to testify. In the coming months, I look forward to working with you, other Members of the committee, and organizations represented here today to answer the questions surrounding the "gag" issue. At this time, I would be happy to answer any questions you may have about either the "gag" issue or our proposal.

THE MANAGED Health Care Handbook

Third Edition

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Legal Issues in Provider Contracting

Mark S. Joffe

The business of a managed health care plan is to provide or arrange for the provision of health care services. Most managed health care plans, such as health maintenance organizations (HMOs) and preferred provider organizations, provide their services through arrangements with individual physicians, independent practice associations (IPAs), medical groups, hospitals, and other types of health care professionals and facilities. The provider contract formalizes the managed health care plan–provider relationship. A carefully drafted contract accomplishes more than mere memorializing of the arrangement between the parties. A well-written contract can foster a positive relationship between the provider and the managed health care plan. Moreover, a good contract can provide important and needed protections to both parties if the relationship sours.

This chapter is intended to offer to the managed health care plan and the provider a practical guide to reviewing and drafting a provider contract. Appendixes 55–A and 55–B are a sample HMO–primary care physician agreement and a sample HMO–hospital agreement, respectively. These contracts, which have been provided solely for illustrative purposes, have been annotated by the author. Although these agreements are used by an HMO, most provisions have equal applicability to other managed care plans.

Contracts need not be complex or lengthy to be legally binding and enforceable. A single-sentence letter agreement between a hospital and a managed health care plan that says that the hospital agrees to provide access to its facility to enrollees of the managed health care plan in exchange for payment of billed charges is a valid contract. If a single-paragraph agreement is legally binding, why is it necessary for managed health care plan–provider contracts to be so lengthy? The answer is twofold. First, many terms of the contract, although not required, perform useful functions by articulating the rights and responsibilities of the parties. As managed care becomes an increasingly important revenue source to providers, a clear understanding of these rights and responsibilities becomes increasingly important. Second, a growing number of contractual provisions are required by state licensure regulations (e.g., a hold-harmless

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clause) or by government payer programs (e.g., Medicare and Medicaid).

An ideal contract or contract form does not exist. Appropriate contract terms vary depending on the issues of concern and the objectives of the parties, each party's relative negotiating strength, and the desired degree of formality. Although the focus of this chapter is explaining key substantive provisions in a contract, the importance of clarity cannot be overstated. A poorly written contract confuses and misleads the parties. Lack of clarity increases substantially the likelihood of disagreements over the meaning of contract language. A contract not only should be written in simple, commonly understood language but also should be well organized so that either party is able to find and review provisions as quickly and easily as possible.

The need for clarity has become more important as contracts have become increasingly complex. Many managed health care plans may act as an HMO, a preferred provider organization, and a third party administrator. Those health care plans will frequently enter into a single contract with a provider to provide services in all three capacities. In addition, this single contract may obligate the provider to furnish services not only to the managed health care plans enrollees but to enrollees of a number of affiliates of the managed health care plan.

The following discussion is designed to provide a workable guide for managed health care plans and providers to draft, amend, or review contracts. Much of the discussion is cast from the perspective of the managed health care plan, but the points are equally valid from the provider's perspective. Most of the discussion relates to contracts directly between the managed health care plan and the provider of services. When the contract is between the managed health care plan and an IPA or medical group, the managed health care plan needs to ensure that the areas discussed below are appropriately addressed in both the managed health care plan's contract and the contract between the IPA or medical group and the provider.

GENERAL ISSUES IN CONTRACTING

Key Objectives

The managed health care plan should divide key objectives into two categories: those that are essential and those that, although not essential, are highly desirable. Throughout the negotiation process, a managed health care plan needs to keep in mind both the musts and the highly desirables. Not infrequently, a managed health care plan or a provider will suddenly realize at the end of the negotiation process that it has not achieved all its basic goals. The managed health care plan's key objectives will vary. If the managed health care plan is in a community with a single provider of a particular specialty service, merely entering into a contract on any terms with the provider may be its objective. On the other hand, the managed health care plan's objectives might be quite complex, and it may demand carefully planned negotiations to achieve them.

"Must" objectives may derive from state and federal regulations, which may require or prohibit particular clauses in contracts. Managed health care plans need to be aware of these requirements and make sure that their contracting providers understand that these provisions are required by law.

Beyond the essential objectives are the highly desirable ones. Before commencing the drafting or the negotiation of the contract, the managed health care plan should list these objectives and have a good understanding of their relative importance. This preliminary thought process assists the managed health care plan in developing its negotiating strategy.

Annual Calendar

Key provider contracts may take months to negotiate. If the contemplated arrangement with the provider is important to the managed health care plan's delivery system, the managed health care plan will want to avoid the diminution of its

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bargaining strength as the desired effective date approaches.

The managed health care plan should have a master schedule identifying the contracts that need to be entered into and renewed. This schedule should include time lines that identify dates by which progress on key contract negotiations should take place. Although such an orderly system may be difficult to maintain, it may protect the managed health care plan from potential problems that may arise if it is forced to operate without a contract or negotiate from a weakened position.

Letter of Intent Compared with a Contract

The purpose of a letter of intent is to define the basic elements of a contemplated arrangement or transaction between two parties. A letter of intent is used most often when the negotiation process between two parties is expected to be lengthy and expensive (e.g., a major acquisition). A letter of intent is a preliminary, nonbinding agreement that allows the parties to ascertain whether they are able to agree on key terms. If the parties agree on a letter of intent, the terms of that letter serve as the blueprint for the contract. Some people confuse a letter of intent with a letter of agreement. Because a letter of intent is not a legally binding agreement, regulators will not consider them in evaluating whether a managed care organization meets availability and accessibility requirements. Therefore, the use of a letter of intent should be limited to identifying the general parameters of a future contract.

Negotiating Strategy

Negotiating strategy is determined by objectives and relative negotiating strength. Depending on the locale or market dynamics, either the managed health care plan or the provider may have greater negotiating strength. Except in circumstances in which the relative negotiating strength is so one-sided that one party can dictate the terms to the other party, each party should identify for itself before beginning negotiations the negotiable issues, the party's initial position on each issue, and the extent to which it will compromise. Because a managed health care plan may use the same contract form as the contract for many providers, the managed health care plan needs to keep in mind the implications of amending one contract for the other contracts that use the same form.

A recurring theme presented at conference sessions discussing provider contracting and provider relations is the need to foster a win–win relationship, where both parties perceive that they gain from the relationship. The managed health care plan's objective should be fostering long-term, mutually satisfactory relationships with providers. When managed health care plans have enough negotiating strength to dictate the contract terms, they should exercise that strength cautiously to ensure that their short-term actions do not jeopardize their long-term goals.

CONTRACT STRUCTURE

As mentioned above, clarity is an important objective in drafting a provider contract. A key factor affecting the degree of clarity of a contract is the manner in which the agreement is organized. In fact, many managed health care plan contracts follow fairly similar formats. The contract begins with a title describing the instrument (e.g., "Primary Care Physician Agreement"). After this is the caption, which identifies the names of the parties and the legal action taken, along with the transition, which contains words signifying that the parties have entered into an agreement. Then, the contract includes the recitals, which are best explained as the "wherein" clauses. These clauses are not intended to have legal significance but may become relevant to resolve inconsistencies in the body of the contract or if the drafter inappropriately includes substantive provisions in them. The use of the word *wherein* is merely tradition and has no legal significance.

The next section of the contract is the definitions section, which includes definitions of all key contract terms. The definitions section pre-

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codes the operative language, including the substantive health-related provisions that define the responsibilities and obligations of each of the parties, representations and warranties, and declarations. The last section of the contract, the closing or testimonium, reflects the assent of the parties through their signatures. Sometimes, the drafters of a provider contract decide to have the signature page on the first page for administrative simplicity.

Contracts frequently incorporate by reference other documents, some of which will be appended to the agreement as attachments or exhibits. As discussed further below, managed health care plans frequently reserve the right to amend some of these referenced documents unilaterally.

The contract's form or structure is intended to accomplish three purposes: to simplify a reader's use and understanding of the agreement, to facilitate amendment or revision of the contract where the contract form has been used for many providers, and to streamline the administrative process necessary to submit and obtain regulatory approvals. Clarity and efficiency can be attained by using commonly understood terms, avoiding legal or technical jargon, using definitions to explain key and frequently used terms, and using well-organized headings and a numbering system. The ultimate objective is that any representative of the managed health care plan or the provider who has an interest in an issue will be able to find the pertinent contract provision easily and understand its meaning.

Exhibits and appendixes are frequently used by managed health care plans to promote efficiency in administering many provider contracts. The managed health care plan, to the extent possible, could design many of its provider contracts or groups of provider contracts around a core set of common requirements. Exhibits may be used to identify the terms that may vary, such as payment rates and provider responsibilities. This approach has several advantages. First, it eases the administrative burden in drafting and revising contracts. Second, if an appendix or exhibit is the only part of the contract that is being amended and has a separate state insurance department provider number, the managed health care plan need only submit the amendment for state review. Third, when a contract is under consideration for renewal and the key issue is the payment rate, having the payment rate listed separately in the appendix lessens the likelihood that the provider will review and suggest amending other provisions of the contract.

COMMON CLAUSES, PROVISIONS, AND KEY FACTORS

Names

The initial paragraph of the contract will identify the names of the parties entering into the agreement. It is always a good idea to ensure that the parties named in the opening paragraph are the parties that are signing the agreement. If a managed health care organization is signing the agreement on behalf of affiliates, the provider may want to have the signing party represent and warrant that it is authorized to sign on behalf of the nonsigning party. If the nonsigning party is much stronger financially than the signing party, it would be worthwhile to have a representation directly from the nonsigning party that the signing party may enter into the agreement on its behalf. In reviewing a contract, providers should be particularly sensitive to the responsibilities of nonparties to the agreement and the ability of the provider to enforce these responsibilities. For example, if a managed care organization is offering services to self-insured employers, is the self-insured employer a party to the agreement? If not, what assurances does the provider have that the self-insured employer will fulfill its responsibilities?

Recitals

A contract will typically contain, in rather legalistic prose, a series of statements describing who the parties are and what they are trying to accomplish. These recitals should be general statements. Periodically, however, contract

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drafters insert substantive requirements in the recitals section. Contract reviewers should be sensitive to this possibility.

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Although a table of contents has no legal significance, the reader will be greatly assisted in finding pertinent sections in a long contract by referring to the table of contents. One common failing in contract renegotiations is neglecting to update the table of contents after the contract has been amended.

Definitions

The definitions section of a contract plays an essential role in simplifying the structure, and the reader's understanding, of a contract. The body of the contract often contains complicated terms that merit amplification and explanation. The use of a definition, although requiring the reader to refer back to an earlier section for a meaning, simplifies greatly the discussion in the body of the agreement. A poorly drafted contract will define unnecessary terms or define terms in a manner that is inconsistent with their use in the body of the agreement.

Defined terms are frequently capitalized in a contract to alert the reader that the word is defined. Definitions are almost essential in many contracts, but their use may complicate the understanding of the agreement. Someone who reads a contract will first read a definition without knowing its significance. Later, when he or she reads the body of the contract, he or she may no longer recall a term's meaning. For this reason, someone reviewing a contract for the first time should read the definitions twice: initially and then in the context of each term's use. Definitions sections tend to err on the side of containing too many definitions. A term that is used only once in a contract need not be defined. On the other hand, a critical reader of a contract will identify instances in which the contract could be improved by the use of additional definitions.

In reviewing a contract, managed health care organizations and providers should not underestimate the importance of definitions of the parties' responsibilities.

An occasional defect in some contracts is that the drafter includes substantive contract provisions in the definitions. A definition is merely an explanation of a meaning of a term and should not contain substantive provisions. This does not mean that a definition that imposes a substantive obligation on a party is invalid. In reviewing a contract, if a party identifies a substantive provision in a definition, the party should ensure that its usage is consistent with the corresponding provision in the body of the contract.

Terms that are commonly defined in a managed care context are *member*, *subscriber*, *medical director*, *provider*, *payer*, *physician*, *primary care physician*, *emergency*, *medically necessary*, and *utilization review program*. Some of these terms, such as *medically necessary*, are crucial to a party's understanding of its responsibilities and should be considered carefully in the review of a contract. In many managed care agreements, payers and not the managed health care organization are responsible for payment under the contract. In this case, who is a payer and how a payer is selected and removed become important to the provider. The definition of *member* or *enrollee* is also important. The contract should convey clearly who is covered under the agreement, but it should be clear as to whom the managed health care organization can add in the future. The managed health care plan and provider should ensure that these terms are consistent, if appropriate, with those in other contracts (e.g., the group enrollment agreement).

Provider Obligations

Provider Services

Because the purpose of the agreement is to contract for the provision of health services, the description of those services in the contract is important. As mentioned above, the recitation of

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services to be furnished by the provider could be set out either in the contract or in an exhibit or attachment. An exhibit format frequently allows the party more flexibility and administrative simplicity when it amends the exhibited portion of the agreement, particularly when the change requires regulatory approval.

Contracts may use the term *provider services* to denote the range of services that is to be provided under the contract. Managed health care organizations frequently adapt physician contracts to apply to ancillary providers. In so doing, the managed health care organization may not revise language that is applicable only to physicians and apply it to an ancillary provider. Nonphysician providers should consider this issue in reviewing a contract.

The contract needs to specify to whom the provider is obligated to furnish services. Although the answer is that the provider furnishes services to covered enrollees, the contract needs to define what is meant by *covered enrollee*, explain how the provider will learn who is covered, and assign the responsibility for payment if services are furnished to a noncovered person. Managed health care organizations and providers frequently disagree on this issue. The providers' view is frequently that if the managed care organization represented that the individual was covered, the managed care organization should be responsible for payment. In contrast, the managed care organization frequently asserts that it should not be responsible for the costs of services provided to noncovered enrollees and that the provider should seek payment directly from the individual. This issue is oftentimes resolved based on relative negotiating strength.

Provider contracts should also cover adequately a number of other provider responsibilities, including the provider's responsibilities to refer or to accept referrals of enrollees, the days and times of days the provider agrees to be available to provide services, and substitute on-call arrangements, if appropriate. Provider contracts may also specify the qualifications necessary for the provider of back-up services when the provider is not available. Some of these functions may be prescribed as conditions of participation in public programs, such as the Medicare risk-contracting program.

If the provider is a hospital, the contract will include language identifying the circumstances in which the managed health care plan agrees to be responsible or not responsible for services provided to nonemergency patients. A fairly common provision in hospital contracts states that the hospital, except in emergencies, must as a prerequisite to admit have the order of the participating physician or other preadmission authorization. The hospital contract also should have an explicit provision requiring that the managed health care plan be notified within a specified period after an emergency admission. A related policy and contracting issue is whether the hospital should be entitled to reimbursement for performing the initial screen that is required when a patient goes to the emergency department.

A good provider contract must be supplemented by a competent provider relations program to ensure that problems that arise are resolved and that the providers have a means to answer questions about their contract responsibilities. Providers will frequently be given the opportunity to appeal internally claim denials and decisions of non-medical necessity by the managed care organization.

Nondiscriminatory Requirements

Provider agreements frequently contain clauses obligating the provider to furnish services to the health care plan's patients in the same manner as the provider furnishes services to non-managed health care patients (i.e., not to discriminate on the basis of payment source). In addition, a clause is used to prohibit other types of discrimination on the basis of race, color, sex, age, disability, religion, and national origin. Government contracts may require the use of specific contract language, including a reference to compliance with the Americans with Disabilities Act. As an alternative, the managed care organization and provider may want to add a second contract clause that requires compliance

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with all nondiscrimination requirements under federal, state, and local law. These obligations may also apply to subcontractors of the provider.

Compliance with Utilization Review Standards and Protocols and the Quality Assurance Program

The success of the managed care organization is dependent on its providers being able and willing to control unnecessary utilization. To do so, the providers need to follow the utilization review guidelines of the managed health care plan. The contract needs to set out the provider's responsibilities in carrying out the managed health care plan's utilization review program. The managed health care plan's dilemma is how to articulate this obligation in the contract when the utilization review program may be quite detailed and frequently is updated over time. One option used by some managed care organizations is to append the utilization review program to the contract as an exhibit. A second option is merely to incorporate the program by reference. In either case, it is important for the managed health care plan to ensure that the contract allows it to amend the utilization review standards in the future without the consent of the provider. If the managed health care plan does not append a cross-referenced standard, the managed health care plan should give each provider a copy of the guidelines and any amendments. Without this documentation, the provider might argue that it did not agree to the guidelines or subsequent amendments.

The contract needs to inform providers of their responsibilities to cooperate in efforts by the managed health care plan to ensure compliance and the implications of the provider not meeting the guidelines. Contracts differ on whether the managed health care plan is seeking the provider's cooperation or compliance. The current Health Care Financing Administration (HCFA) guidelines for provider contracts require that the provider cooperate with and participate in the managed health care plan's quality assurance program, member grievance system, and utilization review program. Providers generally favor an obligation to cooperate with these programs rather than one to comply because a requirement to comply with the programs decisions seems to preclude the right to disagree.

The same basic concepts and principles apply to the provider's acceptance of the managed health care plan's quality assurance program. Some managed health care plans tend to equate their utilization review and their quality assurance programs. This attitude not only reflects a misunderstanding of the objectives of the two programs but is likely to engender the concern or criticism of government regulators, which view the two programs as being separate. In the last several years, as managed health care plans have placed greater emphasis on their quality assurance/quality improvement programs, provider compliance responsibilities have increased correspondingly. To provide some guidance on the nature of these responsibilities, some managed health care organizations have appended summaries of these quality programs to the contracts to give providers a better idea of their responsibilities.

The contract should include a provision requiring the provider to cooperate both in furnishing information to the managed health care plan and in taking corrective actions, if appropriate.

Acceptance of Enrollee Patients

A provider contract, particularly with a physician or physician group, will need a clause to ensure that the provider will accept enrollees regardless of their health status. This provision is more important when the risk-sharing responsibilities with the providers are such that the physician has an incentive to dissuade high utilizers from becoming part of his or her panel. Most provider contracts with primary care physicians also include a minimum number of members that the physician will accept into his or her panel (e.g., 250 members). The contract should also include fair and reasonable procedures for allowing the provider to limit or stop new members from being added to his or her panel (at a point after the provider has accepted at least the minimum number of members) and a mecha-

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nism to notify the managed health care plan when these changes take place. The managed health care plan needs to have data regarding which providers are limiting their panel size to comply with regulatory requirements.

The contract should also specify the circumstances in which the provider, principally a primary care physician, can cease being an enrollee's physician. Examples may be an enrollee's abusive behavior or refusal to follow a recommended course of treatment. This contract language would need to be consistent with language in the member subscriber agreement and in compliance with licensure requirements, which frequently identify the grounds on which a physician may end the physician–enrollee relationship.

Enrollee Complaints

The contract should require the provider to cooperate in resolving enrollee complaints and to notify the managed health care plan within a specified period of time when any complaints are conveyed to the provider. The provider should also be obligated to advise the managed health care plan of any coverage denials so that the managed health care plan can anticipate future enrollee complaints. To the extent that governmental payer programs require special enrollee grievance procedures, the language in the contract should be written sufficiently broadly to ensure provider cooperation with those procedures.

Maintenance and Retention of Records and Confidentiality

Provider contracts should require the provider to maintain both medical and business records for specified periods of time. For example, these agreements could provide that the records must be maintained in accordance with federal and state laws and consistent with generally accepted business and professional standards as well as whatever other standards are established by the managed health care plan. If the managed health care plan participates in any public or private payer program that establishes certain specific records retention requirements, those requirements should be conveyed to the providers. The contract should state that these obligations survive the termination of the contract.

The managed health care plan also needs a legal right to have access to books and records. The contract will want to state that the managed health care plan, its representatives, and government agencies have the right to inspect, review, and make or obtain copies of medical, financial, and administrative records. The provider would want the availability of this information to be limited to services rendered to enrollees, after reasonable notice, and during normal business hours. The cost of performing these services is often an issue of controversy. If there are no fees for copying these records, the contract should so state. When the managed health care organization is acting on behalf of other payers, it is desirable to have language acknowledging that the other payers have agreed to comply with applicable confidentiality laws.

In addition to the availability of books or records, the managed health care plan might also want the right to require the provider to prepare reports identifying statistical and descriptive medical and patient data and other identifying information as specified by the managed health care plan. If such a provision is included in the contract, the managed health care plan should inform the provider of the types of reports it might request to minimize any future problems. Finally, the provider should be obligated to provide information that is necessary for compliance with state or federal law.

An often neglected legal issue is how the managed health care plan obtains the authority to have access to medical records. Provider agreements periodically contain an acknowledgment by the provider that the managed health care plan is authorized to receive medical records. The problem with this approach is that the managed health care plan might not have the right to have access to this information, and, if it does not, an acknowledgment of that right in the contract has no legal effect. Some state laws give

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insurers and HMOs, as payers, a limited right of access to medical records. This right may arise if the managed health care organization is performing utilization review on behalf of an enrollee. Managed health care plans should review their state law provisions on this issue and their procedures for obtaining the appropriate consents of their members to have access to this information. Many managed health care plans obtain this information through signatures that are part of the initial enrollment materials. These consents could also be obtained at the time health services are rendered.

Managed health care organizations frequently include provisions in contracts in which the provider acknowledges that the managed health care organization has the right of access to enrollee records. The provider should be reluctant to agree to this provision without consulting state law. Although the clause acknowledging the right of access may make it easier to persuade a reluctant provider to release an enrollee's medical records, the managed health care plan needs to remember that that statement, or for that matter similar statements in the group enrollment agreement, do not confer that right. Finally, the contract should state explicitly that the provisions concerning access to records survive the termination of the agreement.

A related provision almost always included in provider contracts is a requirement that the provider maintain the confidentiality of medical records. A common clause is a provision that the provider will only release the records in accordance with the terms of the contract, in accordance with applicable law, or upon appropriate consent. State law will frequently allow disclosure of information without patient identifiers for purposes of research or education. Managed health care plans and providers need to be sensitive to confidentiality concerns with regard to minors, incompetents, and persons with communicable diseases for which there are specific state confidentiality statutes governing disclosure of information.

A medical record issue may arise when a managed health care plan wants the right to perform certain medical tests outside the hospital before an enrollee's admission. The contract between the managed health care plan and the hospital may allow for such tests and the inclusion of the test results into the hospital's medical record. The hospital may insist that the results of the tests be in a format acceptable to the hospital's medical record committee, that the laboratory results be properly certified, and that the duties performed shall be consistent with the proper practice of medicine.

Payment

The payment terms of the agreement often represent the most important provision for both the provider and the managed health care plan. As mentioned earlier, the payment terms are frequently set forth in an exhibit appended to the contract and are cross-referenced in the body of the agreement. A number of payment issues should be covered in the contract. For example, who will collect the copayments? If the managed health care plan pays the provider on a fee-for-service basis, a provision needs to state that unauthorized or uncovered services are not the responsibility of the managed health care plan. To avoid members' receiving unexpected bills from providers for noncovered services, contracts may say that the provider must inform the member that a service will not be covered by the health plan before providing the service. In addition, the contract may preclude the provider from ever billing an enrollee when the managed health care organization has determined that the service is not medically necessary.

From the provider's perspective, he or she needs a clear understanding of what is necessary for a service to be authorized. If the provider submits claims to the managed health care plan, the contract should set out the manner in which the claim is to be made and either identify the information to be provided in the claim or give the managed health care plan the right to designate or revise that information in the future. If the contract specifies the information to be included in a claim, the managed health care plan

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should also have the unilateral right to make changes in the future.

The agreement should also obligate the provider to submit claims within a specified period and obligate the managed health care plan to pay claims within a certain number of days. The latter requirement should not apply to contested claims. Also, special provisions will apply to claims for which another carrier may be the primary payer. A common way to address this issue in a balanced manner is to allow a 2-month period for collection from the purported primary carrier. If unsuccessful, the managed health care plan would pay while awaiting resolution of the dispute.

At issue is the time in which the managed health care organization is required to pay on claims. Contracts frequently identify a specific time period (e.g., 30 to 60 days) during which payment on clean claims is to be made. Provider contracts rarely impose an interest penalty for late payment, reflecting the greater bargaining strength of the managed health care organization. Some contracts require the managed health care organization to make a good faith effort to pay within a specified period. From the provider's perspective, the weakness of this provision is that a good faith standard is probably too ambiguous to be enforceable. Some states have laws requiring insurers and HMOs to pay interest on late claims.

The contract needs also to address reconciliations to account for overpayments or underpayments. To avoid these issues from lingering for an inordinately long period of time, some managed health care plans limit the adjustment period to a specified period (e.g., 6 months). Also, some managed health care plans use contract provisions that do not allow for a reconciliation if the amount in controversy falls below a specified amount.

The most complex aspects of provider contracts are often the risk-sharing arrangements (see Chapters 9, 12, and 14). Risk can be shared with providers in significantly varying degrees depending on the initial amount of risk transferred, the services for which the provider is at risk, and whether the managed health care organization offers stop-loss protection. Risk pools with complicated formulas for determining distributions are frequently used both when services are capitated and when payments are based on a fee schedule. Although the primary objective of these arrangements is to create incentives to discourage unnecessary utilization, the complexity of many of these arrangements has confused providers and engendered their distrust when their distribution falls below expectations. Some managed health care plans that had complex risk-sharing arrangements are now realizing that simpler, more understandable arrangements are preferable. If the arrangement designed by the managed health care plan is somewhat complex, the provider's understanding will be greatly enhanced by the use of examples that illustrate for providers the total payments they will receive in different factual scenarios.

The most significant trend in provider payment arrangements has been the growth of arrangements where physician–hospital organizations (PHOs) or other integrated delivery systems are willing to accept a percentage of the managed health care plan premium as compensation for the services they provide (see Chapter 4 and 5). An important, related issue is the extent to which state regulators will want to oversee these arrangements directly or indirectly through licensure requirements applicable to the licensed entities to which the PHOs contract (see Chapter 53). The PHO assumes the role of a super-IPA as it becomes responsible for providing, or arranging for the provisions of, all or almost all the managed health care plan's services for enrollees assigned to it. In fact, the PHO does not typically provide services itself; the PHO arranges for the health services through affiliated hospitals, physician groups, and other health care providers. In developing its relationships with a managed health care plan, the PHO must be mindful of how it is transferring the obligations to provide services to its subcontractors.

The compensation arrangements typically provide that the PHO will receive a specified

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percentage of the amount that the managed health care plan or other payer receives. To reduce the risk of inappropriate adverse or favorable selection, the payment amounts may be adjusted to account for expected utilization based on demographic factors, such as age, sex, and other predictors of health care utilization. Also, the amount of risk assumed by the PHO might be limited until the number of enrollees assigned to the PHO reaches a critical size. The amount of compensation received by the PHO would be reduced to reflect the cost of services that the PHO does not assume responsibility for or stop-loss coverage that is provided by the managed health care plan.

Another issue to consider is whether the managed health care plan will have the right to have the services performed by other providers if it is not satisfied with the contracted provider's performance. Because the PHO is assuming virtually all the risk for the defined population, the PHO needs to consider carefully the assumptions that have been made regarding the demographics and health needs of the covered population.

In recent years, as providers gain more experience with managed health care plans, they are becoming more sophisticated in analyzing and evaluating payment arrangements and are more aware of the ability or inability of managed health care plans to produce the volume promised. A growing number of contracts are being renegotiated in light of the actual volume of patients that a managed health care plan is able to deliver to the provider. Contracts are also now beginning to allow volume as a factor affecting payment amount.

Some of the payment-related issues that should be addressed in a contract are as follows: What if services are provided to a person who is no longer eligible for enrollment? What if services are provided to a nonenrollee who obtained services by using an enrollee's membership card? Who has the responsibility to pursue third party recoveries? What are the notice requirements when the nonresponsible party finds out about a potential third party recovery? Some managed health care plans allow their providers to collect and keep third party recoveries, whereas others will require that the information be reported and the recovered amount deducted (see Chapter 32). One sensitive issue is the potential liability of a managed health care plan if a provider collects from Medicare inappropriately when another carrier under the Medicare secondary payer rules had primary responsibility. Under the regulations of the HCFA, the managed health care plan is legally responsible and may be forced to pay back the HCFA even if the payment was received by the provider without the knowledge of the managed health care plan. Managed health care plans should include a contract provision transferring the liability to the provider in this circumstance.

Another issue that should be addressed in the contract is the responsibility of the managed health care plan as a secondary carrier if the provider bills the primary carrier an amount greater than the amount the provider would have received from the managed health care plan. From the managed health care plan's perspective, it will want a contract provision relieving the managed health care plan of any payment responsibility if the provider has received at least the amount that he or she would have been entitled to under the managed health care plan–provider contract.

Hold-Harmless and No Balance Billing Clauses

Virtually all provider contracts contain a hold-harmless clause, under which the provider agrees not to sue or assert any claims against the enrollee for services covered under the contract, even if the managed health care plan becomes insolvent or fails to meet its obligations. A no balance billing clause is similar (and may be used synonymously) and states that a provider may not balance bill a member for any payment owed by the plan, regardless of the reason for nonpayment; the provider may bill the member for any amount that the member is required to pay, such as copayment or coinsurance, or for

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services not covered under the schedule of benefits (e.g., cosmetic surgery). Many state insurance departments (or other agencies having regulatory oversight in this area) will not approve the provider forms without inclusion of a hold-harmless clause containing specific language. HCFA also has adopted recommended model hold-harmless language applicable to federally qualified HMOs that was approved by the National Association of Insurance Commissioners.

Relationship of the Parties

Provider contracts usually contain a provision stating that the managed health care plan and the provider have an independent contractual arrangement. The purpose of this provision is to refute an assertion that the provider serves as an employee of the managed health care plan. The reason is that, under the legal theory of respondeat superior, the managed health care plan would automatically be liable for the negligent acts of its employees. Although managed health care plans frequently include a provision such as this in their provider contracts, it has limited value. In a lawsuit against the managed health care plan by an enrollee alleging malpractice, the court is likely to disregard such language and to focus on the relationship between the managed health care plan and the provider and the manner in which the managed health care plan represented the provider in evaluating whether the managed health care plan should be vicariously liable.

A related clause frequently used in provider contracts states that nothing contained in the agreement shall be construed to require physicians to recommend any procedure or course of treatment that physicians deem professionally inappropriate. This clause is intended, in part, to affirm that the managed health care plan is not engaged in the practice of medicine, an activity that the managed health care plan may not be permitted to perform. Another reason for this clause is to protect the managed health-care plan from liability arising from a provider's negligence.

Use of Name

Many provider contracts limit the ability of either party to use the name of the other. This is done by identifying the circumstances in which the party's name may or may not be used. Contract clauses may allow the managed health care plan the right to use the name of the provider for the health benefits accounts, the enrollees, and the patients of the participating providers. Otherwise, the party needs the written approval of the other party. The use applies not only to the name but also to any symbol, trademark, and service mark of the entity. The managed health care plan and the provider will want to ensure that proprietary information is protected. The contract should require that the provider keep all information about the managed health care plan confidential and prohibit the use of the information for any competitive purpose after the contract is terminated. With medical groups frequently switching managed care affiliations, this protection is important to the managed health care plan.

Notification

The managed health care plan needs to ensure that it is advised of a number of important changes that affect the ability of the provider to meet his or her contractual obligations. The contract should identify the information that needs to be conveyed to the managed health care plan and the time frames for providing that information. For example, a physician might be required to notify a managed health care plan within 5 days upon loss or suspension of his or her license or certification, loss or restriction of full active admitting privileges at any hospital, or issuance of any formal charges brought by a government agency. Although specific events should be identified in the contract, a broad catch-all category should also be included, such as an event that, if sustained, would materially impair the provider's ability to perform the duties under the contract. The contract should require immediate

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notification if the provider is sanctioned under the Medicare or Medicaid programs. If the managed care organization is contracting with a provider who has been sanctioned, the organization may no longer be eligible to receive Medicare and Medicaid funds.

In a hospital contract, the corresponding provisions would be when the hospital suffers from a change that materially impairs its ability to provide services or if action is taken against it regarding certifications, licenses, or federal agencies or private accrediting bodies.

Insurance and Indemnification

Insurance provisions in contracts are fairly straightforward. The obligations in the contract may be for both professional liability coverage and general liability coverage. The managed health care plan wants to ensure that the provider has resources to pay for any eventuality. The contract will state particular insurance limits, provide that the limits will be set forth in a separate attachment, or leave it up to the managed health care plan to specify. A hospital agreement may require only that the limits be commensurate with limits contained in policies of similar hospitals in the state. From the managed health care organization's perspective, it will probably want a specific requirement to ensure adequate levels of insurance. There also should be a provision requiring the provider to notify the managed health care plan of any notification of cancellations of the policy. Another needed notification in a physician context is notification of any malpractice claims.

Cross-indemnification provisions, in which each party indemnifies the other for damages caused by the other party, are common in contracts. One weakness of the clause is that some professional liability carriers will not pay for claims arising from these clauses because of general exclusions in their policies for contractual claims. Although these clauses are frequently used, this limitation and the fact that a provider should still be liable for his or her negligent acts suggest that these indemnification clauses are not essential.

Term, Suspension, and Termination

One section of most contracts identifies the term of the contract and the term of any subsequent contract renewals. Many contracts have automatic renewal provisions if no party exercises its right to terminate. Both managed health care plans and providers should give careful thought to the length of the contract and the renewal periods.

Some contracts give a right of suspension to the managed health care plan. In suspension, the contract continues, but the provider loses specific rights. For example, if a provider fails to follow utilization review protocols a specified number of times, the provider will not be assigned new HMO members or perhaps will receive a reduction in the amount of payment. The advantage of a suspension provision is that total termination of a contract might be counterproductive for the managed health care plan, but a suspension might be sufficiently punitive to persuade the provider to improve.

Termination provisions fall into two categories: termination without cause, and termination with cause. The value of having a provision that allows the managed health care plan to terminate without cause is that the managed health care plan need not defend a challenge by the provider on the substantive issue of whether the grounds were met. A 90-day period is fairly common. If the managed health care plan has the right to terminate without cause, frequently the provider will also be given that right. A regulatory issue to be aware of is that some state laws require providers to continue to provide services for a specified period of time after their contract has terminated. These requirements relate to the state's requirements for the managed health care plan to have protections against insolvency and have to be reflected in the contract.

Terminations with cause allow the health plan to terminate faster and should be used in situa-

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tions where the managed health care plan needs to act quickly. The contract might establish two different categories: one for immediate termination and another for termination within a 30-day period. Many contracts give either party a period of time to cure any contract violations. This time period, although useful to the managed health care plan if it has allegedly violated the agreement, extends the period of time in which it can terminate the contract. Grounds for termination for cause may be suspension or revocation of a license, loss of hospital privileges, failure to meet accreditation and credentialing requirements, failure to provide services to enrollees in a professionally acceptable manner, and refusal to accept an amendment to the contract agreement. A general clause also allows for termination if the provider takes any actions or makes any communications that undermine or could undermine the confidence of enrollees in the quality of care provided by the managed health care plan. This last clause has been variably interpreted by health plans and has been the subject of some state regulation. The clause should make clear that a physician is free to make medical recommendations, but is not free to disparage the plan.

The contract should be clear that a provider, upon termination, is required to cooperate in the orderly transfer of enrollee care, including records, to other providers. The provider also should cooperate in resolving any disputes. Finally, the provider should continue to furnish services until the services being rendered to enrollees are complete or the managed health care plan has made appropriate provisions for another provider to assume the responsibility. The contract should also be clear that the provider is entitled to compensation for performing these services.

In general, too little consideration has been given to preparing for contract terminations. When the provider and the managed health care plan enter into a contract, little thought is given to what will occur when the contract ends. Often, relationships end acrimoniously, and it is in both parties' best interest to consider how their interests will be protected in the event that the contract is terminated.

Declarations

In declarations, the parties provide answers to a number of "what if" questions. These clauses are common to all contracts.

A *force majeure* clause relieves a party of responsibility if an event occurs beyond its control. In a provider contract, this instance is more likely to arise if the provider is no longer able to provide services. In considering *force majeure* clauses, the parties need to distinguish between events that are beyond a party's control and those that disadvantage a party but for which the party should still be obligated to perform the contract's responsibilities.

A choice of law provision identifies the law that will apply in the event of a dispute. Absent a violation of public policy in the state in question, a court will apply the agreed-upon law. Frequently, lawyers draft contracts using the state in which their client is located without consideration of the advantages and disadvantages of the underlying law. In provider contracts where the managed health care plan and the provider are located in the same state, this clause has little relevance.

A merger clause specifies that only the language in the agreement shall constitute the contract. Such a clause prevents a party from arguing that oral conversations or other documents not included in the contract modify the contract's terms.

A provision allowing or not allowing parties to assign their rights is frequently included in contracts. Provider contracts usually prohibit a provider from assigning its rights under a contract. Some contracts are silent on the right of the managed health care plan to assign the contract. Silence would allow the managed health care plan to assign the contract. An option is to allow the managed health care plan to assign the contract only to an affiliate or a successor without the written consent of the provider.

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A clause identifying how the contract will be amended is almost always included in a provider contract. A contract will frequently give the managed health care plan the unilateral right to amend the contract absent an objection by the provider. This procedure is necessary when the managed health care plan has a large provider panel and it is administratively difficult to obtain the signatures of all the providers.

A severability clause allows the contract to continue if a court invalidates a portion of the contract. This is a common provision in a contract, but it is unlikely that the problem will arise.

Contracts also set forth a notice requirement identifying how notices are provided to parties and to whom. The manner in which notice is provided is important. If a notice requirement that the communication be conveyed by certified mail with return receipt requested, an alternative form of delivery is not valid. Parties should consider what is administratively feasible before agreeing on how notice will be given.

Closing

Both parties need to confirm that the parties identified at the beginning of the contract are the parties that sign the contract. Also, if a corporation is one of the parties, the signatory needs to be authorized on behalf of the corporation to sign the agreement.

CONCLUSION

The provider contract establishes the foundation for the working relationship between the managed health care plan and the provider. A good contract is well organized and clearly written and accurately reflects the full intentions of the parties. In drafting and reviewing provider contracts, the managed health care plan and the provider need to keep in mind their objectives in entering the relationship, the relationship of this contract to other provider contracts and agreements, and applicable regulatory requirements.

Chairman THOMAS. Do we have the next speedreader coming on? [Laughter.]

Mr. Stocker.

STATEMENT OF JOEL STOCKER, SHAREHOLDER, GREENBERG TRAURIG, MIAMI, FLORIDA

Mr. STOCKER. Mr. Chairman, I am Joel Stocker. I am a lawyer and shareholder with Greenberg Traurig. Greenberg Traurig is a law firm with 270 lawyers in Florida, New York, and Washington.

I have practiced for over 20 years, concentrating on health care transactions and regulations. I have negotiated and defended contracts on behalf of individual physicians, hospitals managed care companies and group practices, including for-profit and nonprofit entities.

Today, my written testimony focuses on contract terms, various relationships between physicians and physicians' managed care companies and hospitals. Today, I will center my oral testimony on two key points.

First, I urge you to focus on the purposes of contract terms and on the importance of the business matters they protect. Contracts between physicians and purchasers of physicians' services contain many terms that could be interpreted to impact physician-patient communication. However, these terms are designed to protect business interests: HMOs are concerned that physicians will convince patients to switch HMOs in order to further the physician's economic interests.

Second, this legislation broadly defines a physician-patient communication and, at least, in my opinion, it will have unintended consequences, impacting business interest provisions as well as medical care communications. Physicians today contract with various entities, hospitals, group practices, physician networks, and managed care companies. Attached to my written testimony is a chart describing these contracts.

While physician agreements with different entities contain many differences, they are similar in several respects. The physician is required to provide professional services, but also has obligations to the entity contracting with the physicians. The following are contract term basics: Provisions requiring the delivery of physicians' services; the physician is required to provide services according to the rules and ethics of the physician's profession; provisions on the scope and price of services; provisions regarding the term of the contract and its termination; provisions requiring compliance with quality and other regulations, and provisions protecting the business interests of both parties.

Because it is the physician who develops a direct personal relationship with the patient, the physician often has the ability to influence health care purchasing decisions. This ability to influence decisionmaking is sometimes exercised for medical reasons, but also has been used for personal gain.

Examples include a physician who wants to leave a group practice for a better offer or who has a better contract opportunity with a different managed care company. Consequently, the managed care entity, network, or group practice will include a business in-

terest protection provision that restricts a physician's ability to move to one plan or location and take away patients.

Combining professional and business obligations sometimes creates tension in a business relationship. However, in my experience, it is generally understood that physicians must exercise their professional medical judgment in providing health care services. They must abide by the rules of their profession. Parties to these contracts generally understand and abide by that principle. However, as Congress examines contract terms and provider relationships, it is important to distinguish between communication about business relationships and communications about medical care.

I personally have never seen a term in a contract that restricts communications applied to medical care options. That is not to say that examples do not exist. However, these provisions are generally written to protect business interests and are applied in that way.

Let me describe a few provisions that I consider business interest terms of a contract. They include noncompetes, antidisparagement and confidentiality of business information. Such terms include restrictions on disparagement in the solicitation of members. Group practices, managed care companies and networks attract patients to their groups, plans and networks and want to protect these relationships. For that reason, they include similar provisions in their agreements with physicians. These provisions are developed to keep physicians from aggressively discrediting the managed care companies and moving large numbers of patients to other plans.

Confidentiality provisions protect managed care companies, groups and networks from having other companies and providers know what they pay for their services. It protects their member lists and it protects their unique methods of doing business. These terms are generally not directed at controlling the flow of medical information between doctor and patient.

Medical care is changing and physician agreements are also changing. Sometimes changes have positive and negative results. The doctor-patient relationship is probably not as intimate as it once was and it is certainly not as unfettered. The decision before you is whether this competitive health care market calls for more Federal regulation or whether the market, bound by professional ethics, malpractice considerations, accreditation requirements, customer satisfaction and the good faith of professionals is enough to prevent significant abuse.

Thank you.

[The prepared statement and attachments follow:]

STATEMENT OF JOEL STOCKER
on behalf of
GREENBERG TRAURIG

Introduction

Mr. Chairman, I am Joel Stocker, a lawyer and shareholder with Greenberg, Traurig. Greenberg Traurig firm with over 270 lawyers in Miami, West Palm Beach, Orlando, Ft. Lauderdale, Tallahassee, New York City, and Washington, D.C. I am a heal care lawyer and have practiced for over 20 years, concentrating in health care transactions and regulation. I have negotiated and defended contracts on behalf of individual physicians, hospitals, managed care companies, and group practices including both for-profit and non-profit entities. My experience enables me to provide members of the Committee with an understanding of the rapidly changing health care environment, the growth of contracting between various providers and entities, and some of the practical considerations of provider relationships.

When I started practicing law the doctor-patient relationship was much simpler. Most health care plans were indemnity products where physicians were paid their charges, and where patients were responsible for high co-payments and deductibles. In an indemnity plan, the patients makes a claim on an insurance policy and the physician has no relationship to the insurer.

Then premiums began to rise. Employers found it increasingly difficult to pay for the cost of health care, and began to offer managed care plans to their employees. Managed care typically involves employed or contracted physician services where physicians have a direct or indirect contractual relationship with a managed care company.

Change has also occurred in the way physicians practice medicine. Physicians are increasingly employed by either other physicians, physician service companies, hospitals or managed care companies Physician contract relationships with these entities deal with many of the same issues that exist in the managed care contracting arena.

The health care system has changed, and the role of physicians in supervising and defining health care services for patients is evolving. Physicians no longer make independent decisions regarding the care for a patients without considering of the price of the care. Patients now select physicians not only based on reputation of that individual physician, but also on the reputation of the physician group and the health plan network. Physicians are often employees with employment contracts; are joined with other physicians in a network or group practice; or have multiple contractual relationships with a variety of health care plans. As a result of these changes, the contractual relationship between physician and those to whom they provide services has become increasingly important. Through those contract relationships, decisions on how, when, and where health care is provided is shared between the patients, the physician and the contract entity.

Today, my testimony will describe various types of contracts, including an examination of contract terms, when they are used, and the impact they have on medical care for patients. I will center my discussion on four key points:

(1) Although there are several types of contracts that physicians have with managed care companies, physician group practices, physician networks, and hospitals the terms of the contracts tend to be similar.

(2) Many of the contract terms between physicians and these other entities relate to business matters, not to physician - patients communications.

(3) Most of the business contract terms are designed to protect against a physician taking or moving a block of patients for economic, not medical reasons.

(4) Medical decision making is governed by ethics, state licensing, accrediting bodies, medical liability, and customer satisfaction.

Relationship to Patients

Physicians today contract with various entities: hospitals, group practices, physician .etwc ':s, and/or managed care companies.[1] These entities are modeled in various fashions:

Group Practice/Physician Company

These entities provide physician services, generally by hiring physicians. The entities then contract with managed care companies, IPAs and other Service Provider Networks to provide physician services. Physicians contract with these entities either as employees or independent contractors. Although a physician may have an ownership interest in one of these entities, increasingly, they are large companies that employ physicians.

IPAs/Networks

These are entities that contract with physicians and physician companies to provide services throughout a geographic area. These companies may be physician, hospital, or investor owned. While some such entities are single specialty providers, (e.g. surgical IPA), many provide comprehensive services in wide geographic areas, contracting with multiple managed care plans. They often contain their own credentialing, utilization review/quality assurance, provider and member relations functions, and claims administration functions.

These large scale entities often resemble managed care companies, without the marketing and regulatory compliance functions (they rely on the managed care company for those services). By **not** being directly competitive with managed care companies, they are able to sell their services to multiple managed care services (often for a percentage of the managed care company's total premium).

The IPA/network typically enters into provider contracts with physician groups, IPA/network agreements tend to be very much like physician provider agreements with managed care companies. This is because they ultimately sell services to managed care companies and also because they have similar business interest to protect; provider agreements typically contain non-competition, non-disparagement provisions, etc. These intermediary entities then contract with managed care companies, by providing physicians and services.

Managed Care Companies

Managed care companies, such as HMOs, EPOs, and PPOs, enter into provider agreements with physicians, physician groups, physician service companies, and IPAs/networks. These provider agreements enable managed care companies to provide physician and other health care goods and services to the public. Managed care companies are also able to control the price and quality of the services they render through the provider agreements. Managed care is different from traditional indemnity or fee-for-service care. Managed care controls price through negotiated agreements. Such agreements set a contract price for services, and, ensure quality by selecting providers and monitoring the care provided. Managed care companies are regulated (typically on the State and Federal levels) and , consequently, provider agreements contain provisions to assure regulatory compliance. In addition, provider agreements contain typical business provisions.

Increasingly, managed care companies prefer to contract with larger scale physician entities (group practices, practice companies, IPA/networks), rather than individual physicians. They do this for several reasons: 1) larger entities become involved in the care management process and often share risk with the managed care company; 2) there is less administrative cost in contracting with larger groups; and 3) by aggregating volume, better pricing for services can be negotiated, thereby lowering overall premium costs.

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[1] See Attachments

Contract Terms

Physicians have a variety of relationships with these entities. Sometimes physicians are employed and provide their services to a single entity (physician or group practice); and sometimes they are independent contractors that have contracts with multiple managed care companies, hospitals, networks and/or IPAs. While there are a lot of differences between the types of contracts that are underwritten, they all cover certain basic contract terms.

Scope and Price of Services

These contract sections describe the services the physician is responsible for and how much the physician is paid. There is a greater variety in provisions governing the scope of services and the method of payment. Approaches vary depending on the structure of the provider network and the capabilities and objectives of the parties. We are seeing creative approaches to these issues being proposed by both physician groups and managed care companies. These approaches often include bundling services (physician, hospital and other services) and risk sharing.

Term and Termination

These contract provisions set forth the duration of the agreement and the conditions under which the agreement can be terminated. Some agreements contain no set term -- they are terminable at will. However, others contain a term of one or more years. Early termination covers such issues as material breach, loss of license, etc.

Protection of Business Interests

These provisions protect the relationship of the contracting party with the physician. Generally, the contracting party, rather than the physician, is responsible for obtaining the patient. For example: A patient is generally insured as a result of the marketing efforts of a managed care plan to an employer group. Because the physician develops a direct, personal relationship with a patient, the physician often has the ability to influence health care purchasing decisions. This ability to influence decision making is sometimes exercised for medical, but has often been used for personal gain - the physician wants to leave a group practice for a better offer or has a better contract opportunity with a different managed care company. Consequently, the contracting party (group practice, IPA, managed care company, etc.), includes contract provisions to restrict the physician's ability to move and take the patient.

Quality, Regulatory Compliance and Other Issues

Agreements contain a wide variety of requirements to ensure compliance with quality, licensing requirements, and other regulations. These terms vary depending upon the nature of the agreement. For example, physician provider agreements between managed care companies and IPAs/networks generally contain numerous provisions to ensure quality and regulatory compliance. Physician employment agreements with hospitals often contain provisions regarding licensing and board certification.

Similarities Between Agreements

While physician agreements with different types of entities contain many dissimilarities, they also are becoming remarkably similar in certain respects: the physician is becoming more like other professionals that are employed by large enterprises, such as large scale law, accounting and engineering firms. The physician continues to provide professional services (and is bound by the ethics and rules of the physician's profession), but also has obligations with which the physician contracts. The entity retaining the physician has developed a business, and business relationships with third parties (consumers and other purchasers of health care services) and has an interest in protecting those relationships.

Professional and business obligations sometimes create tension in a business relationship. However, in my experience, it is generally understood that physicians must abide by the constraints of their profession and with community standards of care. The business that contracts with time respects and supports [illegible] 's not to say that problems don't exist, but they are the exception rather than the rule.

Current legislation by Congress focuses on contract terms that protect the business relationship and terms that describe termination of contractual agreements. More specifically, the legislative focus is on health plans and contracts with providers. The following describes how contract terms among the variety of contracts work in practice.

Communications between Patient and Physician

As Congress examines contract terms and provider relationships, it is important to distinguish between communication about business relationships and communications about medical care. I have never seen a term that restricts communication with respect to medical care options. While there are some examples of communication restrictions, they are generally not used in the context of medical care options. There are clauses, however, that are written to protect business interests.

Contract Terms Protecting Business Interests

There are a variety of contract provisions that are used to protect the business of the group practice, managed care company, or hospital network. Provisions include non-competes, anti-disparagement, and confidentiality of business information.

Managed care companies often include restrictions on disparagement and solicitation of members. Managed care companies and networks attract employers and patients to their plans and networks, and have an interest in protecting these relationships. Managed care companies use these provisions to keep physicians from moving large numbers of patients to other managed care companies, and from aggressively discrediting their business or company.

Managed care companies also use confidentiality provision that prohibit the disclosure of confidential information. Such provisions are intended to protect information about the managed care company with respect to that company's costs or fees to physicians, the company's member lists, and information about the company's business methods. Confidentiality provisions are not generally directed at controlling the flow of information between doctor and patients.

In addition, some agreements contain provisions prohibiting a physician or physician network from entering into similar agreements with other managed care companies. In my experience, these provisions tend to be enforced only in egregious cases.

These terms are enforced via threat of termination or legal proceedings. Physicians and group practices generally use non-competes and anti-disparagement clauses to protect the patient base and the reputation of the group. Whether we like it or not, these entities entering into agreements have become big businesses and the contracts involve millions of dollars. We should not think that these agreements focus on a particular patient's relationship with that patients' personal physician.

Termination Clauses

When relationships deteriorate, parties begin to think about contract termination. The issues range from getting out of a bad or undesirable relationship to what happens when the agreement is terminated. Commonly used concepts include the following:

> **Termination without cause**
> This allows a party to terminate an agreement for no reason. Generally the right to terminate without cause is mutual -- either party can exercise it. Physician employment agreements with group practices or physician service companies are

often terminable without cause.

Termination following the end of a term
Agreements often for a term of one or more years. The trend in managed care agreements is a one-year term. At the end of the term, either party can elect to renew, renegotiate or terminate the agreement. This gives the parties the certainty of a one-year agreement, but the ability to move away from it if conditions change.

Termination with cause
This allows a party to terminate if the agreement is materially breached. Most contracts contain these provisions. Generally, a party can terminate an agreement "for cause" on limited, or without any, notice. Where a breach is curable, contracts often provide for a cure period. The breaching party corrects the problem and the contract continues. Where there is a major problem, such as endangerment to the safety of patients, agreements can generally be terminated immediately.

Non-competition and confidentiality
A non-compete term/clause will typically restrict a physician from practicing within a geographic area (1 mile to several counties) of the former employer for a period of time (one year to several years). The scope of these restrictions is often limited by state law. Non-competes and confidentiality provision often continue after the end of an agreement. However, sometimes non-compete provisions bind a party only in certain circumstances. For example, a non-compete may not bind a party if the other party has materially breached the agreement.

These types of continuing obligations appear in both employment and independent contractor agreements. The most restrictive provisions are often used by group practices and physician services companies. When a physician is terminated, the physician must leave the geographic area because of non-compete requirements, and must often resign medical staff privileges at the hospital. Physician groups and medical practice companies view their relationship by requiring physicians that they terminate to leave the patient behind.

Managed care provider agreements may also use these types of continuing obligations. However, their use tends to be more limited than in the physician employment contract.

Medical Care Decisions
Physician contracts also contain provisions that require the physician to abide by ethical standards, remain licensed, be board certified, etc. However, these provisions often mirror governmental and accrediting body requirements. They give the right to terminate the agreement if the physician fails to meet professional standards. A physician must continue to abide by professional standards and requirements: physicians, managed care companies, and the courts recognize this as an overriding principal. Consequently, communications between doctors and patients are required to meet ethical standards. These communications are generally respected by those who contract for physician services.

Medical care decisions are also influenced by malpractice litigation. Physicians are obligated to provide services that meet community standards of care, and physicians are legitimately focused on practicing defensive medicine. A physician's obligation to practice according to community standards often influences decision making and will cause a physician to "do the right thing." This may be a communication to a patient or a referral to a specialist. In my experience, managed care companies will not "go after" a physician for making decisions according to community standards. Managed care companies may not cover the cost of service, but they will typically not "punish" the physician for making the communication or advocating for the patient.

Lastly, both physicians and the entities with whom they contract with are influenced by customer and public opinion of quality and service. In a competitive health care environment, no provider or managed care company wants to be known as a company that gives bad or inadequate care. Consumers and their employers increasingly make health care

purchasing decisions based upon publicly disclosed evaluations, accreditation ratings and adverse news reporting. These important factors tend to keep both physicians and especially managed care companies in check. Without a good quality reputation, employers and their employees will simply choose another plan or another physician.

Conclusion

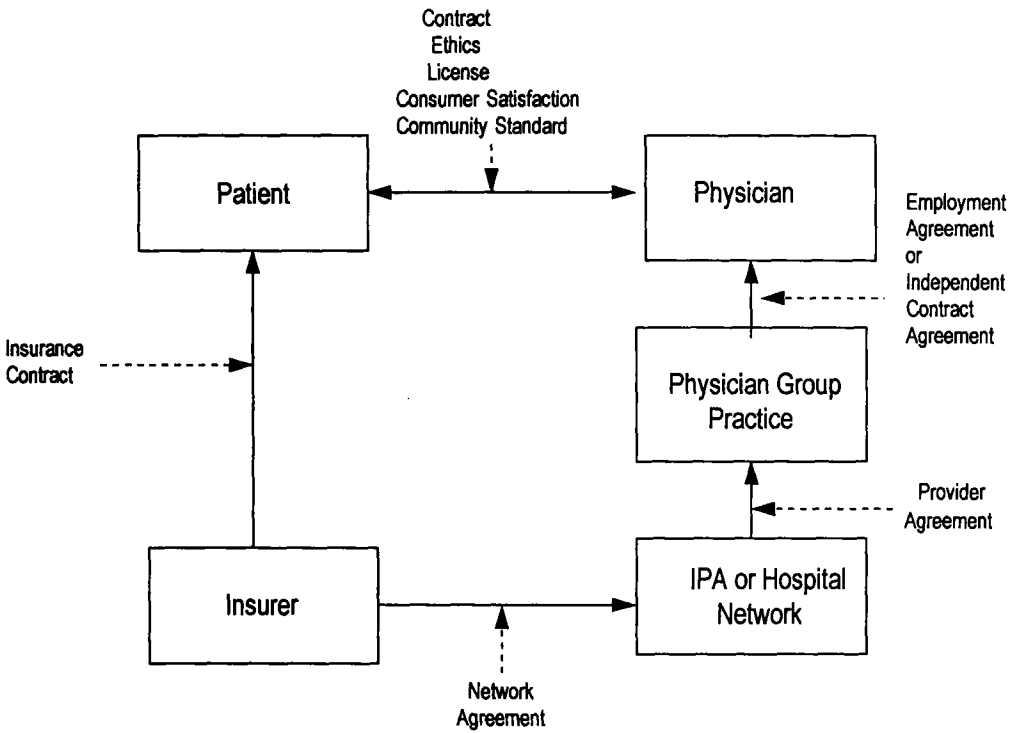
Medical care is changing, and physician agreements are also changing. Sometimes, changes have both positive and negative results. The doctor-patient relationship is probably not as intimate as it was, and it certainly is not as unfettered. Many health care markets are moving in the direction of managed care provided by large scale organizations that contract with physicians. This is a firmly established trend. The issue before you is whether the situation calls for more federal regulation, or whether the market, as influenced by professional ethics, malpractice considerations, accreditation requirements, customer satisfaction, and the good faith of professionals, can prevent significant abuse.

Attachments

Managed Care Network Requirements

- Members restricted to use network
- Managed care company obligated to assure quality & availability
- Managed care company must negotiate competitive price for medical services & limit over utilization of care

Determining Which Contract Applies



Term and Termination

	Employer	Managed Care	IPA/Network	Hospital Network
Termination at will	+/-	—	√	√
Term of Years	√	√	√	—
For Cause	—	√	√	√
Due Process	√	√	√	√

Protecting Business Relationships

	Employer	Managed Care	IPA/Network	Hospital Network
Non-Solicitation	√	√	√	√
Non-Compete	√	—	√	—
Non-Disparagement	—	√	√	√
Confidentiality	√	√	√	√
Resignation of Staff Privileges	√	—	—	—

Chairman THOMAS. Mr. Rust.

STATEMENT OF MARK E. RUST, PARTNER, KAMENSKY AND RUBINSTEIN, CHICAGO, ILLINOIS

Mr. RUST. Thank you, Mr. Chairman and Subcommittee Members. I am pleased to testify before you today and I commend the Subcommittee and Chairman Thomas for holding this important hearing on an issue of great concern to physicians and their patients.

My name is Mark Rust and I am a partner in the law firm of Kamensky and Rubinstein in Chicago and Lincoln Wood, Illinois. We represent some 3,000 physicians throughout the country, either individually or in groups. I might also add that, I am the former chair of the American Bar Association's Medicine and Law Committee, in the tort and insurance practice section. Accordingly, I have had the opportunity to review a wide variety of managed care arrangements.

Mr. Chairman, the managed care contract, when running between an MCO and an individual physician or a small physician group, is a virtual contact of adhesion. It is between two parties of grossly unequal bargaining power. Further, the contract is filled with arcane jargon. Physicians rarely ask their attorneys to review these agreements prior to signing them. They perceive that there is little likelihood that the MCO will be willing to change anything but the most minor items. In my experience, that expectation is reasonable.

As a result, these agreements contain a variety of clauses to which most sophisticated commercial parties would never agree. I describe them more fully in my written statement in order to illustrate why physicians are in no position to spot, much less negotiate out provisions that might negatively affect their patients.

In addition to clauses that allow an MCO to terminate for a breach, such as a gag clause, virtually every such agreement with physicians has a clause that allows the MCO to terminate a physician without explanation on short notice. Given the existence of the without-cause termination provisions, the relative rarity of the crude clause that gags the physician from fully communicating to his or her patient is not striking. The existence of a single such clause generates emotion in the physician community because it articulates what physicians perceive the be the unwritten policy of certain MCOs to punish those physicians who discuss with patients the economic limitations on their treatment options.

Given the power virtually all plans have of terminating the physician on 60-days notice for no reason, physicians fear the existence of a gag policy in each MCO relationship whether the ban is explicit or implicit. Sometimes, such policies are explicit, though not nearly as bold as those that have recently been reported and that we have seen just a moment ago.

One common example is the provision that forbids a physician from counseling a member to sign up with another plan. At first blush, this clause sounds commercially reasonable. Consider, however, this dilemma. When a patient asks her physician whether the physician will be able to provide cutting edge cancer treatment in the event the tests show the patient has breast cancer, how should

the physician respond. If she tells her patient that the plan might not pay for such treatment, the patient will ask, which plan does pay? In that conversation the physician will likely breach her agreement with the MCO, because the net effect of her answer to her patient may be that the patient switches into another plan.

Even when such a policy is not contained in an agreement, an MCO may mean such physician/patient communications reason enough to terminate the physician without cause. I believe the without cause termination provision was employed recently in one midwestern city to chill patient communications. The MCO accounted for approximately 25 to 30 percent of patients in the city. It decided unilaterally that it would switch all of its obstetricians and gynecologists from fee-for-service individualized capitation payment.

Most physicians do not feel they could afford to lose 30 percent of their practice. Even if they could, their loyalty to their patients prevented them from leaving the plan. But, many physicians informed their patients of the new compensation policy of the MCO. Because it was open enrollment season for most employers, the MCO began to notice an immediate loss of customers.

In response, the MCO contacted many of those obstetricians and advised them that it could end the relationship shortly without having to state a reason. It appeared from my observation that the advice had its desired effect, the obstetricians discontinued discussing the matter with patients.

Nothing could be more appropriate than a physician fully disclosing to a patient that he or she now has a financial incentive to not treat rather than to treat. Nothing could be more appropriate than a gynecologist advising her patient in advance of a pregnancy that her plan provides only for a 24-hour stay at the hospital after labor and delivery.

The commercial result of such communication, however, may be that the patient switches plans. In such an event, a physician should not fear retaliation and in case retaliation occurs, she should not be left on why it occurred.

Physicians should not be exempt from the normal rules of contract, but written and unwritten policies, whether communicated directly to the physician or not that chill communication between physician and patient should be disfavored in the law.

When patients are confused by the relentless news of new therapies and new methods of medical payment, they will inevitably try to sort these issues out by talking with the party they trust most, their physician. They should have that right.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF MARK E. RUST
PARTNER, KAMENSKY & RUBINSTEIN
CHICAGO, ILLINOIS
TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIONS
RE: PATIENT RIGHT TO KNOW ACT OF 1996
JULY 30, 1996

MR. CHAIRMAN:

My name is Mark E. Rust. I am an attorney who concentrates his practice in health law, representing primarily physicians and physician groups throughout the midwest. I also am the former Chair of the American Bar Association's Medicine and Law Committee of the Tort and Insurance Practice Section. In addition, I am a member of the Standing Committee on Legislation of the Illinois State Bar Association, which will be considering a measure similar to the one before the Subcommittee for recommendation to the Illinois legislature this fall.

I am a partner in the law firm of Kamensky & Rubinstein in Chicago and Lincolnwood, Illinois. We represent some 3,000 physicians, either individually or in groups of varying size. Accordingly, I have had the opportunity to become quite familiar with a vide variety of managed care contracts and have gained an understanding of the difficulties physicians encounter under such contracts. I am pleased to have the opportunity to testify before you today about managed care contracting arrangements that have the effect of inhibiting physician-patient communications. I commend the Subcommittee and Chairman Thomas for holding this important hearing on an issue that is and has been of great concern to physicians and their patients.

I understand that H.R. 2976 is intended to help resolve the so-called "gag clause" controversy in managed care/physician contracting. I would like to describe for the Committee why enactment and enforcement of laws banning the prohibition on free communication between physician and patient, whether those prohibitions are written or unwritten, is so important to physicians. As a preliminary matter, however, it may be helpful to explain the general nature of contracts between managed care organizations, which I will call MCOs, and physicians from the perspective of an attorney who represents physicians.

The managed care contract, when running between an MCO and an individual physician or a small physician group, is a virtual contract of adhesion. I am well aware that, because it is between two sophisticated parties, the contract is unlikely ever to be deemed a contract of adhesion as a matter of law. But in most other respects, it is. It is between two parties of grossly unequal bargaining power. With managed care penetration at an all time high and rising, most physicians can ill afford to reject offers to join MCO plan panels. Further, the contract is filled with arcane jargon. Interpretation of the finer points of these agreements can be difficult for attorneys who do not specialize in health care law, and virtually impossible for physicians reading the agreement on their own. The non-price terms are rarely brought to the physician's attention after execution. Accordingly, most such agreements remain in file drawers, unexamined, for years.

Physicians rarely ask their attorneys to review these agreements prior to signing them. They perceive that it is not worth paying the fees associated with such reviews because there is little likelihood that the managed care organization will be willing to change anything but the most minor, ministerial items. In my experience, that expectation is reasonable. Further, most physicians do not have attorneys who understand a great deal about managed care. It follows that what little legal advice they do obtain is unhelpful.

As a result, these agreements are filled with a variety of clauses that most reasonably sophisticated commercial parties would never agree to. Methods of payment are often stated to be at a certain rate, subject to change on little or no notice in the sole discretion

of the MCO. Physicians are required to abide by rules and regulations incorporated by reference and contained in a booklet that the physician never receives. Further, those rules are usually subject to change on little or no notice and violation of the rules are cause for material breach. Indemnity clauses are common. These clauses require the physician to pay all awards and costs associated with any liability suit brought against the MCO that was prompted by the physician's alleged negligence. Physicians are unaware that their voluntary agreement to this clause will cause them to be held personally liable for the full amount of such awards and costs: malpractice insurance will not cover such voluntary obligations. Most agreements provide that in the event a payor fails to pay or goes bankrupt, the physician -- who is already obligated to refrain from seeking payment from the patient -- will simply assume the loss on all such patients.

I am well aware that this Committee is uninterested in the plight of physicians with respect to the commercial terms routinely forced on them by MCOs. I simply recount a handful of them here for your examination as background in explaining why physicians are in no position to spot -- much less negotiate out -- provisions that might negatively affect their patients, such as prohibitions or inhibitions on free communication with patients in written policy or in practice.

But before I turn to that subject, let me describe a related subject. It is the single most important non-fee related commercial term that most physicians do understand in their agreements: the "without cause" termination provision.

Virtually every managed care agreement with physicians has a clause that allows the managed care organization to terminate a physician without cause and without explanation on short notice. This clause appears to be reciprocal in the sense that the physician may also terminate on 60 or 90 days notice, but usually the physician is prevented from such termination if the MCO is experiencing difficulty in replacing him or her. Even without that restriction on the physician's ability to terminate, the physician would be prevented ethically and under the common law from discontinuing seeing the patients covered under the MCO in the event the MCO failed to pay and could not replace the physician.

This clause is relevant to our discussion today on "gag" policies even when those policies are not stated directly in the contract. In most cases, the physician lives in constant fear of being terminated without cause for the same reason he or she feels compelled to initially enter into the agreement: many MCOs control a large market share of patients, and such a termination might overnight wipe out a large percentage of the physician's practice. Worse, most MCO credentialing applications ask whether the physician has ever been terminated from a plan. An affirmative answer to this question can be fatal to the application. And since a without cause termination never requires an explanation by the terminating party, no explanation can be given for this blot on his or her career when the physician next applies to participate on an MCO panel.

Given these facts, the relative rarity of the crude, overt clause that "gags" the physician from fully and freely communicating to his or her patient is not striking. When such a clause is noted by investigators and held up to scrutiny in the press, as it has been in recent months, the question naturally arises: How common are such clauses? And: Are they ever enforced? In my experience, the answers are: probably not very, and probably not often.

But the reason the existence of a single such clause generates such a groundswell of emotion in the physician community is that it perfectly articulates what physicians believe to be the real policy of certain unscrupulous, profit-driven, market-share motivated MCOs: terminate those physicians who don't "play ball". They believe MCOs will punish those physicians who fully discuss with patients the economic limitations on their treatment options under their managed care plan. When combined with the option virtually all plans have of terminating the physician on 60 days notice without the necessity of providing a reason, physicians have good reason to fear the existence of a gag clause in each such MCO relationship, whether the ban is explicit or implicit.

Sometimes, such clauses are explicit, though not nearly as direct and bold as those that have recently been reported. For example, I would put the following clause, which is fairly common, in the category of "gag clause" because of its chilling effect on communication between physician and patient:

> "During the term of this agreement, provider shall not advise or counsel any member to disenroll from the HMO, and will not directly or indirectly solicit any member to enroll in any other HMO or PPO or similar health care service plan or insurance program."

At first blush, this clause sounds commercially reasonable to one not sensitive to the physician-patient relationship. Naturally, the HMO wishes to protect what it perceives to be an economic property interest in its patients. In consideration for allowing the physician to intrude into the relationship it maintains with those patients, it desires to prevent her from providing any advice to the patient that would have the effect, directly or indirectly, of causing that patient to switch out of the HMO and into a standard indemnity insurance plan.

It sounds reasonable, that is, until you consider the predicament of a physician at the conclusion of her patient examination. When the patient asks her whether she will be able to provide cutting edge cancer treatment in the event that tests show the patient has breast cancer, how do you suppose the physician will respond?

If the physician answers fully -- that the patient's plan might not pay for such leading edge treatment -- the conversation will logically progress to plans or programs that would. In that conversation, the physician will likely materially breach her agreement with the MCO, because the net effect of her answer to the question may be that the patient switches into an indemnity or other plan to be sure of coverage in the future. In short, the physician may have effectively counseled the patient to disenroll from the HMO

Despite its otherwise commercially reasonable appearance, this clause prohibiting such free communication between physician and patient is unreasonable in practice when applied to the relationship between patient and physician. No party to this agreement should have a proprietary interest in a human being -- the patient -- that is subject to the application of commercial law. The MCO is first and foremost an insurer. The patient has simply chosen it to manage the provision of care and provide coverage, as inexpensively as possible, from the risk of loss associated with that care.

Neither does the physician have a proprietary interest in the patient. The physician does, however, have duties to the patient that are well settled in law and provide the foundation of what we refer to as the physician-patient relationship. The physician has the duty to diagnose and recommend a course of treatment to the patient. The physician has the duty to treat and not abandon the patient. And she has the duty to fully inform her patient, free of commercial concerns, of all relevant treatment options.

Even when such a clause is not contained in an agreement, an MCO may deem the physician-patient communication described above, which results in a patient leaving the MCO's plan, as reason enough to terminate the physician "without cause". In the past 24 months I have witnessed many occasions of physician clients terminated without cause and without explanation. In each case the physician suspects that the termination is the result of over-aggressive patient advocacy, but it is impossible to test the theory because no explanation need be given.

It is virtually impossible to bring an action against the MCO to discover the reason for the termination under the current state of the law. In one freak circumstance, where we were able to properly threaten an action because of a unique set of facts, the MCO relented and provided the reason for the termination. The physician had apparently been unhappy with the processing of patient claims and the MCO feared he was discussing the subject with

patients. The MCO acknowledged that it, like other MCOs, terminate only when a provider no longer meets their selection and retention criteria, which are extra-contractual and not shared with the physician or the public. In this case, apparently, the retention guidelines called for the dismissal of physicians who complained too loudly about claims processing for fear they may share their frustrations with their patients.

I have also been involved recently in a situation where the "without cause" termination provision was employed to chill patient communications that a plan thought was injurious to its commercial health. This incident occurred in a midwestern city of significant size. A managed care organization that accounted for approximately 25%-30% of patients in the city decided unilaterally that it would switch all of its obstetrician and gynecologist providers from fee-for-service to capitation payment. The payment was to be provided to each obstetrician and gynecologist individually, rather than through a legitimate network that could accept actuarial risk. (As you are no doubt aware, capitation is a single payment, per member per month, made to a provider to cover all services required by a patient population in a given month. If services provided are few, the provider makes more money. If services are great, he loses.)

Most physicians did not feel they could afford to lose 30% of their practice. Even if they could, their loyalty to their obstetrical patients prevented them from doing so. As a result, most continued to be providers. But many physicians fully informed their patients of the new compensation policy of the MCO.

Because it was open enrollment season for most employers at that time, and because women inevitably drive the decision to choose a health care plan on behalf of themselves and their family, the MCO began to notice an immediate loss of customers.

In response, the MCO, through its agents, contacted large numbers of those obstetricians and advised them of the possibility that the MCO could end the relationship shortly without having to state a reason. It appeared from my observation that the advice had its desired effect. The obstetricians and gynecologists discontinued discussing the matter with patients.

That was a good illustration of how an MCO can use its power to terminate without giving a reason, thereby stifling what I believe to be legitimate physician communication with patients. Nothing could be more appropriate than a physician fully disclosing to a patient that he or she now has a financial incentive to not treat, rather than to treat, a patient. Nothing could be more appropriate than an obstetrician advising her patient in advance of a pregnancy that her plan provides only for a 24 hour stay at the hospital after labor delivery. The commercial result of such communication, however, may be that the patient switches plans. In such event, a physician should not fear retaliation; and in case retaliation occurs, she should not be left to speculate on why it occurred.

With that in mind, I would support, at a minimum, passage of H.R. 2976. However, while it provides some protection for the physician-patient relationship, it does not address all of the concerns I have expressed in this testimony. I will note, for the record, three significant defects the Committee may wish to consider.

First, the prohibition on restricting medical communication between a health care provider and patient or guardian is limited only to those restrictions that are part of a written or oral communication made to the provider. This does not cover the concerns of a vast number of physicians, who believe they might be terminated for violating an internal MCO policy on physicians who speak too freely with patients, which policy was never communicated to the physician. This concern could be alleviated by simply deleting the phrase "to such a provider" contained at lines 15 and 17 (Section 2(a)(1)(B) and (C)).

Second, the definition of "medical communication" provided in Section 2(b) is not broad enough. Using this definition, a physician who fully disclosed to a patient the capitated method by which she is paid and its possible impact on the patient's care, would

not be engaged in a protected communication. If such communication had the effect of causing the patient to disenroll from the MCO and enroll in an indemnity plan, the physician could be in breach of her agreement to not "directly or indirectly" cause such an occurrence.

Third, enforcement through civil monetary penalties, although helpful, is not, in my view, sufficient. Providing physicians with a private right of action to enforce those restrictions as private attorneys general will force MCOs to be conscious of their obligations to not interfere in the physician-patient relationship. It would give the physician the right to ferret out the reasons for her termination and the motivation to determine its legitimacy.

Physicians should not be exempt from the normal rules of contract law. But the provider agreement between an MCO and a physician is not a normal contract. It has a direct and profound effect on a human being who is not a party to it -- the patient. Throughout this century, state and federal laws have focused on the protection of patients, given the commercial realities of our private health care system. Such concerns are evident in restrictions on fee splitting and the corporate practice of medicine. The latter concept is analogous to the regulation of MCO agreements as they affect patient care, in that both seek to shield the doctor-patient relationship from purely commercial concerns, divorced from common law duties and medical ethics.

In addition, to the degree that such contracts are indeed similar to contracts of adhesion, there is ample legal precedent for legislative oversight, much as is common in policies of insurance and landlord/tenant relationships.

In conclusion, written and unwritten policies, whether communicated directly to the physician or not, that have the effect of chilling communication between physician and patient should be disfavored in the law. This is especially true in an age when managed care organizations, through acquisition, merger, or otherwise, are controlling an increasingly larger portion of the patient population. When patients are being barraged with shrill commercial claims by such plans, and confused by the relentless news of new therapies and new methods of medical payments, they will likely try to sort these issues out by talking with the party they trust most: their physician. They should have that right.

Mr. ENSIGN. I would like to thank the panel.

We will just take a couple of questions here real quick with all of you.

First of all, could you maybe just go down the line and tell me what, say, three or four top concerns that you see that physicians have when they're negotiating their contracts with managed care.

And if each of you would respond.

Dr. KONGSTVEDT. That question is a very moving target, because the old world of individual solo practitioners in small groups negotiating is rapidly giving away to large organized systems of care, through physician hospital organizations, MSOs, management service organizations, vertically integrated, integrated systems and so forth.

There is very rapid movement toward global capitation in which the providers are now receiving a large global capitation and the very issues being debated today are now becoming internal to the provider system and external to the HMOs.

So, it is very difficult to answer that question because those concerns are rapidly moving. Answers that are germane to solo practitioners who are not moving into integrated systems will be very, very different than that answer for physicians who are part of a large, integrated delivery system.

Mr. ENSIGN. OK. Well, why don't you then answer what are the group versus the individual, primary concerns?

Dr. KONGSTVEDT. In my experience on the side of the solo and small group practices, the large concerns are the issue raised that managed care organizations are unlikely to change substantial terms in a contract for one physician and that is true. They will not do so.

The payment provisions are generally whatever they are. It is very common, as has been said, that physicians may or may not read the contract. They rarely do employ a lawyer to review all of the terms to do so.

On the large group side, the large integrated systems, the issues of negotiation involve the level of the global capitation and who will do what function in utilization management, credentialing, quality management and so forth. The more that these processes are moved out to the integrated delivery system, the more these issues are between the individual physicians and the physician leadership of that integrated delivery system.

Mr. ENSIGN. OK. Mr. Stocker.

Mr. STOCKER. My experience is similar. We are seeing a significant movement in south Florida toward very large-scale physician organizations where the physicians are becoming much more sophisticated in negotiating these contracts, and where they have a lot more bargaining power than individual physicians.

In my experience, what they are concerned with is the amount of payment and, frankly, these large groups are encouraging the managed care companies to move to a global cap, some sort of a global cap arrangement.

The role of the physicians in care management, what they are attempting to do is to move a lot of the functions that you typically see in an HMO into the physician arena and, frankly at least in

my view, I see that as a very positive thing because physicians are in a good position to manage care.

And what we are seeing is a redundancy, a deliberate redundancy required in those functions so that the HMO can exercise its responsibility and the physicians can effectively manage the care and control the costs. And also, they want to know to whom payment is going to be made, you know, on what basis. Risk pools, the issue of risk pools, the issue of stop loss insurance and those kinds of economic terms.

Mr. ENSIGN. OK. Mr. Rust.

Mr. RUST. My experience has been very similar. In individual contracts, it is virtually impossible to negotiate particularly the important legal issues that exist there. If it is a ministerial item, you've got the name of my group wrong or it is with me, individually, and I am really in a group of four, they're willing to go ahead and do that. But there's no negotiation otherwise, and physicians do not usually try to, other than what I referred to as hit-and-run tactics where, for example, they do not like the indemnity clause so they strike it out, initial it, sign it, throw it into the hopper, and hope the MCOs do not really notice it.

With respect to larger groups, there is negotiation but, as the other speakers have suggested, usually it is about price-type terms. When you see various kinds of clauses that tend to inhibit what physicians can say and they are put into a commercially sounding, reasonable context, you have to understand most of these groups are relatively newly formed and they are very fearful that they will even be able to get the contract to begin with. Sometimes they put a great deal of capital into building this organization and they do not have much experience. it is not the kind of thing they normally really focus on negotiating.

Mr. ENSIGN. Would you, like to comment on the difference between the way that primary care physicians versus specialists or subspecialists view this negotiating phase? And actually the way that they view the whole idea of this patient protection the gag rule.

Mr. RUST. If I can take a stab at that, Mr. Chairman.

That's a very important distinction because the groups that we are talking about—and it was just referred to a moment ago that we are seeing more large group contracting, as opposed to individuals—are by and large primary care driven, gatekeeper model type groups. And those are the people who are negotiating these contracts and being very concerned about capitation.

Specialists are often times, still even in that environment, entering into contracts individually and they still have the same problem as any of the individual physicians have, it is impossible for them to negotiate these things.

Mr. STOCKER. At least in my experience when you're talking about these larger groups, the physicians that are running these groups have very similar ideas about confidentiality provisions, antidisparagement provisions, and noncompete provisions that the managed care companies do. And they typically put the same kinds of provisions in their contracts with other physicians because both of these types of entities are trying to protect the same thing, the business reputation of their company. And these physician compa-

nies are just like managed care companies in that respect, they have a business interest to protect.

So, the interesting thing about it is that when you see physicians getting together in these arrangements, they behave pretty much the way managed care companies behave.

Dr. KONGSTVEDT. I would echo that. I have been struck by how rapidly providers of care—hospital executives, physicians, and other providers of care—do change their attitude regarding some of these types of provisions. Any willing provider, open access, other types of contractual terms, when they become globally capitated and it is now their business risk.

Mr. ENSIGN. Thank you.

The gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I just want to hop ahead here. we are going to hear later from the AMA, but I think they say it properly. They say the very first fundamental element of the patient/physician relationship—and this is a section of some major issue of ethics published by the AMA's Code of Medical Ethics—the patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action.

Now, in addition, their council on ethical and judicial affairs, the AMA entity responsible for maintaining the Code of Medical Ethics and providing authoritative interpretation stated that, "The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed plan. Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent requirements. If these clauses"—and they are referring here to gag clauses—"are carried out and the physicians are subject to sanctions, a reduction of patient quality of care will result."

Now, that's what the doctors are saying. Dr. Kongstvedt, you would suggest, I think in your closing, that we should trust the professional managers with these things. And they probably are not the recipient of your consulting. So, the Prudential Life Insurance Co. that has stolen over $3 billion from their investors, has had over $300 million in fines, and has been convicted as a corporation and its top executives of felonies, do you think we should trust that company to manage care? No way, you just cannot. You're putting the fox into the hen house.

And there is more than just good faith. When the incentives are skewed, as I think Mr. Rust suggests, that the doctors judgment is pushed.

So, the question today is, How can we handle this. If its a Medicare contract, then aren't we all paying the bill? So, we have a real right to see that the beneficiaries get what they're entitled to. And what they're entitled to is the level of care, which is far higher under an indemnity plan because there are no restrictions on it, as there are in indemnity plans. Even the best managed care plan far more restrictions than an indemnity plan. Just by definition, indemnity plans are better when it comes to choice of quality care that's available.

And what we are trying to find here is a way so that the doctors are not being kicked out or coerced, directly or indirectly, into pushing one kind of treatment.

We will get into what PacifiCare did about withholding vaccine or what another group did in Florida by pushing men to be castrated rather than getting treated by pharmaceuticals that would reduce the growth of testosterone when they got prostate cancer, just because it saves $8,000 on average to have them castrated rather than give them expensive pharmaceuticals.

That's criminal, that's obscene. And none of the witnesses are old enough to get close to having to make that choice. But I want to tell you it is not a choice that you want to be flim-flammed on by some doctor who is being pushed by his health care plan.

So, I hope that you can help us find a way to solve this. The managed care plans aren't going to suffer if they are doing it right. And it is the doctors who are going to lose their jobs. So, Mr. Rust, I think you're heading in the right direction. And I would hope if we take up Dr. Kongstvedt's CPA firm's offer of free help, that we end up with contracts that will protect the patients and not your clients.

Thank you, Mr. Chairman.

Dr. KONGSTVEDT. Mr. Chairman, may I respond, please?

Mr. ENSIGN. Certainly.

Dr. KONGSTVEDT. Mr. Congressman, regarding the issue of Prudential, certainly the legal problems that they had had no relation to their health plans, it was their investment service.

Mr. STARK. The same chief executive officer runs the whole show. When you lie down with skunks, you smell.

Dr. KONGSTVEDT. And in the case of that organization they have voluntarily sought and secured NCQA accreditation and NCQA accreditation rules are very clear that they prohibit such gag clauses.

Mr. STARK. They were in the NASD, too, but that didn't stop them from stealing the money.

Dr. KONGSTVEDT. Well, the only last statement I can make is that our firm actually represents more health care providers than we do payors. Our offer of free assistance is, in fact, we believe a balanced one. We are advocating neither one position nor the other and we, in fact, do not do business with Prudential at this time. They are not a client of mine.

Mr. ENSIGN. The gentleman would be reminded that veterinary services do take care of certain medical procedures that he talked about earlier. [Laughter.]

Mr. ENSIGN. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Rust, in your testimony you state that you represent 3,000 physicians. I want to find out more information about the size of the practice that you represent or if it is all sizes, all kinds?

Mr. RUST. It is a lot of individuals, many of them formed into small to medium groups. And by that, I would say everything from 2 to 10 people. And increasingly these days it is larger organizations of joint venturing physicians who are forming networks to do managed care contracting that range in size from 30 to 150.

Mr. CHRISTENSEN. What would you say is the predominant scope of your practice, the large or the individual size?

Mr. RUST. It has traditionally been the individual and group size, but in the last 2 years, it has become increasingly the large size because of the tremendous activity that was set off a couple of years ago with the introduction of the national health bill.

Mr. CHRISTENSEN. It was either you or Mr. Stocker who made the comment that it is almost impossible to negotiate individual contracts?

Mr. RUST. That's correct.

Mr. CHRISTENSEN. Would you extrapolate on that, please?

Mr. RUST. Yes. Well, first of all, most physicians, as I believe Dr. McDermott mentioned, do have 70 contracts in their office which they never have reviewed because they perceive that they will not get anywhere. And in the few instances where physicians do attempt to do that, there is really only one of two ways to approach it.

Either I am going to write a set of comments on the agreements which I try to limit just to those things which are really reasonable that the other side can focus in on, and the physician can send them off to the managed care organization and say, Look if you will make these changes, I will sign it, or they can ask me to call the attorney directly for the other plan.

In both cases, the managed care organization takes the position that we just do not change any of the things that we consider material to the contract. And what they consider material to the contract is virtually everything but the names of the parties and certain kinds of boilerplate.

Mr. CHRISTENSEN. What I am really interested in is your negotiation on behalf of the large groups versus the small groups.

How does that differ when it comes to actual substance within the contract? I mean don't you see that nondisparagement clauses end up in the large group practice, as well as your individual group practice? Aren't they almost identical?

Mr. RUST. When you say, they end up, what do you mean?

Mr. CHRISTENSEN. As far as the contract language within the agreement between the providers?

Mr. RUST. Actually, I have not yet seen—well, excuse me, I have seen once or twice that kind of nondisparagement language and I counseled the administrator, the executive officer who was negotiating it as to what the problems were and that it should come out. And he took the view that that was a lesser priority than some other issues and it never came out.

Mr. CHRISTENSEN. So, you're saying that in your practice, the predominant representation that you have given to your clients is that there is not a nondisparagement type of clause in the individual practices, would that be correct?

You're shaking your head.

Mr. RUST. I am not understanding you.

Mr. CHRISTENSEN. Would you say that there is predominantly not a nondisparagement clause in the individual practices?

Mr. RUST. I would say you see nondisparagement clauses about one out of every five contracts. They do not all have them.

Mr. CHRISTENSEN. Mr. Stocker, how would your practice and your experience with this differ from Mr. Rust's?

Mr. STOCKER. First of all, you probably think that Florida is—tourism is a big industry there, but really health care is the big industry in Florida, and we see a lot that sort of is advanced guard stuff there.

And one of the things we are seeing is that health plans really do not want to contract with individual physicians very much any more. It is too costly for them to do that, and they cannot get the care management and some other things that they want.

So, more and more we are seeing them contracting with groups, specialty groups and large IPAs, and PHOs and all these other things. And we do see nondisparagement provisions with respect to business types of terms. But I have never seen a gag rule. I have never seen a contract provision that prohibits a physician from discussing treatment options.

That's just in my range of experience, but I see a lot of these things.

Mr. CHRISTENSEN. I have got one last quick question. I just wanted to find out, Mark, it looks like you were also chair on the legislation for the Illinois State Bar as well as the chair of the American Bar's Medicine and Law Committee——

Mr. RUST. I am on the standing committee for legislation.

Mr. CHRISTENSEN [continuing]. Tort and Insurance Practice Law. Where did you come down on, earlier this year when we were trying to put together malpractice reform legislation for the medical community?

Mr. RUST. The Illinois State Bar Association just had a tort reform bill passed, or Illinois just had a tort reform bill passed the previous term. And there were a number of pieces of legislation that arose to reverse those so-called tort reform provisions, and the Bar Association was in favor of reversing those tort reform provisions but that didn't happen.

Mr. CHRISTENSEN. And on the American Bar, as far as the overall—that was on the Illinois side?

Mr. RUST. That was on the Illinois side, that's correct.

Mr. CHRISTENSEN. What about the position that the American Bar has taken?

Mr. RUST. The American Bar Association has been opposed to tort reform, by and large.

Mr. CHRISTENSEN. Yes, unfortunate.

Thank you.

Mr. RUST. That was not my personal opinion, and I am not here to testify for the American Bar Association.

Mr. CHRISTENSEN. Thank you.

Mr. ENSIGN. Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I wish I could get a debate going between the three of you about this whole issue because I am sure there are no gag clauses. There is no contract that says, thou shalt not say, XY or Z. It is much more subtle than that. And it seems to me that from my own experience watching television I saw a classic example of a gag clause. That was on "Chicago Hope." A doctor came into a managed care operation bringing his patients with him. Well, when I got out of

medical school nobody ever thought of ever selling your practice to a hospital or some kind of managed care operation.

But that's what's happening today. There is a major revolution. I do not have to tell you that. This doctor brought his patients in assuring them that they will get the same kind of care in the managed care operation that they got when he was in private practice.

He treated an elderly woman, she was about 75 years old. Later he had to tell her that he could no longer see her, he had been fired by the managed care operation because he did not deliver care according to the standards of that managed care company.

Now, there is a tearful scene with the 75-year-old woman standing there saying, "You mean I am going to have to start with a new doctor and I am going to have to explain my whole life to these people? And there is an ethical dilemma here that this bill is a kind of a blunt instrument trying to reach at but there is going to be something passed out of the Congress. You are going to get treatment du jour or medicine du jour from the Congress and the State legislatures because of the issue that that illustrates.

And that is the question of when the physician is standing there, knowing that he or she is going to be fired by the managed care operation if they do something that is implicit or explicit or in the contract or whatever, then they are going to make decisions for their patients which are based simply on money, not on quality of care.

Now, doc, I want to say doctors are all great people, we are, and we try, but there are a few that will be impacted by money. And the American public is not protected when the physician's livelihood is on the stake. And my question to you is, in these cases or in these situations, number one, Does the doctor have an appeal process that really allows him or her to go back to the managed care operation and say, You cannot fire me, you cannot terminate this contract?

And second, the malpractice questions. Some, one of you commented—I read your written testimony—that doctors are supposed to indemnify the plan. So, if I make a decision and there is a lawsuit has anybody ever put forward their contract and said, Well, my managed care contract said I could not do that or was prohibited from doing it and, therefore, I am not committing malpractice. it is the managed care operation that is committing malpractice.

I would like to hear some talk about that issue, because the doctors feel caught in the squeeze between their livelihood and doing what they think and always knowing that there is this hammer that can come in the darkness.

So, any one of you or all of you?

Mr. STOCKER. Well, first of all, and again, there may be examples of it, but I do not see a situation where a managed care company is going to fire somebody for making a comment to a patient. In a typical managed care network you have several thousand doctors and they're doing things and the managed care company is doing things. And it is only when an issue rises to a very high level that there's some action taken.

But also you have got to look at the structure of the profession and the industry now. You are getting more large-scale organizations and you're having doctors who are working for other doctors

who are working for doctor networks, who are working for very large-scale organizations.

So, there are a number of different levels between the managed care company and the doctor. To me, the gag rule issue isn't nearly as significant an issue as the basic issue of managing care and looking at how doctors are performing with respect to economics and with respect to quality?

And these issues are looked at and will be looked at irrespective of whether you pass any legislation with respect to gag rules or not. So, if a doctor is down there and he's making a lot of referrals for a lot of expensive things that are not medically necessary, he may very well be fired, irrespective of a gag rule.

Because if you are going to manage care, you are going to have to manage care and, at some point or another, somebody is going to have to do it in order to keep the costs down.

It is a different reality I think than the reality we are talking about where you have got a doctor who has no bargaining power, who has this managed care contract that is shoved in front of him. The way I see it, that's not the reality that we are dealing with today.

Mr. MCDERMOTT. If that's not the reality why have, whatever it is, some 17 or 20 legislatures plus the U.S. Congress passed laws against drive-by babies, drive-by baby delivery? And said that managed care contracts cannot prevent women from staying in a hospital overnight after childbirth?

Explain to me what's going on that all over the country in legislative bodies people are jumping up and doing that kind of thing?

Mr. STOCKER. Well, first of all, drive-by babies have nothing to do with gag rules. The issue with drive-by babies—and I think it is a very legitimate issue—is what level of care, what standard of care should be common, I mean should be the baseline?

And that's a different issue from gag rules.

Mr. MCDERMOTT. But it gets back to the question of what level of care is expected and using a managed care contract as a defense against malpractice.

Mr. STOCKER. Well, irrespective of whether there's a gag rule or not, every physician and I think at this point, managed care companies, as well if they are telling physicians what to do, are bound by community standards of care. I mean that will be the standard. And, if an HMO is directing a physician to do something that is below community standards, my view of it would be that the HMO would wind up being liable and probably if the physician went along with it, he would be, too.

I would never counsel a client, HMO, or a physician client, to provide any services below the community standard of care.

Mr. MCDERMOTT. Have you defended any physicians who have been dropped off the panel?

Mr. STOCKER. I represent both physicians and HMOs and other kinds of—and I haven't had that come up ever.

Mr. MCDERMOTT. Have you, Mr. Rust?

Mr. RUST. I am sorry, what was the question?

Mr. MCDERMOTT. Have you ever represented anybody who has been dropped off the panel by an HMO?

Mr. RUST. Oh, yes, certainly.

Mr. MCDERMOTT. And what kind of success?

Mr. RUST. Absolutely zero and the reason is that no plan in their right mind would ever tell the physician the reason they were terminating them. Every time a managed care plan wishes to terminate a physician, they exercise the without clause provision. Whether or not it has to do with gag clause, bad care, rotten whatever, it just does not make any sense for them to do otherwise, because they have the legal power to do it. And they would have to be absolutely crazy not to.

Let's talk about the reality for a moment. Let's assume, as my colleagues are suggesting, that the managed care organizations are a bunch of very sophisticated players who would never do something like this or exercise a gag clause. But, at the same time, they're turning over that responsibility to large organizations of physicians. And that's happening.

So, now, we are going to have provider agreements under the large group of physicians. Now, we all know that physicians are a bunch of greedy yahoos, so, what do you think the physicians are going to do if they have these clauses? They're going to enforce them.

And the fact is that this bill would also make that illegal with respect to the physician organization just the same way it would be illegal with respect to the managed care organization. In either case, it is important to have and, possibly even more importantly, it is important to have in a situation where you are now shifting all this responsibility from our sophisticated chief executive officers of the managed care organizations to the unsophisticated physicians sitting on the board of their large groups.

You asked about two issues specifically. Is there an appeal mechanism? There always is an appeal mechanism but it only exists when you are terminated for a breach or for some reason. So, it is never used.

If a physician is terminated without cause, it is virtually impossible to find out the reason unless you have, as I have had before, the freak circumstance of something else going on where you can pressure the organization to tell you why they did what they did.

With respect to the malpractice indemnity issue, this is the way it works. Now, under this language that most human beings cannot possibly read, much less, comprehend, it basically says that if the HMO ever finds itself as a defendant in a malpractice action, because of some events that involved the alleged negligence of a physician, the physician will indemnify and hold harmless the managed care organization.

Now, at first that sounds kind of reasonable for a physician to say, OK, I do not commit malpractice so if that happens, I do not care; besides that, I have insurance. What they do not understand is that their insurance never covers them for that liability. They are bare with respect to that indemnification under virtually all malpractice policies.

So, when the issue actually arises that there is a lawsuit and the HMO has a great deal of fees and costs and possible awards to be lodged against it and finds itself, as a defendant, sitting along side the physician, the managed care organization will use that as a

club to tell the physician how his defense should operate, what he should say and what he should do.

And that is why that indemnity provision is important.

Mr. MCDERMOTT. My time has expired.

I think this is an issue we are going to come back to.

Thank you.

Mr. ENSIGN. I would like to thank the panel. I think that we have a couple of goals in common and it is a difficult issue to determine how we get to those goals. One is that we want the best quality of medical care that we can give to everybody.

Managed care has come into being because there was nothing out there controlling costs in the marketplace and so, it was a legitimate niche that managed care came into being. Now, you have to negotiate that delicate balancing act of controlling costs with providing the best quality medical care, and we can see the difficulties in doing that.

I would like to thank the panel and call up the next panel.

I would like to welcome our next panel. Dr. Nelson representing the American Medical Association and Dr. Nelson is an obstetrician-gynecologist and a deputy director of the Department of Health, Salt Lake City, Utah and a member of the Board of trustees of the American Medical Association. Dr. Chris Jagmin is vice president and medical director of Health Affairs, PacifiCare in the Southwest, Dallas, Texas, on behalf of the American Association of Health Plans.

Gentlemen, if you would, please keep your statements to 5 minutes. And the yellow light means that you have about 1 minute to go.

So, please proceed, Dr. Nelson.

STATEMENT OF JOHN C. NELSON, M.D., DEPUTY DIRECTOR, DEPARTMENT OF HEALTH, SALT LAKE CITY, UTAH; AND MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. NELSON. Thank you, Mr. Chairman.

My name is John C. Nelson, M.D., and I am a practicing obstetrician-gynecologist from Salt Lake City, Utah. I also serve as a member of the Board of Trustees of the American Medical Association and as part-time deputy director of the Utah Department of Health.

I am a participant in several managed care plans. I see all comers. I am a participating physician in Medicare and am pleased to see Medicaid patients, as well. We commend, of course, the Subcommittee for holding this important hearing on H.R. 2976 about gag clauses but also about gag practices.

Mr. Chairman, gag clauses strike at the heart of the patient-physician relationship. They present an inherent ethical conflict of interest.

As AMA's CEJA, Council on Ethical and Judicial Affairs recently stated, "The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent require-

ments. If these clauses are carried out and physicians are subject to sanction, a reduction of patient quality of care will result."

Patients must be able to trust and rely on information that physicians provide to them. Physicians have an ethical as well as a legal duty to ensure that their patients are fully informed of all options. Gag clauses place a wedge between patients and their physician. They wear away at the most fundamental element of the healing process, trust.

Although gag clauses fall into many categories, they are all designed to control physician behavior and limit patient access to information. I point out, of course, that the legal responsibility continues to lie, however, with the physician.

Some in the managed care industry have stated that there aren't any gag rules. We strongly disagree. The media has documented a number of written and, more importantly, unwritten gag practices.

For example, last week's Washington Post reported about a gag practice by the Washington area's largest operator of managed health care known as Mid-Atlantic Medical Services or MAMSI. MAMSI recently told its doctors, "Effective immediately, all referral from Primary Care Physicians to Specialists may be for only one visit." Continuing on in bold print, "We are terminating the contracts of physicians and affiliates who fail to meet the performance pattern for their specialty."

In another example, a recent bulletin regarding preadmission guidelines stated, and this is at Humana, "Effective immediately all Humana participating providers must telephone the Preadmission Review Department—before an admission occurs and before conveying the possibility of admission to the plan member." Mr. Chairman, we call those plan members, patients.

Although a followup memo blamed "poor wording" for any "misinterpretation" of that bulletin as a restriction of communication, we think the effect of the announcement clearly is chilling.

Some health care plans, such as U.S. Health Care and Blue Cross/Blue Shield of Kansas City, have voluntarily removed gag clauses in response to the AMA's urging last January.

We believe these managed care organizations should be commended. Clearly, more is needed. As noted in a recent editorial in the "L.A. Times," "Today HMOs are less likely to require physicians to sign restrictive contracts than to simply fire them for referring too many patients to expensive specialists."

The AMA is on record supporting the Patient's Right To Know Act. We are encouraged by the Commerce Committee's unanimous vote on the Senate version of the bill. We are concerned, however, about attempts to dampen support for that bill. These efforts include advertising by the managed care industry that falsely suggests that the National Governors' Association is opposed to H.R. 2976. The NGA has assured us that they have taken a position on H.R. 2976 and do not intend to do so. My own Governor, whose wife is my patient, Mike Levitt of Utah, told me yesterday the same thing.

The term "gag clause" should not be viewed in an overly narrow or restrictive manner. We encourage the Subcommittee to resist narrowing the bill's gag clause protections. The Commerce Committee bill would go a long way toward restoring the patient-physician

relationship. If patients are to be truly free to make informed medical decisions, the bill should be strengthened to resemble more the original measures introduced.

Responding to the loud public outcry against gag clauses, States have begun to enact "antigag clause" legislation. Given the number of States moving forward, we expect some to ask, Is the Federal antigag clause necessary? We say, emphatically, yes, because even if all the States enacted similar measures, not all health plans will be reached by the State law. Consequently, Federal legislation is necessary to make all the gag clauses null and void.

In conclusion, the AMA maintains gag clauses and, more importantly, gag practices create an unacceptable ethical conflict of interest for physicians. It is simply bad medicine. We will continue to work to support H.R. 2976 and help physicians and our patients fight gag clauses. The AMA stands ready to work with you; we will do all we can to help and I am certainly willing to take questions.

Thank you very much.

[The prepared statement follows. The attachments are being held in the Subcommittee files.]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

RE: H.R. 2976, the "Patient Right to Know Act of 1996"

Presented by John C. Nelson, MD

July 30, 1996

INTRODUCTION

My name is John C. Nelson, MD. I am a practicing obstetrician and gynecologist from Salt Lake City, Utah. I also serve on the Board of Trustees of the American Medical Association (AMA) and as part-time Deputy Director of the Utah Department of Health. On behalf of the 300,000 physicians and medical students of the AMA, I am pleased to have this opportunity to testify before you today about so-called "gag clause" provisions and practices that are commonly found in many of today's managed care contracts and H.R. 2976, "The Patient Right to Know Act of 1996," a bill that would prohibit managed health insurance organizations from restricting patient-physician communications. We commend the Subcommittee Chairman Bill Thomas for holding this important hearing.

As you may know, recent estimates suggest that over 58 million Americans are enrolled in health maintenance organizations. In addition, another 81 million receive care through some type of managed care arrangement. To date, almost 80 percent of the AMA's members maintain some form of managed care contract. Many observers believe that the near-term result of this trend has been a marked decrease in the rate of health care inflation. A number of studies have suggested that managed care provides care at least equal to that provided in fee-for-service medicine. Other studies, press accounts, anecdotal evidence, and a growing wave of public opinion, however, have begun to point out that needed care may be denied because of the financial pressures put on physicians and other health care providers to reduce costs to the detriment of their patients. We believe that a patient's needs must come first.

The AMA believes that "patient protection" and "antitrust relief" provisions similar to those contained in the House-passed Medicare reform package of last year should be enacted. As you know, the AMA supported these Medicare reforms and although the President vetoed the final bill we believe that, now more than ever, "anti-gag clause" legislation should be enacted not just for Medicare, but across the board to encompass all health benefit plans. We also believe that only in this way will some of the more egregious examples, in which physicians have been prevented from providing relevant information to their patients, be addressed.

"GAG CLAUSES" DISTORT THE PATIENT-PHYSICIAN RELATIONSHIP

"Gag clauses" strike at the heart of the patient-physician relationship because they present an inherent ethical conflict of interest. The AMA's *Code of Medical Ethics*, which lays out the guiding principles for the entire medical profession, is very specific on this point. In it we find a very important section entitled *Fundamental Elements of the Patient-Physician Relationship*. The very first "*Fundamental Element*" is as follows:

"The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patient should receive guidance from their physicians as to the optimal course of action."

In addition, the AMA's Council on Ethical and Judicial Affairs, the AMA entity responsible for maintaining the *Code of Medical Ethics* and providing authoritative interpretations of its contents, has recently stated that:

"The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan...Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent requirements. If these clauses are carried out and the physicians are subject to sanction, a reduction of patient quality of care will result" (see attachment).

The AMA staunchly believes that patients must be able to trust and rely on the information their physicians provide to them regarding appropriate medical treatment and care. In short, physicians, as providers of health care, have an ethical and legal duty to ensure that their patients are fully informed of their options regardless of cost or potential treatment limitations. Unfortunately for patients, "gag clauses" create a real or perceived potential conflict of interest for physicians by placing a wedge between them and their physician. "Gag clauses" and "gag practices" wear away at a most fundamental element of the healing process -- trust.

WHAT ARE "GAG CLAUSES"

The Subcommittee's "Hearing Advisory" suggests that "gag clauses" fall into three categories:

1.) Those that restrain disclosure of treatment options;

2.) Those that restrain disclosure of payment and financial incentive arrangements; and,

3.) Disparagement clauses.

We would respectfully add two other types of "gag clause" provisions:

4.) Those that prohibit communicating with patients in the event the physician is "deselected" (raising concerns of continuity of patient care); and,

5.) Those that prohibit physicians from referring patients to other specialists or facilities not participating in the plan.

Assuming that medical communications are being made in good faith by a physician to a patient, these contractual provisions are designed and implemented with the intent to control physician behavior and to limit a patient's access to the full range of information that is needed to make informed decisions and provide informed consent about the proper course of medical treatment. While we acknowledge a legitimate business interest in attempting to control costs and to avoid unjustified disparagement of a plan's operations, we firmly believe that such efforts should not undermine the quality of care received by patients. To be sure, not all health plan contracts contain written "gag clauses," yet some in the managed care industry have stated that "there are no gag rules" in managed care contracts. While we strongly disagree with this latter statement, we do agree with the recent editorial in the *Los Angeles Times* which states "today HMOs are less likely to require physicians to sign restrictive contracts than to simply fire them for referring too many patients to expensive specialists" (see attachment).

WRITTEN AND UNWRITTEN "GAG CLAUSES"

Recent media reports in *Time Magazine*, *USA Today*, *The New York Times*, *Chicago Tribune*, NBC Nightly News, *Newsweek*, National Public Radio, *Boston Globe*, CNN, *Newsday*, AP, and the *San Francisco Examiner* have documented a number of written and unwritten "gag" practices. While all differ in detail, most tell a story of health insurance programs that value

cost containment and financial gain for shareholders over the well-being of members and policyholders. Although these reports are anecdotal, they are, nevertheless true and indicative of a widespread problem. Written contract provisions continue to be of great concern. **However, a number of physicians have also become concerned about the more subtle, unwritten, plan policies and procedures that are used to impede physicians from discussing treatment options if the plan does not cover those treatments.**

One example of "gag" practices was reported in last week's *Washington Post* regarding the Washington area's largest operator of managed health care known as Mid Atlantic Medical Services (MAMSI). In a recent letter, the health plan, also known as M.D. IPA, Alliance, Optimum Choice and MAPSI, told participating physicians that "effective immediately, all referrals from Primary Care Physicians to Specialists may be for only one visit." The letter continued, in bold type, **"we are terminating the contracts of physicians and affiliates who fail to meet the performance patterns for their specialty"** (see attachments).

In another example, a recent plan bulletin regarding preadmission review guidelines stated that **"effective immediately, all Humana participating providers must telephone the Preadmission Review Department...before an admission occurs and before conveying the possibility of admission to the plan member."** Although a follow-up memorandum blamed "poor wording" in the original announcement for any "misinterpretation" of the bulletin as a restriction of communication between physicians and patients, the AMA maintains that the original effect of the announcement is clearly chilling (see attachments).

Another "gag clause" example is provided in the following physician contract provision with Aetna: "Upon notice of termination or nonrenewal, Consulting Physician shall cooperate fully with Aetna and comply with Aetna's procedures, if any, in the transfer of Members to other Providers. In addition, upon notice of termination or nonrenewal, at Aetna's option, Members shall not be permitted to select Consulting Physician as their provider of health care services" (see attachment). The AMA believes such contract provisions are harmful to patients. This particular provision raises important concerns regarding patient choice and continuity of care issues. We believe that in instances where the patient-physician relationship is severed by the plan for non-clinical reasons, there should be rules providing for the continuity of care for some reasonable period of time to allow for a smooth and satisfactory transition. These are only a few "gag clause" examples. The AMA would be pleased to provide further examples of other "gag clauses" and practices.

NOT ALL HEALTH PLANS CONTAIN "GAG CLAUSES"

Some health care plans, such as U.S. Healthcare, Blue Cross/Blue Shield of Kansas City, ChoiceCare and Health Net of Missouri, have voluntarily removed onerous "gag clauses" in response to the AMA's urging to do so last January. We also note that the American Association of Health Plans, the Washington representatives of the managed health care industry, adopted a non-binding statement of purpose which suggests that the industry should "encourage physicians to share information with patients on their health status, medical conditions, and treatment options." The Association of Managed Healthcare Organizations also recently issued a statement in support of "a patient's right to full clinical information about the physician's recommended treatment and other options for care." Finally, the National Committee for Quality Assurance (NCQA) issued a clarification of their standard for Members' Rights and Responsibilities which states that "at a minimum, the organization has a written policy that recognizes the following rights of members to: participate in decisionmaking regarding their health care and prohibits restrictions on the clinical dialogue between practitioner and patient." We believe these managed care organizations should be congratulated for understanding the importance of this issue. Clearly, however, more is needed.

"PATIENT RIGHT TO KNOW ACT OF 1996" (H.R. 2976)

The AMA is on record in firm support of H.R. 2976, the "Patient Right to Know Act of 1996," a bipartisan measure sponsored by Representatives Greg Ganske (R-IA) and Edward Markey (D-MA). While we are encouraged by the Commerce Committee's recent and

unanimous vote on the amended version of this important measure, we are concerned about attempts by the for-profit managed care and insurance industries to pare back this legislation to the point where it may become unrecognizable from the bill as originally introduced. These efforts include placing advertisements in well read publications that falsely suggest that the National Governors' Association (NGA) has taken a position in opposition to H.R. 2976. We urge Congress to be cautious not to mistake these calculated attempts by the managed care industry to leverage the reputation of a prominent group such as the NGA. In fact, the NGA has assured us that they have not taken a position on H.R. 2976, the "Patient Right to Know Act" and do not intend to do so in the near future (see attachment).

In general, the AMA believes that the term "gag clause" should not be viewed in an overly narrow, legalistic or restrictive manner. The AMA maintains that a more common sense approach to this issue should prevail because of the fact that "gag clauses" often go beyond the mere elements of contract law and include a pattern of practice that is limiting to physician-patient communications. We encourage the Subcommittee to resist the urge to narrow the definition of "gag clause" protections. The AMA believes that narrowing the important provisions of the bill would allow plans to neglect those concerns reported by physicians and others in the actual delivery and practice of health care. While we are confident that, in the end, we would also prevail on the merits of such provisions, narrowing these provisions at this time would affect patient care in the interim.

We believe that the bill passed by the Commerce Committee would go a long way toward restoring the patient-physician relationship, which has been damaged by "gag clauses." We also believe, however, that if patients are to be truly free to make informed medical decisions, the legislation should be strengthened to reflect the following concerns:

"GAG" CONTRACTS AND PRACTICES SHOULD BE BANNED. The legislation should be amended so that health plans would no longer be allowed to "gag" their physicians through policies and other unwritten conduct, which intimidate physicians and interfere with a patient's right to receive essential medical information. As reported from the Committee on Commerce, Section 2 (a)(1) is both unclear and potentially harmful to patients. In short, this provision would merely prohibit health plans from including written or oral "gag clauses," thus leaving it questionable whether those well documented cases in which a physician has been "gagged" by a plan's own internal procedures would, indeed, be prohibited by the bill. Patients need to be protected from plans retaliating against their doctors for advocating on their behalf and following ethical medical practices;

THE DEFINITION OF "MEDICAL COMMUNICATIONS" SHOULD BE EXPANDED. The Amendment's definition of "medical communications" is narrow and limits what patients should be allowed to know. For example, the original "Patient Right To Know Act" expressly stated that physicians would be free to inform patients about the "basis or standard for the decision of [a health plan] to authorize or deny health care services or benefits." The original bill also specifically protected medical communications between physicians and patients regarding "the process used by [a health plan] to determine whether to authorize or deny health care services or benefits." Physicians should be free to inform patients if and when certain health services will be covered by the plan. The definition of "medical communication" contained in the original "Patient Right To Know Act" should be restored; and,

HEALTH PLANS SHOULD NOT GET MORE THAN ONE BITE AT THE APPLE. Another provision in the Substitute bill would let health plans off the hook if they only occasionally use gag clauses. Under the amended version, civil money penalties could be leveled against a health plan only if the physician has been "gagged" as a part of a "pattern" or practice of the plan. Thus, a plan that gags physician communications on "an occasional" basis would be immune from punishment. The effects of "gag clauses " are too dangerous to the health, safety and welfare of patients to be allowed more than one bite at the apple.

Although we would prefer that the amended "Patient Right To Know Act" be restored to its original form, we are pleased that the amended bill would set the ground rules for physician-patient communications and would cover all health plans, including self-insured "ERISA"

plans. The AMA has worked closely with the sponsors of H.R. 2976 in developing this bill and maintains that it is a necessary first step to rid the health system of these egregious contract provisions without unduly interfering with the legitimate business practices of managed care companies.

STATE/FEDERAL INTERPLAY NECESSARY TO CORRECT "GAG" PROBLEMS

In reaction to the loud public outcry caused by local cases where physicians have been "gagged," thereby threatening patients, a number of states have begun to enact "anti-gag clause" legislation. For example, legislatures in Massachusetts, Colorado, Maryland, Georgia, Indiana, Virginia, Maine, New Hampshire, Rhode Island, Tennessee, Vermont and Washington have all passed such measures. Another twelve states currently have similar proposals pending while a number of other states have chosen to address this issue through regulation. Finally, the National Association of Insurance Commissioners (NAIC) recently adopted a non-binding model bill that would, in part, ban plans from contracting to limit or prohibit a participating physician from discussing treatment options with patients regardless of the health carrier's position on the treatment options, or from advocating on behalf of patients within a utilization review or grievance process.

Given the number of states moving forward with legislation, the NAIC's model bill and various private sector activities to educate the public about these provisions and practices, we expect some to pose the question, "is federal anti-gag clause necessary?" The AMA believes the clear and simple answer is "yes!" Even if all the states enacted similar "anti-gag clause" measures, not all health plans can, nor will, be reached by state law. Consequently, federal legislation is necessary to make "gag clauses" null and void in all health plans. Although the courts have yet to speak on this issue, we believe waiting for the courts to render their final judgment could, in the interim, prove harmful -- if not fatal -- for many patients.

In addition, an increasing number of Medicare beneficiaries have begun to join managed care plans. Because this population often uses a greater number of specialists, managed care "gag clauses" could pose especially acute problems for unsuspecting Medicare beneficiaries. Although the path for Congressional reform of Medicare remains uncertain, we would expect efforts to change the system to include an even greater role for managed care plans in the immediate future. Federal legislation covering all private and public sector health plans is, therefore, needed in order to ensure that every patient is adequately protected from these contractual provisions and practices.

CONCLUSION

In conclusion, the AMA maintains that "gag clauses" and "gag practices" should be made unenforceable and null and void. Toward this end, we support both private and public sector efforts to prohibit "gag clause" provisions and practices. The AMA maintains that such practices are an unreasonable burden on physicians and create an unacceptable ethical conflict of interest, as well as being "bad medicine." In addition, to our support of the "Patient Right To Know Act of 1996" (H.R. 2976), we will continue to work to support physicians fighting against such practices and provisions. The AMA stands ready to work with you, Mr. Chairman and Members of the Subcommittee, on this important issue. I would be pleased to answer any questions you may have at this time. Thank you.

Mr. ENSIGN. Dr. Jagmin.

STATEMENT OF CHRIS L. JAGMIN, M.D., MEDICAL DIRECTOR, PACIFICARE IN THE SOUTHWEST, DALLAS, TEXAS; ON BEHALF OF AMERICAN ASSOCIATION OF HEALTH PLANS

Dr. JAGMIN. Thank you, Mr. Chairman.

Mr. Chairman, and Members of the Subcommittee, I am Chris Jagmin, medical director at PacifiCare in the Southwest. Today, I am testifying on behalf of PacifiCare and the American Association of Health Plans. PacifiCare and the American Association of Health Plans believe that physicians must be free to discuss all appropriate treatment options with their patients. We believe this information should be complete, unbiased, and presented to patients in a language they can understand.

PacifiCare uses no contract clauses which limit a physician's ability to discuss treatment options with his or her patients. PacifiCare in the Southwest is a network model HMO. We have 290,000 members and 75,000 Medicare members. We are the largest Medicare risk contractor in Texas and Oklahoma. Of our 8,200 contracting physicians, approximately 1,800 are primary care physicians and 6,400 are specialists.

Because of our strong commitment to the patient-physician relationship, PacifiCare does not use contract clauses that limit a physician's ability to discuss treatment options with his or her patient. Contracts with physicians and other providers are a key feature of network-based care. Contracts enable plans to hold physicians accountable, set out physician and plan roles and responsibilities and set payment arrangements. They protect all the parties involved.

Legislation prohibiting so-called gag clauses is unnecessary because, despite all the recent headlines and news articles, available information suggests that health plans rarely, if ever, use provider contracts to restrict communications on patient care.

Although some may find this surprising, it is fully consistent with the plans' strong incentive to encourage, not stifle, such communications.

Legislation regulating provider contracts is unwise because it would launch the Federal Government down the long and unprecedented road of deciding what private contracts may or may not contain. This will almost certainly produce unintended consequences.

There has been a lot of confusion around the issue of what is a gag clause and I would like to address two types of clauses that have been erroneously labeled as gag clauses—antidisparagement clauses and proprietary information clauses.

The purpose of an antidisparagement clause is simply to prevent a physician from involving patients in disputes and disagreements between physicians and health plans. Patient care, not a physician's disagreement with the plan, should be the focus of a member's encounters with the health delivery system.

As a medical director, I believe that a physician who has some knowledge or understanding of the system in which he or she works has an obligation to work within the system to correct it. At PacifiCare, a member physician can pursue a number of avenues. First, a physician can bring the concern to the attention of the medical group's or IPA's medical director or administrator. If the

problem is still not resolved, then the doctor may appeal directly to PacifiCare's physician advisory committees. PacifiCare also has a separate provider appeal mechanism available to physicians in the network.

Proprietary information clauses protect information such as the specific financial arrangements between the plan and physicians, whose release of this information would undermine competition among plans.

Disclosure of precisely how much a physician is paid per member per month, which I note can be an incomplete and misleading measure of payment, will do little to help patients answer the question that is foremost in their minds: Am I receiving the health care services needed for my disease or illness? Both antidisparagement and proprietary clauses in no way restrict physicians from discussing treatment options. And, in fact, are commonly found in many other professional and business agreements.

In addition, even though the Commerce Committee bill was narrowed in scope, the legislation still includes language that would bar a health plan from including "any provision that prohibits or restricts" any medical communication in contracts with health care providers.

The vagueness of this term opens the doors to broad interpretation by the Secretary of HHS. The bill also bans a health plan from prohibiting or restricting medical communication as part of an oral communication. Including oral communication that would change longstanding rules of contract law which have relied on written agreements between two parties.

Regulating the terms of contractual agreements between providers and health plans is not the way to ensure that patients receive the information that they need about their care, nor is it the way to ensure that physicians put patient interests first.

Quality improvement systems and holding physicians accountable for patient satisfaction are more effective. At PacifiCare physicians, along with senior management, lead our commitment to quality through our quality improvement council. Each market in our region has a physicians' advisory committee composed of practicing physicians in our network. These physicians perform peer review activities, as well as design studies in collaboration with PacifiCare to improve our members' health.

We currently have 52 practicing physicians, including specialists, who actively participate in our monthly quality improvement activities. We have targeted quality improvement activities in clinical areas such as congestive heart failure, diabetes, early detection of breast cancer, depression, and pediatric asthma.

These measurement and improvement activities will allow us to improve the care and outcomes for our members. HMOs and other integrated networks provide the unique vehicle for systematic quality improvement that is not readily available in fee-for-service arrangements.

What PacifiCare and other plans understand is that if you offer high quality care at an affordable cost, members will remain in your plan. While the record of network-based care in terms of the quality of choice and affordability is impressive, we are always striving to better fulfill our aim. Together we make lives better.

Thank you very much for this opportunity to be a part of this hearing. I would be pleased to respond to any questions that you and other Members of the Subcommittee have.

[The prepared statement follows:]

STATEMENT OF CHRIS L. JAGMIN, M.D.
MEDICAL DIRECTOR
PACIFICARE IN THE SOUTHWEST

Mr. Chairman, members of the Committee, my name is Chris Jagmin, M.D. I am the Medical Director of PacifiCare in the Southwest, and today I am testifying on behalf of PacifiCare and the American Association of Health Plans (AAHP). AAHP (formerly GHAA/AMCRA) represents more than 1000 HMOs, PPOs, and similar health plans. AAHP member companies are dedicated to a philosophy of health care that puts the patient first by providing coordinated, comprehensive health care. AAHP plans care for more than 100 million Americans.

PacifiCare is a network model HMO, which means we provide services through a network of contracted medical groups and Independent Practice Associations (IPAs). I appreciate the opportunity to address you today and hope my comments will be helpful to you. **Let me say at the outset that PacifiCare uses no contract clauses which limit a physician's ability to discuss treatment options with his/her patient. Also, AAHP and its member plans are committed to a policy of unrestricted communication between physicians and their patients with respect to diagnosis, treatment, and other information affecting the course of patient care.**

My testimony will highlight three areas:

1. Describe PacifiCare in the Southwest and how we work collaboratively with our physicians.

2. Review our activities to increase the value of health care, improve the quality of care/services provided, and improve health outcomes for our membership.

3. Discuss health plan contracting issues and related proposed legislation.

PacifiCare in the Southwest is a network model HMO, as noted above. We have 290,000 members including employees from small to very large companies, union trusts, and individuals. Our senior risk plan for Medicare beneficiaries (Secure Horizons) has over 500,000 members nationally and over 75,000 members in the Southwest. We are the largest Medicare risk contractor in Texas and Oklahoma. There are 58 medical groups/IPAs with 8200 physicians in our network. Of these, approximately 1800 are primary care physicians and 6400 are specialists.

Our providers include small primary care offices of one or two physicians, as well as large multi-specialty medical groups. We also contract with academic medical centers such as the University of Texas Medical Branch in Galveston and the University of Texas Health Science Center in Houston.

This large network provides our membership a wide choice of physicians. Members may change physicians within their medical group freely or may change medical groups on a monthly basis. With such a wide choice, members are encouraged to select the physician who best meets their needs and preferences. Our medical groups take both quality of care and customer service seriously. This is reinforced by medical groups' intense competition with one another for patients. A medical group that responds to patients' needs will be successful. In contrast, medical groups that are not sensitive to individual patient needs will lose patients and will not thrive.

PacifiCare in the Southwest is driven by our corporate aim: "Together we make lives better." We take great pride in our relationships with our medical providers. We have worked collaboratively over the years to ensure that physicians have the tools they need for improving care and service. Our "Art of Caring Program" was developed five years ago to improve service. It consists of intense one-to-two day training programs for physicians, nurses and office staff, focused on improving customer service and enhancing patient satisfaction. We have also funded two-day training programs to promote better communication between patients and their physicians. We have invested in our physicians' commitment to quality by giving practicing physicians the opportunity to attend intense, four-week courses in quality improvement.

Quality Improvement and Continuous Improvement are two values we believe in deeply. Along with physicians, senior management leads our commitment to quality through our Quality Improvement Council. Each market in our region has a Physician's Advisory Committee composed of practicing physicians in our network. These physicians perform peer review activities

as well as design studies in collaboration with PacifiCare to improve the health of our members. We currently have 52 practicing physicians -- including specialists -- actively participating in our monthly quality improvement efforts.

A major objective of our quality program is to assure that each of our members receives the best, most appropriate care for his or her particular case. As you may know, there is a great deal of variation in physician practice across the country, with the residents of some areas being two or three times more likely to receive a particular treatment -- such as an angioplasty -- than those in other parts of the country. These variations strongly suggest that, under fee-for-service medicine, some patients are receiving treatment that is inappropriate for their case. A Rand study, for example, reports that 25% of carotid endartectomies and coronary artery bypass surgeries are probably unnecessary or inappropriate. PacifiCare's quality improvement mechanisms are designed to assure that patients are not over-treated or under-treated -- that they receive the care they need. Working with physicians to develop and refine practice guidelines and utilization management techniques, we have been able to reduce the incidence of inappropriate care and its associated risks. In one case, for example, heart bypass surgery successfully averted the need for a more serious and risky heart transplant; in another, a patient whose physician initially recommended a kidney transplant was found instead to need a more complex -- and costly -- kidney-pancreas transplant.

It is likewise important to note that there may be several treatments available for the same diagnosis. Prostate cancer is an example. Current treatments include radical surgery, standard radiation therapy, brachytherapy (seed implants), cryoablation (freezing), hormonal therapy, or watchful waiting. Choice of treatment must be based upon the full clinical picture -- the stage of cancer, its aggressiveness, the age of the patient, and the values or preferences of the patient. In these, and in fact all circumstances, we believe that patients need the most complete, unbiased information available to assist them in making the right choices for them. We do not believe in limiting physicians' discussion of patients' choices or of other information important to helping patients make decisions about their care. We do not believe either that physicians are always unbiased in their treatment recommendations. It might be unusual, for example, for a radiation oncologist to recommend surgery to a prostate cancer patient. He/she would be much more likely to recommend radiation therapy. Our approach is to encourage patients to make these choices when all the information has been provided to them.

PacifiCare believes that we need to be accountable for these activities. To that end we have published HEDIS data for three years. We have targeted quality improvement activities ongoing in the following clinical areas:

- Congestive Heart Failure
- Diabetes
- Pediatric Immunization
- Mammography
- Pap smears
- Depression (study in collaboration with the Rand Institute)
- Pediatric Asthma

These measurement and improvement activities will allow us both to improve the care and outcomes of these populations and to report our results. A GHAA survey of 125 HMOs in 1994 indicated that 96 of them have implemented programs to improve childhood immunizations -- even though immunization rates already are higher in HMOs than in fee-for-service. Others have programs in asthma, arthritis, and other diseases. These efforts are in addition to other quality improvement initiatives which might be directed at improving record keeping systems, developing missed appointment tracking systems, or improving follow up of abnormal lab/x-ray results.

In this way, HMOs are organized systems for financing and delivering health care. They provide a vehicle for systematic quality improvement that is not as readily available in more episodic financing arrangements such as fee-for-service plans, because HMOs combine a number of interrelated features that foster a comprehensive approach to quality. These include:

- Selection of a defined, fully credentialed network of providers who can work together on delivery and quality issues.

- Delivery of comprehensive services across the spectrum of inpatient and outpatient settings, providing a full range of quality interventions.

- Clinical and fiscal accountability for the health care of a defined population -- allowing population-based data collection, analysis, intervention, and monitoring -- and establishing accountability for health plan performance.

A comprehensive review of the literature published from 1980-1994 appeared in the May 18, 1994 Journal of the American Medical Association. It analyzed 167 studies comparing quality of care in HMOs with care provided to similar populations in other settings. The study concluded that HMO quality is better than or equal to the fee-for-service results on 14 of 17 measures. People cared for in HMOs consistently receive more preventive care -- such as breast, pelvic, rectal and general physical examinations -- as well as more health promotion counseling. Some specific examples of studies on quality of care in HMOs are outlined below.

- Elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the fee-for-service system, according to a HCFA study that compared Medicare records for 12 different types of cancer. Breast, cervical and colon cancers, along with melanomas, were diagnosed significantly earlier in HMOs than fee-for-service. The largest difference was for cervical cancers: almost 60 percent of HMO members were diagnosed at the earliest stage, compared with just 39 percent of fee-for-service patients (American Journal of Public Health, October 1994).

- Women in HMOs were more likely to obtain mammograms, pap smears and clinical breast exams than women in fee-for-service settings. For example, 62 percent of women HMO members age 50-64 had a mammogram within the past year, compared to 50 percent of women with fee-for-service coverage (CDC/NCHS Advance Data No. 254, August 3, 1994).

- Finally, HMO members -- elderly and non-elderly -- are more satisfied overall with their health plan than fee-for-service enrollees. For example, a survey of 19,000 elderly Americans by the National Research Corporation found those enrolled in HMOs had higher satisfaction levels than traditional fee-for-service Medicare enrollees for every level of health status.

At PacifiCare we measure member satisfaction in several ways. One measure is the Member Satisfaction Tracking System (MSTS). This program involves a telephone survey of a statistically valid sampling of members for each of our contracted medical groups/IPAs. For example, the most recent results for 4 months ending 5/96 show that 97% of Secure Horizons members in San Antonio are satisfied on an overall basis and 98% said they would recommend PacifiCare. Also, the survey results indicate that 100% of Secure Horizon members of Tulsa are likely to continue coverage.

The second measure of satisfaction (or dissatisfaction) is the number of complaints. This has consistently been low, and currently is less than 5 complaints per thousand members per year for all complaints related to clinical care or service. In 1995, we estimate there were over 1,000,000 doctor-patient visits in our system. During this same period, there were less than 500 complaints related to quality issues (less than .05% of visits). Of these, less than 50 were found to represent true quality-of-care issues. This represents less than .005% of visits. All complaints are carefully reviewed and action plans developed when appropriate. Unlike fee-for-service, HMOs have systems in place to address problems with the objective of preventing their recurrence.

Perhaps a more important indication of satisfaction than enrollment rates is disenrollment rates. People can join a plan, but that means very little if they disenroll in a short period of time due to dissatisfaction. According to a recent study based on Health Care Financing Administration (HCFA) data, only 4% of Medicare beneficiaries enrolled in HMOs return to fee-for-service plans.

Contracting Issues

Before commenting on H.R. 2976, Mr. Chairman, we want to underscore one vital point. We firmly believe that there should be open communication between health professionals and their patients about health status, medical conditions, and treatment options. Such communication is key to prevention and early treatment, which AAHP member plans have long emphasized as an integral part of network-based care. Likewise, the full participation of patients in decisions affecting their treatment helps to assure that they receive quality, cost-effective care. Viewed from this perspective, such communication is in the best interests of the patient, the physician, and the health plan.

Federal legislation regulating the contractual relationships between physicians and health plans is both unnecessary and unwise. Contracts with physicians and other providers are a key and distinguishing feature of network-based care, ensuring that most of the services their enrollees need are provided through selected panels of providers. Contracts are how our plans hold these providers accountable, how they make clear the respective roles and responsibilities of the provider and the plan, and how they codify the payment arrangements between the provider and the plan. As such, they protect all of the parties involved.

Legislation prohibiting so-called "gag" clauses in these contracts is unnecessary because -- despite all the recent headlines and news articles -- available information suggests that health plans rarely -- if ever -- use provider contracts to restrict communications on patient care. Although some may find this surprising, it is fully consistent with plans' strong incentive to encourage -- not stifle -- such communications.

Provider Contracts

Legislation regulating provider contracts is unwise because it would launch the federal government down the long and unprecedented road of deciding what private contracts may and may not contain -- and in a sector of the economy that is so complex and rapidly changing that any efforts to ban specific arrangements will almost certainly produce unintended consequences. *As introduced*, for example, H.R. 2976 would effectively nullify two types of contractual provisions -- "anti-disparagement" clauses and confidentiality clauses -- that in no way restrict treatment-related communications between doctor and patient. Because these types of clauses have been misconstrued as "gag clauses," I would like to briefly discuss them.

Anti-disparagement clauses

The primary purpose of an anti-disparagement clause is simply to prevent a provider from involving patients in disputes and disagreements between physicians and health plans. Patient care -- not a physician's disagreements with the plan -- should be the focus of a member's encounters with the health care delivery system. If a provider disagrees with a health plan decision, he or she should seek to resolve the matter directly with the plan, not by enlisting patients to do the job. Such disputes do not belong in the examining room. These types of disputes relate to communication between a provider and a plan, not a provider and a patient.

Anti-disparagement clauses are also designed to assure that a provider who has contracts with more than one health plan does not use his or her position to encourage patients to switch from one plan to another simply because that plan's contract is more advantageous to the physician. It is important to remember that many physicians are affiliated with multiple health plans with quite different compensation arrangements.

As a medical director, I believe that a physician who has some knowledge or understanding of the system in which he/she works has an obligation to work within the system to correct it. The system -- within network-based plans -- has a number of avenues that a physician can pursue. First, a physician can bring the concern to the medical group or IPA's medical director or administrator. If the individual problem still cannot be resolved, then individual doctors may utilize an appeal mechanism directly to PacifiCare. PacifiCare engages its physician providers at a variety of levels to permit this to happen. Concerns may be brought to the Physician Advisory Committees. PacifiCare also has a separate provider appeal mechanism available to physicians in the network.

Permitting physicians to criticize the health plan irresponsibly is unacceptable. Protecting physicians making incorrect and misleading statements is not a rational solution, and in fact, would undermine the premise that patients should be given complete, accurate and unbiased information. Further, such protection would be unprecedented, and would afford health care providers protection not available to any other contractors.

Disclosure of Proprietary Information

When used, confidentiality clauses are intended primarily to protect against disclosure of proprietary information. We believe that patients should be informed about how their health plan works, and why, in their specific case, particular treatment options are appropriate or inappropriate. Likewise, patients should be fully informed about how their health plan made a decision about whether a particular service was covered, how to appeal that decision, and in general terms what the plan's financial arrangements are with the health professionals who provide patient care.

Health plan contracts with providers often contain legitimate requirements that providers not disclose proprietary information, such as specific protocols and specific compensation amounts. Restricting the disclosure of such financial information is appropriate. First, competition among health plans is intense, and the release of such information about one plan can give its competitors an unfair advantage, erode any competitive advantage it has achieved, and eliminate the incentive to find more effective methods for delivering care. Second, plans themselves are often bound by contract not to disclose coverage decision procedures and other protocols that are licensed by companies that have developed them as commercial products. Preventing plans from requiring their affiliated providers to respect this confidentiality will make it difficult, if not impossible, to comply with such obligations and to protect intellectual property appropriately.

Releasing proprietary decision procedures will do little to help patients understand the particulars of their case. These documents are frequently highly complex, sometimes voluminous, and almost always involve extremely technical terminology. More importantly, disclosure of precisely how much a physician is paid per member per month will do little to help patients answer the question that is foremost in their minds: Am I receiving the appropriate health care services needed for my disease or illness?

As a recent article in the New England Journal of Medicine points out, network-based health plans have developed highly sophisticated mechanisms for paying physicians -- mechanisms that take into account patient satisfaction and other measures of quality, as well as practice profiles, in order to avoid both under- and over-utilization of services.[1] The article reports, for example, that "more than half of the group or staff model HMOs and the network or IPA HMOs adjusted payment [physician compensation] on the basis of patients' complaints and measures of the quality of care." Thus, simply telling a patient that her plan pays a physician $X per month for her care fails to tell the whole story. In fact, it can be misleading if the patient does not understand that the plan is also paying the physician a similar amount each month for an entire group of patients, many of whom do not need any care -- or if the patient does not know that the physician has "stop-loss" protection for high cost cases, as is frequently true. **However, patients should know how the decisions affecting their care are made and how they can appeal any decisions with which they disagree.**

PacifiCare and "Gag Clauses"

PacifiCare believes categorically that physicians must be free to discuss all appropriate treatment options with their patients. We believe that this information should be complete, unbiased, and sensitive to the patient's own values. Patients should have information presented to them in ways they can understand and in language that they can understand.

As a medical director, I'd like to point out that not all physicians may be aware of all treatment options. There is much changing in the practice of medicine and new treatments are available all

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[1] Gold, Hurley, Lake, Ensor, and Berenson, "A National Survey of the Arrangements Managed Care Plans Make with Physicians," New England Journal of Medicine, vol. 333, No. 25 (December 21, 1995), pp. 1678-83.

the time. Nonetheless, PacifiCare encourages our doctors to discuss all treatment options, including those which may not be covered.

PacifiCare agrees with the statement: "Patients cannot make appropriate health care decisions without access to all relevant information relating to those decisions". This information should include an understanding of whether the treatments are covered by the plan as this information may be very relevant. **Our PacifiCare Provider Contract does not contain a clause limiting a physician's ability to discuss treatment options.**

Over the years, PacifiCare has enjoyed substantial growth, a high level of member satisfaction, a low level of disenrollment, and a high mutual regard with our medical providers. Regulation of our provider contracts is not necessary and could potentially impair the communication between the doctor and the patient.

Legislating Contracts – H.R. 2976
The Committee on Commerce made significant changes to the *introduced version* of H.R. 2976. Changes include a shorter definition of medical communication with the addition of a specific reference to oral communication; a change in the amount of civil money penalties; deletion of the "prohibition on adverse action by a health plan"; and redrafting of the rule of construction.

While the scope of H.R. 2976 has been improved since it was first introduced, we still have serious problems with the bill. Today I am going to address two areas of concern.

"Restricting" Communications
We believe that the intention of H.R. 2976 is to protect patient care by assuring unrestricted physician-patient communication regarding medical diagnosis and treatment options. Unfortunately, this bill could actually place patient care at risk by interfering with our health plans' quality assurance initiatives. H.R. 2976 includes language that would bar a health plan from including "any provision that prohibits or *restricts*" any medical communication in contracts or agreements, written statements, or oral communications with health care providers. The vagueness of the term "restricts" opens the door to broad interpretation by the Secretary of Health and Human Services and the federal courts, leading to extensive government micro management of health care delivery.

Some health plans and physician group practices currently require physicians to refer to clinical practice guidelines or practice protocols before discussing diagnoses and treatment options with their patients. For example, some require physicians to check with the plan before recommending an organ transplant, to make sure the doctor knows about the plan's use of centers of excellence for transplant surgery. If broadly interpreted, such practices, designed to ensure high-quality care, could be deemed "restrictive." Other health plans and medical group practices require physicians to discuss complex cases with their peers, i.e., doctor-to-doctor, to assess the medical appropriateness of a course of treatment for a particular patient, prior to discussing treatment options with their patients. These discussions focus on the tough cases for which a clear-cut treatment may not be obvious. H.R. 2976 could prohibit this quality improvement practice. These types of quality improvement activities do not interfere with plans' commitment to free and open communication or their commitment to placing no restrictions on discussion of medical treatment options.

Limits on "Oral Communications"
We are concerned that H.R. 2976 not only bans a health plan from including any provision that prohibits or restricts medical communication as part of a written contract or written statement, but also as part of an "oral communication." The inclusion of "oral communication" in H.R. 2976 is unnecessary as the relationship between a plan and its providers invariably is governed by a written agreement.

The purpose of written contracts is to assure that all parties involved have a clear understanding of what is expected of them. Currently contracts are enforced on the basis of mutually agreed to *written* terms and conditions, precisely because oral communications are easily subject to misinterpretation. H.R. 2976, which permits disputes to be based on undefined oral

communications between health plans and physicians, creates several problems. First, the bill would create the potential for litigation based on a provider's misinterpretation of a casual comment. Second, the bill does not make clear who is a "representative" of the health plan or who is responsible for the plan's oral communications. Is the representative solely a health plan administrator, or do physicians also speak as representatives of the plan? If a physician suggests to one of his colleagues that he should conduct more tests before revealing a diagnosis to a patient, would this be interpreted as prohibited communication under this bill?

Further, in a dispute on the issue between a plan and a provider, it would be the language of the written agreement between them which would govern. Oral statements made by a plan to a provider which restricted or prohibited medical communication would violate the written contract.

Finally, regulating "oral communications" would force health plans to document all oral communications that they have with providers to protect themselves from future litigation. Informal conversations about medical care, for example between a medical director and a plan physician would be difficult, as remarks would have to follow an approved script. Maintaining daily records of every interaction would be tremendously laborious and administratively burdensome. Moreover, it would inhibit the free flow of information between medical professionals that is vital to providing high quality care.

Concluding Comments

While the record of network-based care in terms of quality, choice, affordability, information, partnership and prevention is an impressive one, we certainly recognize that there is always room for improvement. Due to the complexities of modern medicine, the best outcome is not always achieved in every circumstance -- regardless of the type of delivery system. Press reports critical of HMOs and other network-based health plans focus on anecdotes without even mentioning the numerous studies reporting that quality of care in network-based plans is equal to or better than care in fee-for-service plans. It is this evidence -- and not anecdotes -- that should drive our policy discussions. Moreover, such stories fail to acknowledge that the very same problems can and often do occur in fee-for-service plans.

We intend to continue to support efforts for continuous quality improvement, to encourage dissemination of comparative plan data, and to respond promptly to identified problems. At the same time, we urge those who have the responsibility for public policy-making to reject legislation or regulation that would reduce network-based care plans' ability to deliver quality, affordable care. Regrettably, all too often opponents of HMOs, PPOs and other similar plans have tried to use legislation to unnecessarily burden health plans and thereby limit consumers' choices.

We know there are tens of millions of very satisfied consumers enrolled in PacifiCare and other AAHP member plans. What they illustrate is that as Americans have direct contact with network-based care plans, they recognize and appreciate the advantages these plans provide. Each and every day our member plans focus on improving or maintaining the health of their patients as well as making health care more affordable. HMOs, PPOs and other network-based plans have been at the center of efforts to reform our health care system for decades and as study after study shows, they have done it with high quality at lower costs and with high levels of patient satisfaction.

Thank you very much for this opportunity to be a part of this hearing. I would be pleased to respond to any questions that you or other members of the Committee may have.

Mr. CHRISTENSEN [presiding]. Thank you, Dr. Jagmin.

Dr. Nelson, earlier one of the panels talked about the insurance commissioners taking a look at this and letting it be handled at the State level. In your opinion, what would be wrong with allowing us to go that route as we are in, six or seven States now and growing, rather than, as Dr. Jagmin has stated, down that slippery slope of Federal regulation?

Dr. NELSON. Thank you, Mr. Chairman.

One of the roles I have in Utah, as being the deputy director of our State Health Department—and there are many groups which would not fall under that group—there are about 60 percent or more of individuals who are insured by employer-owned insurances which simply do not come under the regulation for a State insurance commissioner.

Further, there are many patients also in Federal programs, specifically Medicaid or the State programs. So, a tremendously large number of individuals would not be affected by that.

Mr. CHRISTENSEN. Dr. Jagmin, I wanted to find out under PacifiCare how autonomous are the doctors under PacifiCare's managed care plans?

Dr. JAGMIN. When you talk about autonomous, I assume you mean clinical decisionmaking processes?

Mr. CHRISTENSEN. Correct.

Dr. JAGMIN. We delegate medical necessity and the determination of clinical decisions to physicians in our network.

Mr. CHRISTENSEN. So, do they have to get approval every time they are presented a case scenario versus a specialist, that type of situation?

Dr. JAGMIN. Physicians in our network do not call the health plan for approval. We delegate utilization management to provider physician groups. Now, within their medical group, the physicians may have set up mechanisms where they call each other for approval, but we do not maintain a 1–800, call a nurse program, or anything like that.

Mr. CHRISTENSEN. Do they lose money if they refer, as a primary care giver, if they refer out of the network or to a specialist within the network?

Dr. JAGMIN. Providers lose money if they refer inappropriately.

Mr. CHRISTENSEN. What is determined inappropriately?

Dr. JAGMIN. The physician who is taking care of the patient determines what is inappropriate. If a patient needs care and the plan's physician or whoever is contracted to take care of the patient does not take care of the patient, they will become sicker, they are going to require more resources, they are ultimately going to cost the system more. So, the emphasis in good managed care plans is to determine illness, discover it early, and treat it early.

Mr. CHRISTENSEN. How do the HMOs and, specifically PacifiCare, encourage doctors to discuss all the possible alternatives with the patient?

Dr. JAGMIN. Sometimes the health plans have to raise all the possible alternatives with the patient and the physician. The PruCare issue we were talking about earlier is a good example—PruCare has centers of excellence that they use for transplants. When a member has an unusual disease that requires a transplant,

they can go to a center of excellence. Involving a national center broadens the range of choice and opportunities.

In my particular case, I have a friend in San Antonio who is an attorney whose daughter has cystic fibrosis. At age 26, she is still alive and required a lung transplant. PruCare arranged for them to go to Barnes, in St. Louis, which is one of the best programs and they were very happy with the outcome of that care.

Mr. CHRISTENSEN. Should a patient have the right to know financial arrangements and incentives that doctors have with managed care organizations?

Dr. JAGMIN. Yes. I think patients should have a right to know incentives. I do not think they should know proprietary information and I will give you an example.

When I was practicing in my group, we put out a letter to our patients and said, you've joined our practice. You should know if you are a PacifiCare patient, we are paid by capitation. We are accountable for your health care and here is how we are reimbursed.

We found that to be a fair and equitable way to be reimbursed. We did not tell them our capitation rate is x dollars and cents per member per month because that would be proprietary information.

Dr. NELSON. Mr. Chairman, it is so much more subtle than that. Let me tell you about a real live patient not too long ago and I will do it as briefly as I can. Just to tell you the bind we are in.

I am an obstetrician-gynecologist and I see high-risk patients. I hope they do not become high risk because they come to me but high risk in the first place. This is a patient I had not rendered care for before, who had five previous cesarean deliveries. She was pregnant for the seventh time, having had a miscarriage. It was about 33 weeks out of 40 gestation. She was in preterm labor.

Now, the question is, what do we do? Every once in a while at 33 weeks, a patient will be mature enough that if her baby were delivered it might do very well, with intensive care but very expensive intensive care. If the baby were not mature, if we simply kept it in the womb a little bit longer it could become mature relatively rapidly with not much difficulty.

In this particular case, it also meant an expensive operation which, of course, puts the patient at some risk. Now, what do we do? Because of my training I did what I thought I was supposed to do: I called an expert. A colleague of mine who is a perinatal doctor, a person specializing in high-risk obstetrics.

We agreed together that the appropriate thing to do was to do an amniocentesis and remove a small amount of fluid from the womb, analyze that and see if the baby were mature and make our decision based upon that. As I had the abdomen prepped, the patient reminded me that she was a member of XYZ corporation. Of course, I took my sterile gloves off and called XYZ. I do not know where the people came from, and I am sure the person I talked to did graduate from high school, but not much more.

That person could not spell amniocentesis, could not tell me if it was covered or not, and could not find a supervisor who could tell me. I was finally told, after many minutes on the phone, that this was not a covered benefit. Now, what am I supposed to do?

Am I supposed to allow my patient to go into labor, maybe let her baby die and, at any rate, cost thousands and thousands of dol-

lars if I make the wrong judgment? Or do I go ahead and try to keep the baby in utero which if I do inappropriately could make the uterus burst and she could lose her life?

Oh, by the way, all these young folks are making these decisions in a cavalier fashion on the telephone some place in a clandestine place, never having seen my patient. I am the one who takes the medical-legal hit. If there were a problem, I am the one who has to go to court.

What did I do? I did what was right, I prayed and I did the amniocentesis. I ate the cost of it. I ate the cost of the test which was several hundred dollars, found out that my patient was not mature, kept her on tributelene or medication to make her not contract and successfully delivered her several weeks later of a term infant.

What was my thanks? A letter of reprimand for telling my patient something she should not have been told, even though I provided good care.

So, it is not just, Mr. Chairman, what's written in the contract, it is the implementation and the subtleties, the vagaries, the regulations, and so forth, that come out. It was very difficult.

Mr. CHRISTENSEN. Would you be able to give a copy of that letter of reprimand to the Subcommittee?

Dr. NELSON. I am sure I can find it.

Mr. CHRISTENSEN. I would be interested in seeing that.

[The information was not available at the time of printing.]

Mr. CHRISTENSEN. Dr. Jagmin, Dr. Nelson earlier talked about a Humana contract that he recently testified from. Would you consider that a gag clause?

Dr. JAGMIN. If I am remembering the contract correctly, it was an issue about informing the patient.

Mr. CHRISTENSEN. Dr. Nelson, do you have that, would you reread that?

Dr. NELSON. Right here. This is the Physician Bulletin 96001–5896. And it says, "Effective immediately, all Humana participating providers must telephone the preadmission review department at 1–800, before an admission occurs and before conveying the possibility of admission to plan member."

Now, it talks about many group contracts that specify a 50-percent penalty for not getting preadmission review authorization.

Dr. JAGMIN. I think the issue of the particular quote, before conveying the possibility of admission to the plan member, is wrong. And I think Humana subsequently said that that was a wrong statement, that there was an inappropriate person who issued it. That is inappropriate behavior, clearly.

Now, the issue of what is covered under a benefit is definitely in the plan's purview. Something may be medically necessary and not covered in the plan's benefit. So, it is important for physicians to notify patients that you need to have this done, and now we are going to figure out if your plan covers it or not. I am going to call the plan to see if I can do it. I think we are starting to confuse medical necessity with benefit plan coverage issues.

Mr. CHRISTENSEN. And under the association you are representing, the medically necessary words, would be, something that under Dr. Nelson's scenario would have been covered?

Dr. JAGMIN. Now, in PacifiCare, Dr. Nelson or the physician involved in this Humana issue, would not have called me or anybody else for approval to do the procedure.

Mr. CHRISTENSEN. OK. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I would like to follow that line of questioning. If the physician delivers the care, at some point you are going to go after Dr. Nelson if he does too many amniocentesis. Ultimately, your computer printout is going to come out that he does one on practically every case he has.

Now, what's the penalty for that in your organization?

Dr. JAGMIN. The penalty for being an outlier is not a penalty. I learned from Brent James of Inter-Mountain Health Care in Salt Lake City, and I am sure that Dr. Nelson knows, the fact that a physician is in variation compared to his or her peers does not mean they are wrong. It means there is a variation and we should investigate it and explain it.

It may be that the patients who went to Dr. Nelson were truly sicker, truly did require those procedures. That every one of them was justified. Fine. Variance is explained.

It may be that there is a learning opportunity for Dr. Nelson to learn what the rest of his colleagues are doing. It may be that Dr. Nelson is doing the right thing and all the other doctors should be doing more amniocentesis.

Mr. MCDERMOTT. Well, you puzzle me because obviously Dr. Nelson thinks there is a situation of subtle kind of gag or subtle restriction on his practice. You say it does not exist. I do not understand why your organization would oppose this bill, since you say you rarely use this, I think that the language you actually used in your testimony rarely, if ever, use these kinds of antidisparagement or any other kind of clause, why would you resist this being in the law?

Dr. JAGMIN. Physician health plan contracts are very complicated. And what we really oppose is the Federal regulation of that contract and that interaction. This is only one example that once we get started into we are going to be micromanaging every detail of that relationship. We are all going to be unhappy, both providers and health plans.

Mr. MCDERMOTT. But I said to the last witness, as I think you may have heard, I suspect that Dr. Nelson's going to win in the end, because his story is much more compelling than your kind of rational presentation of this. You got billions of dollars, I mean you got the front page of Time magazine last December with a doctor, with a mask in his mouth, being gagged. When you have got that going on out there, I cannot understand why you, on a business basis, would resist something that you say you rarely, if ever, use and there would be no penalty on Dr. Nelson. You would never, ever deduct anything out of his paycheck if he did an amniocentesis on everybody.

Dr. JAGMIN. Let me give you an example where I think we have problems with the language of the bill. Theoretically now some of the communications that happen between a medical director and a physician in the plan I would consider would be a restriction.

For instance, if we know a patient's having a certain procedure done at a particular hospital, and I know from dealing with other patients that hospital B over in this other city has a much better success rate. If I call that physician and say, Did you know this?, am I gagging that physician?

We read that potential communication as a gag and it is very much up to the whim of the Secretary in determining that. I am concerned about that.

Dr. NELSON. If I may, I take exactly the opposite approach. I say how can anybody be opposed to it? The groups like PacifiCare that are doing a good job, do not have anything to fear. The ones who are doing a bad job are the ones that need to fear. It is so subtle, Dr. McDermott, so subtle. Within the last 2 weeks I received from one of my groups I have worked with for 13 or 14 years now, a new way in which I will be paid. There are four tiers. I happen to hit tier three, so I am going to be paid a little bit more but not as much as if I were to hit tier four.

Now, the way this was determined is that they took the number of dollars I spent for my patients and compared the number of dollars I spent to my patient to the number of other doctors, all specialties, and divided it by the number of doctors.

Mr. MCDERMOTT. All specialties, not just——

Dr. NELSON. Yes.

Mr. MCDERMOTT. You weren't compared against obstetricians?

Dr. NELSON. No, sir. All doctors.

Mr. MCDERMOTT. So, that's kind of a universal salary schedule?

Dr. NELSON. Correct. So, what they got was an average. And 0.3 was the average and I was 0.4, some small number. I said to the person explaining this, Does that mean I am a better doctor or worse doctor? We do not know was the answer.

Well, if I am a better doctor, you should pay me more, not less. The fact you are paying me less makes me believe you think I am a worse doctor. No, sir, we do not know. Well, then why are you paying me less? Well, because you spent more than average and it went around like that.

The sum and substance of it was, well, if, in fact, I am doing the correct thing, maybe you should be paying me more, maybe all the other guys are wrong. Maybe I am the worst doctor in history and I need to repent but the point is you cannot tell me and, yet, I am being treated as if I were the person who is not doing it well.

So, these are the things that are really happening right now.

Mr. MCDERMOTT. What's the differential between tier 1, 2, 3, and 4?

Dr. NELSON. It is about 5 or 7 percent. Among a large number of patients in a capitated plan that could be more.

Mr. MCDERMOTT. Five percent each tier?

Dr. NELSON. Roughly.

Mr. MCDERMOTT. So, you could be making 20 percent more if you were at the top?

Dr. NELSON. It is 15 to 20 percent, I am sorry I do not remember the numbers exactly but I could get them for you.

But it is a different percent per tier.

Mr. MCDERMOTT. I think it would be useful for the Subcommittee to see how that actually operates.

Dr. NELSON. I would be very happy to submit that.

[The information was not available at the time of printing.]

Mr. MCDERMOTT. One of the things about this that is very difficult to talk about in detail but it is on television and that's why we get the term gag clause. There are no obvious gag clauses. But there are these subtle pressures on people which I find very hard to believe that a managed care operation is not using one way or another.

You say you are not. So, I think you make a very serious error in coming here on a business basis and allowing all this bad publicity to continue going because you resist having a law in place which prevents the use of gag rules.

Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Mr. Cardin.

Mr. CARDIN. No questions.

Mr. CHRISTENSEN. Dr. Nelson, I just have a couple of other questions. First of all, the bill that passed the Commerce Committee applied to all providers not just physicians. How does the AMA or yourself, personally, feel about the free communication of medical advice not just from a physician but also, say, from hospital nurses and other medical personnel?

Dr. NELSON. I suppose, Mr. Chair, it would have to do with intent. We would think that information from any source is beneficial. A very simple example. If you were to have the misfortune to have adult respiratory distress syndrome, a very serious disease which kills lots of people, you would hope that that happened to you in Salt Lake City, because we have the best outcomes in the world, literally.

But the fact is that when rounds are held—the rounds are conducted by the attending physician, the resident physician, the intern physician—the nurse, the nurse specialist, the physical therapist, the respiratory therapist, the occupational therapist, the social worker, the clinical pharmacist, and so forth, we do everything as a team. So, if anyone of those members found a problem with the process we would want that information.

Mr. CHRISTENSEN. OK.

I have no further questions. I would add, Dr. Jagmin, I think you have a very difficult position. I mean I think you are in a bit of a quandary. In one aspect I understand the position you are taking, because I understand, you know, the group that you also work for. But, I also believe that this is an area that needs to be addressed and investigated. It is tough for you to have to be in the position that you are in.

I appreciate your testimony.

Dr. JAGMIN. I understand, Mr. Chairman, there is one point I would like to clear up from Congressman Stark's comments earlier.

Mr. CHRISTENSEN. Yes, sir.

Dr. JAGMIN. California was requested by the State government to supply over 50,000 patient charts for review of complaint issues in California, which run a little bit less than 5 per 1,000 members per year. Those 50,000 charts included 39,000 members who had never complained about the health plan.

Imagine having your personal chart put into the hands of the State government where we know that confidentiality is not always

observed. So, the judge who ruled on that case in California agreed with PacifiCare. PacifiCare ultimately did provide the charts for which there were complaints documented for which there were concerns.

Dr. NELSON. There are a lot of other ways to handle it. In the State of Utah, where the health department does have access, we are so incredibly careful about confidentiality that we cannot trace the chart back to the patient or to the doctor.

But we certainly have the information. it is by that information that we can improve the quality of care.

Mr. CHRISTENSEN. Thank you both for your testimony.

The next witnesses, please, come forth.

Josephine Musser, vice president of the National Association of Insurance Commissioners; Diane Archer, executive director of Medicare Rights Center; and Lisa Craft from the Blue Ridge Regional Health Care Coalition.

STATEMENT OF DIANE ARCHER, EXECUTIVE DIRECTOR, MEDICARE RIGHTS CENTER, NEW YORK, NEW YORK

Ms. ARCHER. My name is Diane Archer, and I am the executive director of the Medicare Rights Center, a national nonprofit organization that works to ensure equitable access to quality health care for seniors and people with disabilities on Medicare. I thank the Subcommittee on Health for inviting me here to testify on the Patient Right To Know Act.

The Medicare Rights Center, under a contract with the New York State Office for the Aging and with funding from the Health Care Financing Administration, operates a telephone hotline that provides direct assistance to more than 6,000 people each year who have health insurance questions and problems.

More than 20 percent of our cases concern HMOs. Most of these cases are from clients who want to know whether they should remain in fee-for-service Medicare or switch to an HMO, or which HMO to choose and how to distinguish among them.

Our staff spends considerable time studying the HMOs in New York State but we are still unable to offer much guidance. HMOs do not disclose the basic information our clients need to know to make informed health care choices.

In particular, they do not disclose the specialist to whom patients will have access for a particular health condition, or the circumstances under which they will cover particular treatments for cancer, heart disease, stroke, and other costly and complex illnesses. To compound the problem, many HMOs do not allow their network physicians to disclose two crucial types of information that their patients need to know in order to make informed health care choices.

First, some HMOs prohibit their doctors from disclosing treatment options which the HMO will not authorize even when the doctors believe these treatments may be in their patient's best interest. While HMOs might have good reason to regulate the care that network doctors deliver, permitting HMOs to prevent full disclosure of all medically appropriate treatment options serves no public interest.

Indeed, many of our clients, and I suspect a large number of HMO enrollees, currently choose their HMO because their doctor is in the network. They believe that they can trust their doctor to disclose their best health care options and they should be able to trust their doctor without fear that their medical advice has been censored by the HMO.

Second, many HMOs prohibit providers from disclosing financial incentives that may influence provider decisions about the care they deliver. Without information about physician financial incentives, patients cannot make informed choices about their health care.

While a patient may choose an HMO because it covers a particular treatment, HMO financial incentives may discourage physicians from providing this care in all but the rarest of instances. Medical practice is a regulated industry analogous in some ways to the distribution of pharmaceuticals. As a matter of longstanding public policy, the government requires comprehensive warnings to accompany the sale of pharmaceuticals in order to ensure that consumers understand the risk they are taking when they use particular drugs.

The medical policies and practices of HMOs merit similar scrutiny because they have a direct bearing on people's health and well-being. At the very least, a Patient Right To Know Act should protect the ability of physicians to disclose how HMO financial incentives can discourage delivery of costly specialty care.

While constraints on physician disclosures may serve HMO business interests, none serve any legitimate health care interest. They only undermine consumer choice about which HMO to join and what kind of care they need. None of these constraints have any place in our health care system and, indeed, many States already outlaw one or more of them.

If Congress sincerely wants informed consumer choice, it should pass H.R. 2976, as originally introduced, and outlaw HMO constraints on physician disclosure about treatment options and financial incentives, as well as nondisparagement clauses in HMO contracts.

However, even this legislation will not serve its purpose unless Congress addresses the ability of HMOs to terminate physician contracts for any reason. You have heard testimony earlier today about this issue. Even if Federal law forbids HMOs from restricting some or all types of physician communications, HMOs can, nonetheless, terminate doctors because of their communications. This ability to terminate physician contracts without cause has perhaps the greatest chilling effect on patient-physician communications.

In order for the Patient Right To Know Act to achieve its desired objective, informed health care decisionmaking, in order for patients to take responsibility for their health care, Congress must forbid HMOs from terminating physicians for disclosing treatment options, financial information, and any other information that bears on the quality of care the HMO delivers.

In conclusion, the Patient Right To Know Act, as originally introduced, is an excellent first step to helping patients take responsibility for their health care. But, in order for consumers to make informed choices about their health care, Congress will need to mandate far greater disclosure from HMOs. Most importantly, HMOs will need to disclose their medical protocols, including the terms under which they pay for particular treatments and the conditions under which they disallow care. Without these additional HMO disclosures, consumers cannot assess the nature of the care HMOs deliver, cannot make informed choices about their HMOs, and cannot take responsibility for their health care.

Thank you.

[The prepared statement follows:]

Testimony of Diane S. Archer, Executive Director, Medicare Rights Center

I am the Executive Director of the Medicare Rights Center, a national not-for-profit organization that works to ensure equitable access to quality health care for seniors and people with disabilities on Medicare. I thank the Subcommittee on Health for inviting me to testify today on the Patient Right to Know Act.

The Medicare Rights Center, under a contract with the New York State Office for the Aging, with funding from the Health Care Financing Administration, operates a telephone hotline that provides direct assistance to more than six thousand people each year who have health insurance questions and problems. More than 20% of our cases concern HMOs. Most of these cases are from clients who want to know whether they should remain in fee-for-service Medicare or switch to an HMO or which HMO to choose and how to distinguish among the HMOs. Our staff spends considerable time studying the HMOs in New York State, but we are still unable to offer much guidance. HMOs do not disclose the basic information our clients need to know to make informed health care choices. In particular, they do not disclose the specialists to whom patients will have access for a particular health condition or the circumstances under which they will cover particular treatments for cancer, heart disease, stroke and other complex and costly illnesses.

To compound the problem, many HMOs do not allow their network physicians to disclose two crucial types of information that their patients need to know in order to make informed health care choices.

First, some HMOs prohibit their doctors from disclosing treatment options which the HMO will not authorize even when the doctors believe these treatments may be in their patients' best interest. While HMOs may have good reason to regulate the care network doctors deliver, permitting HMOs to prevent full disclosure of all medically-appropriate treatment options serves no public interest. Indeed, our clients and, I suspect, a large number of HMO enrollees, currently choose their HMO because their doctor is in the network. They believe that they can trust their doctor to disclose their best health care options; and they should be able to trust their doctor, without fear that their medical advice has been censored by the HMO.

Second, many HMOs prohibit providers from disclosing financial incentives that may influence provider decisions about the care they deliver. Without information about physician financial incentives, patients cannot make informed choices about their health care. While a patient may choose an HMO because it covers a particular treatment, HMO financial incentives may discourage physicians from providing this care in all but the rarest of instances. Medical practice is a regulated industry analogous in some ways to the distribution of pharmaceuticals. As a matter of long-standing public policy, the government requires comprehensive warnings to accompany the sale of pharmaceuticals in order to ensure that consumers understand the risks they are taking when they use particular drugs. The medical policies and practices of HMOs merit similar scrutiny because they have a direct bearing on people's health and well-being. At the very least, a Patient Right To Know Act should protect the ability of physicians to disclose how HMO financial incentives can discourage delivery of costly specialty care.

While constraints on physician disclosures may serve HMO business interests, none serve any legitimate health care interest. They only undermine consumer choice about which HMO to join and what kind of care they need. None of these constraints have any place in our health care system and, indeed, many states already outlaw one or more of them. If Congress sincerely wants informed consumer choice, it should pass HR 2976 as originally introduced and outlaw HMO constraints on physician disclosure about treatment options and financial incentives as well as non-disparagement clauses in HMO contracts.

However, even this legislation will not serve its purpose unless Congress addresses the ability of HMOs to terminate physician contracts for any reason. For example, even if federal law forbids HMOs from restricting some or all types of physician communications, HMOs can nonetheless terminate doctors because of their communications. This ability to terminate physician contracts without cause has perhaps the greatest chilling effect on physician-patient communications. In order for the Patient Right to Know Act to achieve its desired objective -- informed health care decision making -- Congress must forbid HMOs from terminating physicians for disclosing treatment options, financial information and any other information that bears on the quality of care the HMO delivers.

In conclusion, the Patient Right to Know Act as originally introduced, is an excellent first step to helping patients take responsibility for their health care. But, in order for consumers to make informed choices about their health care, Congress will need to mandate far greater disclosure from HMOs. Most importantly, HMOs will need to disclose their medical protocols, including the terms under which they pay for particular treatments and the conditions under which they disallow care. Without these additional HMO disclosures, consumers cannot assess the nature of the care HMOs deliver, cannot make informed choices about their HMOs and cannot take responsibility for their health care. Thank you.

Mr. CHRISTENSEN. Thank you, Ms. Archer.
Ms. Craft.

STATEMENT OF LISA BRITTS CRAFT, EXECUTIVE DIRECTOR, BLUE RIDGE REGIONAL HEALTH CARE COALITION, ROANOKE, VIRGINIA; ON BEHALF OF NATIONAL BUSINESS COALITION ON HEALTH

Ms. CRAFT. Mr. Chairman, Members of the Subcommittee, good afternoon. I am Lisa Craft, executive director of the Blue Ridge Regional Health Care Coalition, a business group on health representing 80 employers in the Blue Ridge Mountains of Southwest Virginia.

I am here today to represent the interests of many employers, all members of health care coalitions across the United States with regard to H.R. 2976. Health care coalitions nationally include more than 7,000 employer members and represent more than 35 million employee lives.

Because of the many negative implications to employer sponsored health plans and managed care, I strongly oppose this legislation and any legislation that does not provide for uniformity in the rules affecting benefit plans. The bill is intended to protect communication between patients and providers regarding available treatment options from undue contractual restrictions and employers do not oppose this. I repeat, employers do not oppose the intent of this bill.

As written, however, the bill reaches far beyond this purpose to affect written agreements and oral communications between health plans and providers. H.R. 2976 poses a serious threat to managed care contracting, as well as to the delivery of high-quality affordable health care.

Employers are opposed to this bill for many reasons, but I will focus on three. Implications to ERISA, communication issues, and erosion of managed care from both quality and cost standpoints.

First, H.R. 2976 does not provide for any uniformity in the rules affecting health benefit plans that contractors have agreements with any type of provider, comparable to uniformity provided by ERISA. H.R. 2976 fails to ensure uniformity by granting States authority to impose their separate and mutually inconsistent standards. Since ERISA does not supersede other Federal laws, this effectively modifies the ERISA preemption in a manner that is unacceptable to employer plan sponsors.

In addition, the bill also creates a new enforcement role for the Department of Health and Human Services, a role which we do not feel HHS is prepared to fulfill.

Health and Human Services will determine violations and impose civil penalties on health plans which could affect a broad range of the various provisions, terms, and other requirements of an employee welfare benefit plan and third party administrator.

Second, the overly broad prohibitions on health plan communications create ambiguities which will lead to increased litigation. Health plans support open discussion of treatment options by providers with patients. However, this bill subjects more than the terms and agreement of the contract to the prohibition on protected medical communication. The bill includes any provision of a con-

tract, statement, or oral communication that prohibits or restricts protected patient/provider communication. The term "restricts" can be interpreted to mean limiting, confining, affecting, or may apply to such communication as utilization review.

Currently, contracts are enforced on the basis of written terms and conditions. Employers, health plans, and providers come to the bargaining table as business partners to negotiate the terms and conditions, setting forth the obligations of the parties. This bill provides Federal statutory rules that allow disputes to be based on all communications between the provider and the health plan.

Communications could include direct verbal statements, impressions, conversations, and so forth. If the government is to monitor all these communications, including reports, memos, newsletters, educational materials, and all conversations to and with participating network providers, costs will surely increase because each communication will have to be scrutinized by the health plan to ensure they are not interpreted or perceived as prohibiting, limiting, or confining protected communications.

In addition, this bill will open up a new arena of litigation relating to communication with at least two new types of evidence. One, showing a pattern of oral communication violations; and two, demonstrating a preponderance of oral communication violations. How these patterns and preponderances are proven is uncertain and may be subject to fabrication.

Third, the bill will erode managed care and the higher quality and lower costs associated with managed care. Employers have used managed care arrangements in order to lower costs and maintain quality health benefits for employees. Many managed care options include performance guarantees and information requirements which allow employers to include contract provisions aimed at assessing and maintaining the quality of health care services delivered. Without the ability to contract in this manner, employers will have no incentive to continue the managed care relationships.

With the return to traditional indemnity coverage, we will see cost increases and decreased quality initiatives. Not only is this a negative for employers, the erosion of managed care will be identical for public plans, including Medicare and Medicaid, Indian Health Services, and Federal and State government employee plans.

In addition to the erosion of managed care and associated cost increases, this bill will drive up administrative expenses by requiring plans to renegotiate contracts, review all contracts, written statements, oral communications, and greatly increase medical costs by favoring fee-for-service options as a means to avoid HHS micromanagement.

In conclusion, employers are opposed to H.R. 2976 because of its negative impact on employer provider contracting, thus minimizing the positive effects of managed care. The communication regulations created by the bill and the regulatory function created for Department of Health and Human Services is an additional layer of unnecessary burden and expense. These provisions also greatly diminish ERISA and create new liability for employer sponsored plans and third-party administrators.

Thank you.

Mr. CHRISTENSEN. Ms. Musser, we are going to have to go and vote. We have two votes and it is going to be 25 minutes or so. If you would go ahead and start your testimony and if we have to break off and come back for questions, that's what we will do.

So, we are pleased to hear your testimony at this time.

STATEMENT OF JOSEPHINE MUSSER, VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; AND CHAIR, SPECIAL COMMITTEE ON HEALTH INSURANCE; AND COMMISSIONER, OFFICE OF THE COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Ms. MUSSER. Thank you, Mr. Chairman, and Congressman Cardin.

My name is Josephine Musser, and I am the vice president of the National Association of Insurance Commissioners and the chair of the NAIC special committee on health insurance. I am also commissioner of insurance for the State of Wisconsin.

Celebrating its 125 anniversary this year, the NAIC is the Nation's oldest association of State government officials. Its members are the chief insurance regulators from the 50 States, the District of Columbia, and the 4 U.S. territories. On behalf of Governor Thompson and the NAIC, I thank you for the opportunity to address you here today.

H.R. 2976 addresses the important issue of communication between patients and their doctors. As you may know from my background biography, in one of my former lives I was a nurse, a patient advocate, an educator. My ethics are ingrained with informed consent and patients bill of rights.

Consumers need reassurance that a provider will discuss all treatment options with them, even when a plan's policy might not cover that treatment. The NAIC Managed Care Plan Network Adequacy Model Act proposes to protect these communications and offers other consumer protections.

As always, the NAIC encourages the inclusion of provisions allowing for State flexibility. We are pleased to see this proposed legislation give States the authority to establish or enforce more stringent requirements.

Further, we applaud the fact that the bill applies to both State-licensed and ERISA-governed plans, thereby, creating in fact a level playingfield with respect to its requirements.

The advantage of State flexibility highlights the strength of State-based insurance regulation. My home State of Wisconsin, for example, has a different experience and a different managed care climate than many other States.

For example, we enacted a statute more than 20 years ago that has the effect of prohibiting restrictions on provider communications. We have a very sound managed care market; 53 percent of our insured market is enrolled in managed care. This is due, in part, to the development of a strong relationship between providers and insurers, and the large number of provider-based plans. In Wisconsin, 19 of the 27 HMOs in Wisconsin were founded and owned by providers. And Wisconsin is the only State which requires HMOs to be licensed as insurers. This regulatory approach is different from other States' approaches.

For example, my office reviews all contracts between HMOs and providers. We would know if an HMO was contractually implementing a gag rule. As this debate began to grow nationally, I requested that my Market Regulation Bureau review the history of complaints and market conduct exams, searching out operational gag rules in addition to contractual gag rule provisions.

Not only have no HMOs implemented a gag rule in Wisconsin, but also we have received no complaints from providers or consumers on the issue. Obviously, this approach works for Wisconsin.

In fact, our State has the lowest uninsured rate in the country, according to the U.S. Census Bureau. I am proud of the climate of innovation fostered by Wisconsin Governor Tommy Thompson, who has helped our State advance significant small employer insurance reform, as well as Medicaid managed care. Working together, we have created a regulatory structure that works for Wisconsin, and we have a thriving managed care industry.

Managed care simply does not seem to get the headlines that Governor Thompson's welfare and education reforms get.

Mr. CHRISTENSEN. Ms. Musser, at this time, I am going to have to go and vote. I will come back and we will finish this off and give you ample time to finish your testimony and have some questions.

So, at this time, the Subcommittee stands in recess.

[Recess.]

Mr. CHRISTENSEN. Ms. Musser, we will let you finish up your testimony. We will give you a couple of extra minutes to finish up and then go into some questions.

Ms. MUSSER. Thank you.

As I was saying, my office reviews all contracts between HMOs and providers. And we would know if an HMO was contractually implementing a gag rule. But, as was mentioned earlier today and as the debate began to grow nationally, I requested that my Market Regulation Bureau review the complaints and market conduct exams searching out an operational gag rule, in addition to any contractual provisions that might exist.

Not only have no HMOs implemented a gag rule in Wisconsin, but also, we have received no complaints from providers or consumers on this issue.

Obviously, this approach works for Wisconsin. In fact, our State has the lowest uninsured rate in the country, according to the U.S. Census Bureau. Among the NAIC members, the gag clause has been discussed at great length as we have worked to develop managed care standards. Knowing this issue is of critical importance to consumers, our proposed Managed Care Plan Network Adequacy Model Act includes a provision similar to the provision in H.R. 2976 relating to medical communications.

During the past year, 17 States have taken legislative or regulatory action to prohibit gag clauses. Another 10 States have considered the issue. And of course, as I mentioned before, the great State of Wisconsin took action more than 20 years ago.

The NAIC Model Act suggests ways to bolster existing State requirements and to strengthen consumer safeguards in the rapidly evolving marketplace. The NAIC has either adopted or is developing models in the following areas: Quality assessment and improvement, utilization review, provider credentialing, managed care plan

network adequacy, data reporting, confidentiality, and grievance procedures.

In addition, the NAIC's CLEAR, Consolidated Licensure of Entities Assuming Risk, initiative seeks to promote a more competitive marketplace by ensuring that managed care providers are subject to a level regulatory playingfield.

As another example of the progress the States are making is Ohio's proposed Managed Care Uniform Licensure Act. This legislation would comprehensively rewrite existing managed care laws. Ohio, like other States, is engaged in an intensive effort to define the role and scope of the new provider organizations which are being created everyday.

Ohio's bill includes financial quality and utilization review requirements. It streamlines financial regulation and oversight of all managed care operations, placing them all under one chapter law. These organizations, of course, include HMOs, PPOs, provider sponsored networks, and multiple employer welfare arrangements or MEWAs.

I would like to return for just a moment to the subject of ERISA. The NAIC has stressed repeatedly that all consumers of health coverage should have the benefit of crucial consumer protections. In our white paper, "ERISA: A Call For Reform," and in testimony before Congress, we have emphasized that a significant portion of the health care market, including the managed health care market, is outside the jurisdiction of State law.

In previous testimony I have discussed my State's and all the States' inability to assist the thousands of consumer complaints we receive each year—from those covered by ERISA plans who do not know that they are covered by ERISA plans, and those who have no recourse or effective due process.

We recommend that when the opportunity arises, you consider additional protections for consumers of such plans in order to afford similar levels of security.

Again, let me urge you to maintain the States' ability to implement innovative and effective protections for the reform of the health insurance market. By doing so, in H.R. 2976, you have recognized the expertise of the States in regulating the health insurance market and in dealing with health insurance reform.

I want to thank you for the opportunity to testify, and I would be pleased to answer any of your questions.

[The prepared statement follows:]

STATEMENT OF JOSEPHINE W. MUSSER
VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
CHAIR, SPECIAL COMMITTEE ON HEALTH INSURANCE
COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Introduction

Good morning Mr. Chairman and members of the Subcommittee, my name is Josephine Musser. I am the Vice President of the National Association of Insurance Commissioners (NAIC) and the Chair of the NAIC's (EX) Special Committee on Health Insurance ("the NAIC Committee"). I am also Commissioner of Insurance for the State of Wisconsin. I have had the pleasure of meeting with you, Mr. Chairman and several other members of this subcommittee concerning various health insurance-related measures over this past year. It is a pleasure to return to testify before you today to discuss H.R. 2976, the "Patient Right To Know Act of 1996", and the issues of health care provider contracting and managed care regulation and to inform you of recent NAIC and state-level efforts in these areas.

The NAIC, the nation's oldest association of state public officials, is composed of the chief insurance regulators of the fifty states, the District of Columbia, and the four U.S. territories. This year, we are celebrating our 125th anniversary. The NAIC's (EX) Special Committee on Health Insurance is a committee composed of 38 of our members. The NAIC established this special committee a few years ago as a forum to discuss the many health care reform proposals and to provide technical advice on a nonpartisan basis to all who sought our expertise.

On behalf of the NAIC Committee, I would like to thank you for providing me with the opportunity to address you this afternoon at this hearing. My testimony will focus upon H.R. 2976, some of the legislation in place in Wisconsin and other states in this area, and the efforts underway at the NAIC to update and expand upon the NAIC's model state laws in the area of managed care. I will highlight provisions within certain proposed NAIC models that address the critical issues of provider-patient communications, health plan-provider communications and contracts, and other protections for enrollees and providers within managed care health plans.

Background

On July 27, 1995, the NAIC provided a statement for the record of a joint hearing held by the Subcommittee on Health of the Committee on Ways and Means and the Subcommittee on Health and Environment of the Committee on Commerce regarding standards for health plans providing coverage in the Medicare program. In this testimony, we provided some background information about state regulation of managed care organizations and NAIC efforts in this area, which I will update and expand upon today.

States currently regulate managed care organizations through a variety of statutes and regulations governing health maintenance organizations (HMOs), preferred provider organizations (PPOs), Blue Cross and Blue Shield plans, indemnity health insurance plans with a managed care component, and limited prepaid service organizations, among other types of organizations. Many states also regulate organizations that perform certain managed care functions, including free-standing utilization review organizations.

As you may know, the states, through the NAIC, have developed, and continue to develop, model state laws and regulations in the health care area. The NAIC's model HMO Act has been adopted with some variation in a majority of states and has served a pivotal role in promoting certain state-level protections. The NAIC also has a model addressing preferred provider arrangements and prepaid limited service organizations. These models are discussed in more detail herein.

H.R. 2976, the "Patient Right To Know Act of 1996"

The House Committee on Commerce has approved H.R.2976 and the Committee on Ways and Means is considering it on sequential referral. As adopted by the Committee on Commerce, the bill would prohibit health plans, both state-licensed and those governed by the federal Employee Retirement Income Security Act ("ERISA"), from prohibiting or restricting any medical communication as part of either a written contract or agreement with a health care provider, a written statement to such a provider, or an oral communication to such a provider. The bill also covers third-party administrators having responsibility for contracts with health care providers under the plan. The bill defines "medical communication" as "a communication made by a health care provider with a patient of the provider (or the guardian or legal representative of such patient) with respect to the patient's physical or mental condition or treatment options." We note and applaud the fact that H.R. 2976 applies to both state-licensed and ERISA governed health plans -- thereby treating both types of plans on a "level playing field."

As discussed below, the provisions of this bill are similar to a provision within the NAIC's proposed Managed Care Plan Network Adequacy Model Act that restricts health carriers from prohibiting participating providers from discussing treatment options. This model also addresses issues not discussed within the proposed legislation that relate to consumer, provider, and health plan rights and obligations.

The NAIC Committee appreciates that the proposed legislation specifically allows states to "establish or enforce requirements with respect to the subject matter of this section" as long as the requirements are "more protective" of medical communications than the requirements established under this section. In the course of commenting on federal health insurance reform legislation, the NAIC Committee has encouraged the inclusion of provisions allowing for state flexibility, such as in this

provision. The advantage of allowing each state some flexibility highlights the strength of state-based insurance regulation.

For example, Wisconsin has a different experience and a different managed care climate than that in many states. We have had language in our laws that equates to a restriction on gag rules for over 20 years. As this debate began to grow nationally, I requested that my market regulation bureau review the history of complaints, market conduct exams, and provider contracts for gag-rule provisions. In Wisconsin, not only have no HMOs implemented a gag rule in Wisconsin, but we have received no complaints from providers on this issue.

Obviously, this approach works for Wisconsin. In fact, our state has the lowest uninsured rate in the country, according to the U.S. Census Bureau. I am proud of the climate of innovation fostered by Wisconsin Governor Tommy Thompson, who has helped our state advance significant small employer insurance reforms. Working together, we have created a regulatory structure that works for Wisconsin and we have a thriving managed care industry.

Wisconsin's experience, however may be the exception and not the rule. Many key factors in the development of our managed care industry may have affected the relationship between HMOs and providers in our state. As a bit of background, Wisconsin does have a very sound managed care market. HMOs cover 53 percent of the states's insured group business, and cover an even higher percentage in urban areas. Nineteen of our 27 HMOs were founded by providers, creating a tradition of a strong relationship between providers and insurers. In addition, Wisconsin is the only state that requires HMOs to be licensed as insurers, which offers a different regulatory focus than most states where HMOs fall under a separate insurance licensure structure.

Our regulatory structure has worked for Wisconsin, and managed care has thrived with high satisfaction levels. That does not mean that our structure would work well in other states. The strength of state regulation is that each state is able to adapt to its environment and establish strategies most likely to work. H.R. 2976 recognizes that strength and enhances it.

On a technical note, the NAIC Committee recommends clarifying the scope of the preemption language by replacing the term "subject matter of this section" with the specific topics intended, such as "medical communications and health plan requirements relating to such communications." Such a clarification would assure that the scope of the provision is not construed to include subject matter not intended to be affected by the legislation.

The enforcement of H.R. 2976's requirements is to occur through the imposition of federal civil money penalties. However, as noted above, the preemption language also clarifies the states' ability to enforce more stringent requirements. In the past, the NAIC Committee has supported certain federal minimum standards relating to insurance, as long as state flexibility and the states' role as primary regulators and enforcers of insurance law is maintained. The NAIC Committee commented favorably upon the portability provisions within H.R. 3103, as adopted by the House and Senate respectively, and appreciated Congress' retention of the states' role as prime regulators of insurance within those sections of the bills. The NAIC Committee would recommend a similar division of enforcement authority within this bill, with federal enforcement for plans regulated by ERISA and state enforcement for those regulated under state law. Therefore, even in states which choose to not adopt standards that are more stringent than the requirements of the bill, the states' role as primary enforcers of insurance law should be retained. Such a division of authority may have been intended by the legislation, in which case we would simply recommend clarifying language

State Laws Addressing "Gag Clauses" and Utilization Review

The proliferation of so-called gag clause legislation around the country this year is one indication of tremendous public attention to issues raised by the growth of managed care. The term "gag clause," which refers to clauses in the contracts that managed care plans have with providers, particularly physicians, is used to describe at least four distinct situations. The term most commonly refers to clauses that prohibit or impede a provider from discussing with a patient all possible medical treatments, including those not covered by the plan. This type of gag clause is addressed by H.R. 2976 and by most enacted state laws. The second meaning of the term refers to limitations on a provider's freedom to discuss the compensation and other financial arrangements that the provider has with the patient's managed care plan. A particularly sensitive issue is the extent to which a provider's compensation can be adversely affected by hospitalizations of their patients, referrals to specialists, and the prescribing of expensive diagnostic tests or treatments. A third meaning of the term refers to contractual provisions prohibiting a provider from revealing a plan's proprietary information or trade secrets. Finally, the term is sometimes used to mean a broader contractual provision preventing a provider from making disparaging remarks about the specific plan or about HMOs and managed care in general.

H.R. 2976 and most state legislation are directed primarily at eliminating any constraints on the provider's ability to discuss all treatment options with the patient, regardless of the plan's policy with respect to coverage of that treatment. However, the public's concern about full and fair disclosure of all available treatment options is a symptom of the more general concern that managed care creates incentives for plans and providers to withhold necessary health care services.

At least 13 states have enacted legislation addressing the gag clause issue, and a fourteenth state has addressed the issue by administrative action. Bills were introduced during the 1995-1996 legislative session in an additional 12 states, but were not enacted. During the past year, then, at least 26 states moved to address this issue, and 14 have taken action. These figures are necessarily approximate because there is not always agreement about whether the provisions of a bill meet the definition of gag clause legislation and because, in some states, more than one bill may address this topic.

In general, these state statutes make clear that providers may not be contractually impeded from furnishing a patient with information that is relevant to the patient's medical condition, including information about treatment options that are not covered by the plan. The language used to achieve this objective varies from state to state; in some cases the statutory language also protects the provider's right to advocate on behalf of the patient who seeks reconsideration of a plan's decision. The issue of a provider's financial arrangements with the plan is less frequently addressed, although the language of some statutes is sufficiently broad to prohibit a managed care plan from impeding discussions of this subject between patient and provider. Relatively few states explicitly address the issues of protection of trade secrets or contractual prohibitions of disparaging remarks, but the state legislation addressing these subjects appears to uphold the right of managed care plans to prevent providers from revealing trade secrets or from making maliciously critical statements that could harm the carrier.

The NAIC discussed at some length the gag clause issue in the course of developing our proposed Managed Care Plan Network Adequacy Model Act. The provision in our model addressing this issue was drafted after much discussion and reflects the experience of regulators from very diverse states. The NAIC's effort reflects our recognition that this issue is of critical importance to consumers.

At least 33 states already regulate organizations and entities that conduct UR, and some additional states considered UR legislation during this past session. In 22 of these states, the insurance commissioner has the regulatory authority. In the remaining states, the health commissioner is usually the state official having jurisdiction over UR organizations. In rare instances a state official other than the insurance commissioner or the health commissioner has the regulatory authority.

The NAIC's "CLEAR" Initiative and Its Proposed Model State Laws Governing Managed Care Plans

Managed Care Plan Standards

Over the past two and a half years, the NAIC, in a public process, has been developing reasonable standards to suggest ways to bolster existing state requirements. The NAIC has either adopted, or is developing, models in the following areas relating to managed care: quality assessment and improvement, utilization review, provider credentialing, managed care plan network adequacy, data reporting, confidentiality, and grievance procedures. At this point, the NAIC members have adopted two of these models, one relating to provider credentialing and one relating to quality assessment and improvement. The full NAIC, at its Fall National Meeting in September, will consider three of these models, in the areas of utilization review, managed care plan network adequacy, and grievance procedures. In general, the NAIC has drafted these standards to apply to all plans performing managed care functions. In some cases, the provisions apply to other health carriers as well.

"CLEAR"

The NAIC's Regulatory Framework Task Force (the "Task Force") has been charged with the development of the above-mentioned model laws. The Task Force formed the Health Plan Accountability Working Group (the "working group") to undertake the initial drafting. The working group held numerous public meetings to discuss these models. At the NAIC's June 1995 Summer National Meeting, the working group recommended to its parent committee that the current NAIC model laws governing health carriers and other health care organizations be reviewed with an aim toward increased use of common definitions and common regulations of similar functional and risk-sharing/risk-transferring characteristics among health plans. The working group further recommended that the NAIC's existing models should be expanded to include, at a minimum, the health plan accountability standards under development by the working group, and that the effort be coordinated with other NAIC committees, such as the Health Organizations' Risk-Based Capital Working Group, and the Blanks Task Force. This comprehensive effort has been denominated as "CLEAR," or "Consolidated Licensure for Entities Assuming Risk," and seeks to promote a more competitive marketplace by ensuring that entities performing the same or similar functions are subject to a level regulatory "playing field." In addition, this effort seeks to clarify that the wide array of entities performing managed care functions fall within the scope of state regulation.

When we complete work on the health plan standards, the first priority will be to analyze the NAIC's other current models and begin the process of recommending ways to consolidate existing health models and incorporate the new standards.

Risk-Based Capital

The NAIC's Health Organizations Risk-Based Capital Working Group (HORBC) is developing a risk-based capital formula for all health organizations. These requirements seek to provide more flexible and sound requirements for plans' fiscal soundness, taking into account organizations' unique

characteristics. The American Academy of Actuaries ("AAA") is providing the technical assistance in developing a formula that is effective, but does not impose onerous data requirements. The results of this effort will be incorporated within the "CLEAR" effort.

There are four principal risk elements inherent in the insurance function:

C-1 Asset Risks: Risk that existing assets will decline in value and erode surplus as a result of that decline.

C-2 Pricing and Obligation Risks: Risk of any mispricing in the determination of premium rates or deviations between assumptions and experience in the payment of claims liabilities. This is the predominant risk for health carriers.

C-3 Interest Rate Risks: Risk of loss due to unforeseen changes in interest rate levels.

C-4 General Business Risks: Catch-all category that includes general business risk. Includes risk of assessments, administrative expense overruns, and environmental changes such as health care reform.

For health plans, regulators are principally concerned with C-2 risks. This is the risk that insurers may not have adequate funds available to cover insurance risks.

In December 1994, AAA presented to the HORBC a proposed model reflecting the variability inherent in health care coverages. The model applies factors to various asset, premium, and reserve items and contains credits for actions taken by an entity which reduce risk and loads for actions taken which increase risk. An example is managed care credits for activities or payment arrangements which reduce risk. The model also attempts to capture the impact of regulatory activity on an entity. An example is state rate approval requirements which may increase risk.

HORBC asked AAA to develop a simplified formula which maintained the formula's precision while at the same time minimized the costs to the health organization in collecting the data. The simplified formula must meet the following criteria:

specific — to the extent possible, the data should come directly from the annual statement or a supplemental blank (or be added to the annual statement) or from other specifically referenced source for all reporting organizations.

auditable — to the extent possible, the data should be included in the annual statement information that is electronically captured by the NAIC and that it be easily measured for consistency and quality through cross-checks with other annual statement data.

available — the data should be relatively easy for health organizations to obtain without substantial modifications of current reporting systems. One organizational form should not bear excessive data-gathering costs relative to another organizational form.

The AAA has submitted its proposed simplified formula to the HORBC working group. The working group will commence testing of the formula this summer and fall, and anticipates providing a detailed report by the end of the year. The results of the survey will determine what types of modifications to the formula will be required and whether another survey will be necessary.

State Activity in the Area of Consolidated Licensure

As I mentioned, Wisconsin is the only state to regulate HMOs as insurers, having always done so. This strategy of regulation allows a high level of flexibility and monitoring. For example, Wisconsin requires a business plan to be filed by HMOs which include a detailed description of provider access. My office reviews these plans to assist HMOs in creating a structure that will provide adequate levels of provider access. Also, by reviewing this plan and by requiring provider contracts to be filed with my office, we can monitor emerging changes in the managed care industry and develop the proper oversight strategies. This flexible approach contributed to a managed care climate that allowed Governor Thompson to lead the country in implementing managed care for AFDC recipients.

Other states have made significant progress. The state of Ohio is considering proposed legislation that seeks to accomplish many of the same goals as the NAIC's CLEAR effort. Ohio's Managed Care Uniform Licensure Act proposes to rewrite comprehensively existing managed care laws. This effort is the result of an intensive effort to define the role and scope of risk-assuming entities. The bill includes financial, quality, and utilization review requirements and would streamline the financial regulation and oversight of all operations of managed care insurance organizations and place such regulation within one chapter of law. These organizations include HMOs, PPOs, provider-sponsored networks, and multiple employer welfare arrangements.

NAIC Proposed Health Plan Standards

In undertaking the development of health plan standards, the NAIC recognized that the delivery of health care services was evolving away from fee-for-service insurance arrangements to managed care arrangements of many types. In light of the fact that most state insurance departments have a principal role in regulating managed care entities, and have therefore observed the market evolution firsthand, insurance regulators recognized the need to strengthen consumer safeguards in the managed care arena. The models under development apply in general to a wide array of managed care organizations. When appropriate, these models restrict the application of certain provisions to certain types of network plans.

The models include the following broad definition of "health carrier":

an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

In addition, the models define "managed care plan" as "a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier." Certain requirements within the models apply to managed care plans and certain subsets of such plans, as appropriate. Other requirements apply to all health carriers.

Many of the issues relating to provider contracting and consumer protections are addressed in the "Managed Care Plan Network Adequacy Model Act," but several other important issues are also addressed in the other models. I will briefly summarize these models and highlight provisions particularly relevant to the issues under discussion at this hearing.

Managed Care Plan Network Adequacy Model Act

The model establishes standards for the creation and maintenance of provider networks by health carriers and applies to all health carriers that offer managed care plans. It requires the arrangements between participating providers and health carriers offering managed care plans to address specific issues set forth in the act. The model also contains requirements for the contracts between health carriers and intermediaries.

Section 5 of the model, which addresses network adequacy, requires health carriers to maintain a provider network that is sufficient in the numbers and types of providers to assure that services to covered persons will be accessible without unreasonable delay. Section 5 also requires a health carrier to file with the insurance commissioner an "access plan" for each of its managed care plans. The access plan must describe the health carrier's network and other specified processes and procedures. The act requires a health carrier to make these access plans -- with protections for proprietary information -- available on its business premises and to provide them to any interested party on request.

Of particular relevance to today's discussion is Section 6 of the Model, which sets forth requirements that a health carrier must address in its contractual and other arrangements with participating providers. Importantly, it is worth noting that the model contains a provision prohibiting health carriers from preventing providers from discussing treatment options with covered persons, irrespective of the health carrier's position on the treatment options, or from advocating on behalf of a covered person within the plan's utilization review and grievance processes.

This provision is somewhat broader than the similar provision within H.R. 2976 as it also addresses a provider's ability to advocate on a covered person's behalf. H.R. 2976 prohibits plans from restricting "medical communications," defined as communications from a provider with a patient relating to the patient's physical or mental condition or treatment options. Because H.R. 2976 explicitly allows states to establish or enforce requirements that are "more protective of medical communications than the requirements established under this section," we assume that the provisions of this model act (and any state law based on the model act), that protect a broader range of provider actions would be clearly protected by the preemption language of H.R. 2976.

Other important requirements and provisions set forth within Section 6 of the model include: a provision requiring the health carrier to establish a mechanism for notifying participating providers of the specific covered services for which they are responsible; a provision prohibiting providers from attempting, under any circumstances, to collect from a covered person any money owed to the provider by the health carrier; and a provision prohibiting carriers from using standards to select providers that would allow the carrier to avoid providers serving potentially high-risk populations.

In addition, the model act contains a requirement that carriers make their provider selection standards available for review by the insurance commissioner and a provision prohibiting any inducement under the managed care plan for the provider to furnish "less than medically necessary services" to a covered person. The model also includes a requirement noting that when a provider's contract is terminated for whatever reason, the health carrier must make a good-faith effort to notify covered persons who are patients of that provider within 15 working days; a requirement that the health carrier ensure that providers treat all covered persons without regard to the person's status as a private purchaser or participant in a publicly-financed health care program; and a prohibition against the health carrier's penalizing a provider for reporting in good faith to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Section 7 of the model act addresses contracts between health carriers and intermediaries. It requires that intermediaries and participating providers must comply with all the model act's applicable requirements for the relationship between health carriers and providers. The model act specifies that the health carrier retains the statutory responsibility for monitoring the provision of covered benefits to covered persons and that the carrier cannot assign or delegate that legal responsibility to the intermediary.

Other provisions of this section establish recordkeeping and related requirements intended to ensure that the health carrier and the insurance commissioner have appropriate access to the books and records of intermediaries.

Sections 8 and 9 of the model act contain requirements for regulatory filing and oversight of the health carrier's provider contracts and material changes to those contracts.

The NAIC developed this model, along with all of the managed care models, through a public process in which the working group received and considered significant input from the health insurance and managed care industries, consumer representatives, and health care providers. The regulators attempted to strike the appropriate balance among the relevant concerns, while maintaining the protection of health care consumers as the paramount objective.

Utilization Review Model Act

The Utilization Review Model Act requires a health carrier to have a written description of its utilization review (UR) program addressing the issues set forth in the act. A health carrier must file with the insurance commissioner an annual summary describing its utilization review program activities, and its UR program must meet the operational requirements set forth in the model.

One managed care issue of prime interest to consumers and providers is the ability of a consumer to seek the closest and most convenient medical care in emergencies. Consumers and providers are understandably concerned when managed care plans retrospectively deny coverage for emergency care that seemed very justified at the time the services were received. The recommendation of the NAIC's Accident and Health Insurance (B) Committee for a regulatory approach to this problem reflected consideration and deliberation of several issues. These include the ability of consumers to determine the existence of a true emergency, health plan procedures to screen emergencies, and the need to control casual and inappropriate use of emergency rooms. The extensive testimony received by the working group on this issue from representatives of consumers, providers, and plans revealed the importance of this issue to all parties involved.

Section 12 of the utilization review model addresses emergency services and specifies a standard to be used by entities that conduct UR in making decisions about the coverage of emergency services. The standard requires a health carrier to cover emergency services necessary to screen and stabilize a covered person, without prior authorization of those services, if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a covered person may obtain care from a non-contracting provider within the service area of a managed care plan for emergency services necessary to screen and stabilize the covered person, without prior authorization, if a prudent layperson would have reasonably believed that using a contracting provider would cause a delay worsening the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The NAIC working group adopted this standard after much public debate. The model defines the terms "emergency medical condition," "emergency services," and "stabilized."

Another provision of the Utilization Review Model Act prohibits the compensation to any individual or entity that provides UR services to a health carrier from containing incentives to make inappropriate review decisions. The provision specifies that the compensation of these individuals and entities may not be based on the quantity or type of adverse determinations that they render.

As with its other health plan standards, the NAIC developed its Utilization Review Model Act through a public process that included extensive participation from representatives of the insurance and managed care industries, health care provider groups, and consumers. These participants included the Utilization Review Accreditation Commission (URAC), the National Committee on Quality Assurance (NCQA), and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The NAIC's working group made every effort to ensure that our model was consistent with the requirements of these other organizations.

In general, the NAIC's Utilization Review Model Act builds upon the authority already granted the insurance commissioner to regulate UR organizations, but provides a more detailed regulatory framework. As with all NAIC models, states are free to adapt this model to accommodate existing law and other circumstances. For example, some states may choose to alter the model for adoption as a regulation or may use the substantive provisions of the model, but enact a statute authorizing the health commissioner to regulate UR activities rather than the insurance commissioner.

Grievance Procedures Model Act

The NAIC committees drafting the Health Carrier Grievance Procedure Model Act recognized the importance of providing enrollees with a clear and accessible mechanism for addressing their complaints and appealing health plan decisions. This model contains standards for the procedures used by health carriers to resolve grievances submitted by covered persons. "Grievance" is broadly defined and includes complaints about the availability, delivery, or quality of health care services, including a complaint about an adverse determination made in the UR process. The term also includes complaints about claims payment, handling, or reimbursement issues, or about any matter pertaining to the contractual relationship between a covered person and a health carrier.

The model requires all health carriers to provide a "first level grievance review." These reviews enable a covered person to submit written material to a health carrier, but do not include the right to have a meeting with representatives of the health carrier. However, the model requires the carrier to provide a written decision within a specified timeframe, and the decision must contain certain information specified by the model.

In addition, the model requires a health carrier that offers managed care plans to establish a "second level grievance review" process. A second level review provides a covered person with the option of appearing in person before authorized representatives of the health carrier. If a face-to-face meeting is not practical for geographic reasons, the health carrier must provide and pay for the option of communication between the covered person and the reviewers by means of technology, such as a conference call or a videoconference. The health carrier must also provide a written decision containing specified information within a prescribed time period.

The grievance model also specifies the appropriate grievance procedures for a complaint involving a UR decision. These sections are intended to be completely consistent with similar provisions in the Utilization Review Model Act.

Quality Assessment and Improvement Model Act

The Quality Assessment and Improvement Model Act establishes criteria for the quality assessment activities of all health carriers that offer managed care plans. It also establishes additional criteria for the quality improvement activities of carriers issuing "closed plans," which are essentially HMO-type managed care plans. The model requires health carriers to develop quality assessment and quality improvement programs and to file a written description of these programs with the insurance commissioner or other appropriate regulatory authority.

"Quality assessment" is defined as "the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups or populations." "Quality improvement" means "the effort to improve the processes and outcomes related to the provision of care within the health plan."

The model requires a health carrier to include a summary of its quality assessment and quality improvement programs in its marketing materials and to describe them in its certificates of coverage. The health carrier must also make available each year to providers and covered persons the findings from its quality assessment and improvement programs and information about the carrier's progress in meeting internal goals and external standards. In addition, a health carrier must give covered persons the opportunity to comment on the quality improvement process.

Health Care Professional Credentialing Verification Model Act

The Health Care Professional Credentialing Verification Model Act requires all health carriers that offer managed care plans to establish a "credentialing" verification program to ensure that the professionals participating in the carrier's managed care plans meet specific minimum standards of professional qualification. "Credentialing verification" refers to the process of obtaining and verifying information about the professional's education, current licensure status, board certification, hospital privileges, and other qualifications. The act requires a health carrier to verify specified credentials when a professional first applies to participate in the carrier's managed care plan and to reverify the professional's credentials at least every three years. The act specifies that the credentialing process is separate from the selection process that a health carrier may use to choose its participating providers. Carriers may use separate or additional criteria to choose their providers. The act also establishes the right of the health care professional who is the subject of the credentialing verification process to review information obtained to satisfy the requirements of this act and to submit corrected or supplemental information.

Health Information Confidentiality Model Act

The NAIC has essentially completed its work on the five models just described. Over the next six months, the NAIC will devote considerable attention to our draft Health Information Confidentiality Model Act. This draft model is in a preliminary stage. The model requires a health carrier to provide written notice of its information practices to all applicants and covered persons. The draft also requires health carriers to provide an individual with access to his or her own recorded personal information. Also, the draft specifies a procedure for an individual to request a health carrier to amend the individual's recorded information. The act also limits the circumstances under which a health carrier may disclose personal or privileged information.

The NAIC is aware of congressional interest in legislation addressing the confidentiality of health information. The (EX) Special Committee on health insurance has commented on S. 1360, "The Medical Records Confidentiality Act", sponsored by Senator Bennett and others and has highlighted issues raised by the bill in the areas of state flexibility and regulator access to information. The NAIC Committee also appreciated that the provisions within H.R. 3103, as passed by the House, relating to Administrative Simplification, specifically allow states to enact different confidentiality standards for health information from the federal standards, as long as the state standards are more stringent.

We hope to obtain the advice and participation of experts from the federal government and representatives of consumer groups as we work on our Health Information Confidentiality Model Act. We

have an open drafting process in which we invite public participation, both at our quarterly meetings and through written comments solicited by circulating our draft models. We hope that the expertise of state insurance regulators in dealing with highly sensitive financial information, combined with extensive public input on the subject of health care information, will enable us to contribute to the current effort to define a regulatory framework for health information.

Existing NAIC Models and State Laws Governing Managed Care Plans

NAIC Health Maintenance Organization Model Act, Preferred Provider Arrangements Model Act, and the Prepaid Limited Health Service Organization Model Act

The proposed NAIC health plan standards expand upon many of the protections within the NAIC's existing model laws and those in place in many of the states. Forty-nine states have laws regulating HMOs and 29 of these laws are based upon or similar to the NAIC's Health Maintenance Organization Model Act. This act includes several consumer protections, including specifications for group contracts, requirements that HMOs maintain a quality assurance program and a grievance procedure approved by the relevant state agency, and confidentiality and insolvency protections. The proposed health plan models therefore build upon existing requirements in place in many of the states.

The NAIC's Preferred Provider Arrangements Model Act contains requirements relating to disclosure, access, and provider contracts to ensure that consumers of preferred provider arrangements are informed of differences in benefit levels and that providers are not unfairly discriminated against, among other protections. The NAIC's Prepaid Limited Health Service Organization Model Act contains protections for enrollees of managed care plans providing a limited number of health services, such as dental care services or vision care services. These models have served as the basis for several state laws in these areas.

Health Plans Governed by ERISA

In the NAIC's ERISA white paper (ERISA: a Call for Reform) and in our testimony before Congress over the past year, we emphasized that all consumers of health care coverage should have the benefits of certain critical consumer protections. We would like to highlight that a significant portion of the health care market, including the managed care health care market, is outside the jurisdiction of state law. ERISA-governed plans differ from state-licensed managed care plans in terms of the applicable financial and other licensure requirements. However, the plans are similar in their ability to restrict enrollees' choice of providers and to specify requirements in provider contracts. Hence, many of the same provider contracting issues that arise in the regulation of state-licensed plans and HMOs also arise in the ERISA context. The NAIC Committee appreciates that H.R. 2976 extends its scope to ERISA plans, over which the states do not have jurisdiction, and thereby recognizes this market reality. The NAIC Committee also recommends consideration of additional protections for such plans so that consumers of both ERISA-governed and state-licensed health plans have similar levels of security and ability to challenge any possible unfair treatment by health plans.

Conclusion

As insurance regulators, we are concerned about consumer protections, which include the fair and equitable treatment of enrollees and providers in their dealings with health plans. We believe that the application of health plan standards to all health plans will help ensure that the health care received by consumers is of the highest quality and will ensure that consumers receive medically-necessary care based on medical decisions. We believe that the augmentation of consumer protections represented in the proposed NAIC's models, together with the upcoming development of a consolidated licensing scheme, will ensure that all state-licensed health plans that finance and deliver health care will be solvent and able to deliver the services promised.

We urge you to maintain the states' ability to implement innovative and effective protections for reform of the health insurance market. By doing so in H.R. 2976, as in H.R. 3103, you have recognized the expertise of the states in regulating the health insurance market and in dealing with health insurance reform.

We appreciate the opportunity to testify before this subcommittee concerning the NAIC's and state activities in this area. The NAIC looks forward to continuing to work with the 104th Congress as it attempts to enact meaningful market-based reforms of the health care insurance market.

Mr. CHRISTENSEN. Thank you for your testimony.

Thank you all for your testimony.

Ms. Musser, first, I would like to ask you, Does your department review contracts of health plans seeking licensure of each plan?

Ms. MUSSER. Yes. They have to file a business plan, any material changes to their business plan, all provider contracting arrangements, and all financial data, including the IPA or the network financial data.

Mr. CHRISTENSEN. Do you specifically look for gag clauses or those types of paragraphs that might be interpreted by physicians as gag clauses?

Ms. MUSSER. We specifically look for all violations or, stated more positively, all areas of compliance with our State statutes, including compliance with the provision prevents the interference by an insurance company with the professional relationship of a physician with his patient.

Mr. CHRISTENSEN. How many various presentations have you reviewed in your tenure in Wisconsin?

Ms. MUSSER. I believe that we have reviewed and licensed six or seven new HMOs. We have a total of 27 now in the State. And we have renewed and reviewed material changes which, of course, mean mergers and acquisitions and other changes of ownership, I would say in another half dozen.

Mr. CHRISTENSEN. Have you turned down any HMO or managed care contracts that have applied for doing business in Wisconsin yet?

Ms. MUSSER. We do not exactly turn them down. We send them back.

Mr. CHRISTENSEN. Have you sent any back?

Ms. MUSSER. Yes.

Mr. CHRISTENSEN. Sending back for the provision that would be called a gag clause?

Ms. MUSSER. Not to my knowledge. All of my examiners, market conduct and financial, in reviewing the HMO contracts have not seen the contractual provisions. That is why we have looked for the operational effects and found none there, as well. The examiners also look for operational effects in the market conduct exams.

Mr. CHRISTENSEN. Do other States, as you know, review these types of contracts as closely as Wisconsin?

Ms. MUSSER. I believe that several other States do. The problem is that the insurance commissioners regulate HMO plans in most States. The health commissioners regulate them in a number of other States. And in a few States it is the department of corporations that regulates HMOs.

In fact, no other State licenses them as insurers, like we do. So, we have, I think, a different evolution of the regulation.

Mr. CHRISTENSEN. What would be the general consensus across the country? You said that some have the department of corporations, some have the insurance commissioners, some have the health regulators. What is the predominant way that the States handle this area?

Ms. MUSSER. The insurance commissioners.

Mr. CHRISTENSEN. And do the insurance commissioners generally have the authority to ask health maintenance organizations to

remove clauses from the contract, or does that have to come from the Governor or the State elected body?

Ms. MUSSER. I am sorry. I do not know the answer to that. I can find out and provide you with the information. A State's authority varies depending on requirements for filing.

Mr. CHRISTENSEN. Do most States require HMOs to establish a process for consumers complaints, and how does Wisconsin handle that area?

Ms. MUSSER. Most of the States have adopted the NAIC Model HMO Act which establishes a grievance process. Wisconsin handles it by providing, within the department of insurance, a grievance process for all consumers, all plans are required to notify each plan participant of our 800 number and plan participants right to file a complaint on all their billing and other materials.

Mr. CHRISTENSEN. How is the term provider defined in that act?

Ms. MUSSER. In the grievance?

Mr. CHRISTENSEN. No. In the——

Ms. MUSSER. In the HMO?

Mr. CHRISTENSEN. Yes. I am not certain, but I know that in the health plan accountability standards, the provider terminology is broad, similar to the definition in H.R. 2976.

Mr. CHRISTENSEN. OK.

Ms. Archer, I wanted to ask you, you stated that as originally introduced H.R. 2976 would accomplish the goals that you had set out for the needed change in this area. What changes in H.R. 2976 have occurred that you do not agree with and what would you like to see changed to move back to the original H.R. 2976?

Ms. ARCHER. I believe that the physician disclosure of financial incentives should be permitted. HMOs should not be permitted to forbid disclosure of financial incentives. And also, that nondisparagement clauses should not be included in HMO contracts. I understand the HMO's business interest in keeping providers from speaking against them. On the other hand, one doctor's comment either about the way the HMO deals with his or her particular specialty or the way the HMO deals with mental health from a gynecologist is not going to affect the HMO business. More likely a reporter's, who knows very little about care, story in the New York Times will do that. And I think that open communication is always a good idea.

Mr. CHRISTENSEN. In your testimony you stated that the ability to terminate physician contracts without cause may have the greatest chilling effect on patient-physician communications. Could you explain more fully what you meant by that?

Ms. ARCHER. Well, it goes back to the point that's been made throughout the afternoon by some of the witnesses which is that there may not be any gag rule in the contract with a provider but the fact that the HMO can terminate a physician for any reason will silence or can silence the physician.

Again, it is not going to be every physician who is silenced, but the point is we want to encourage open communications between physicians and patients. The HMO certainly will always have and should have the ability, both to screen physicians before admitting them to the network and to terminate physicians who do not prac-

tice good medicine and we want that. But open communications is something that we should also want.

Mr. CHRISTENSEN. Ms. Craft, have any of your employers mentioned concerns about whether physicians are telling their employees about all treatment options or that they might be holding back information because of the way they have been paid?

Ms. CRAFT. That has been a concern within some employers. Primarily within our business coalition, that has been a concern of large employers with multiple locations. Managed care has moved very slowly into Southwest Virginia. At this point, we only have HMO offerings that are still discount fee-for-service. We are not into a capitation arena. So, we are hearing that, but from some of our larger employers with multiple locations.

Mr. CHRISTENSEN. Dr. Jagmin's testimony earlier reflected his concern and the association's concern about a sliding scale, a slippery slope approach to the Federal Government getting into this area of the law. What is your coalition's view on the Federal Government moving into this area to try to, what I think maybe needs to be corrected, what is your coalition's view on that?

Ms. CROFT. Our view, as a business coalition and representing many business coalitions, is that this kind of legislation to prevent gag rules and that kind of thing is not a bad thing. However, especially with this piece of legislation, there are so many ambiguities, so many things that do not seem to be very clearly defined that I think employers fear what could come out of this. There could be multiple layers of regulation from the Federal Government, the State government, from different areas, and from Health and Human Services, that they have never been regulated by before.

And I think that they just would like to see some of these ambiguous areas clearly defined. I think they would like to see some of the terms, such as oral communication, very clearly defined so that it could not be a passing comment that a doctor made one time or it could not be simply what a patient perceived that the doctor said to them. I think with some definition some of this could become more acceptable.

Mr. CHRISTENSEN. OK. Would any one of you want to have any kind of closing statement? I apologize for the interruption we had earlier, and I want to give you each a fair opportunity just to have a closing comment.

Yes, Ms. Musser.

Ms. MUSSER. I think there is an advantage to going last because there are many things that I would like to comment on this afternoon, but I will mention just a couple of issues. I would like to caution all of us not to confuse issues related to informed consent or issues of responsibility for knowledge of what is covered in an insurance policy. Whose responsibility is it to understand what is covered and what is not covered? I would maintain it is not the physician's responsibility to find out or to be prepared for a coverage issue. Those issues are the patient's responsibility, except in emergency situations when patients do not have the time to call the human resource managers or to find out what is covered or not.

To address the anecdote that Dr. Nelson shared with us earlier, I do not believe it is the physician's responsibility to stop a procedure to find out what is covered. And if it is an indemnity plan,

you would find out in retrospect what was covered. I think that this is where we may confuse informed consent and knowledge of coverage issues.

I think the issue of informed consent and the ethics and the code that is related to informed consent is a very important one. Physicians are required to discuss treatment options, and I would say it is the physician's responsibility not to sign a contract that violates his or her code of ethics.

Now, I realize there are market pressures, and maybe we need to address some of those, including termination without cause. I think the Code of Ethics ought to separate sort of the wheat from the chaff in this issue. Physicians are required to behave according to their code of ethics.

The third point that I would caution us against confusing are issues related to employment law. In the high-tech industry, employees are restricted by noncompletion clauses. Employees are frequently, or can be, fired for issues of disparagement or disloyalty. We have to avoid confusing informed consent issues with issues related to proprietary information. We have to be careful not to hogtie the HMO and the managed care industry from achieving what we want them to achieve. As you pointed out earlier, there is a balancing act between cost containment and what we want in terms of quality care. There exists employment law. I think we need to focus and not to overstep in that arena.

The area of a patient's right to know his or her treatment options is a critical one. Some of the other areas related to proprietary information in terms of capitation rates and others, are business issues, and I would caution us to be careful to separate them. That is why I like this version of H.R. 2976 more than the prior one.

I also found out the definition of "provider" in our managed care act, our HMO model act. "Provider" means a physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

Mr. CHRISTENSEN. Thank you.

Ms. Archer.

Ms. ARCHER. Yes. I would just like to urge you, the Subommittee, to remember that there really is not a level playingfield here. That it is the HMOs with all the power and as powerful as we may believe the doctors to be or the consumers to be, we just do not have the leverage that the HMOs have right now. And the HMOs are out there rightly promoting what they have to offer. And as I said before, I think a lot of it is very good. They are giving the positive spin on everything and they should because they want to sell their product.

But just as we require cookie companies to discuss their fat content, I think that because we want the public to understand that the cookie isn't only as delicious as the company says it is, but is made up of certain ingredients and has certain nutritional values, we should want the HMOs to make public and disclose what they are really doing, what product they are selling. And a piece of that is to have the physicians able to tell the patients what is being sold.

And if we do not make the patients aware of that, then we do not have the HMOs truly competing in the marketplace and consumers are not making the choices.

Mr. CHRISTENSEN. Thank you.

Ms. Craft.

Ms. CRAFT. Yes. I would like to repeat that I think there are a lot of unclear and ambiguous points within this bill and to over simplify, if I could liken employers sponsoring ERISA plans to children getting on a schoolbus, right now those employers get on the bus and they know that DOL is driving the bus and they know what the rules are. According to this bill, with all the different layers of people that could be involved in regulation, how many drivers is the bus going to have?

Mr. CHRISTENSEN. Well, we are going to try to hopefully make this bill a better bill when it comes out of our Subcommittee.

I want to thank you all for your testimony and I appreciate the time that you have taken out of your schedule this late afternoon.

The Subcommittee stands adjourned.

[Whereupon, at 4:31 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

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July 29, 1996

The Honorable
Bill Thomas
Chairman, Ways and Means Committee Member
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Please include this letter in the record for the July 30 hearing to be held by the House Committee on Ways and Means on H.R. 2976, the Patient Right to Know Act. The American College of Cardiology (ACC) strongly supports H.R. 2976 and urges the members of the Committee to act favorably on this legislation on behalf of our patients.

As a member of the Patient Access to Specialty Care Coalition, the ACC believes strongly in empowering patients to make the best possible health care decisions. Such decisions can only be made in an atmosphere that allows maximum communication between physicians and patients. We believe that H.R. 2976 would guarantee - unequivocally - that such an environment exists in *all* practice settings and would enhance the quality of health care in this country.

The American College of Cardiology is a 23,000 member non-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

Please do not hesitate to contact Marie E. Michnich, Dr.P.H., Senior Associate Executive Vice President, at the ACC if we can be of any additional assistance.

Sincerely,

Richard P. Lewis, M.D., F.A.C.C.
President

President
Richard P. Lewis, MD
President-Elect
Richard L. Popp, MD
Immediate Past President
J. Ward Kennedy, MD
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Sylvan Lee Weinberg, MD
Michael J. Wolk, MD
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Executive Vice President
David J. Feild

STATEMENT OF

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

to the

Committee on Ways and Means
United States House of Representatives

July 30, 1996

RE: Patient Right to Know Act (HR 2976)

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.

We commend Committee Chairman Bill Archer for holding this important hearing, and wish to thank the Ways and Means Committee for the opportunity to submit this written statement about "gag clause" provisions commonly found in many of today's managed care contracts.

Gag clauses undermine a physician's ability to provide his or her patients with the best possible care. The inclusion of these provisions in contracts between physicians and managed care entities also raises significant ethical concerns for physicians. We maintain that patients should receive the most complete information available about their health care options from their physician without interference from third parties. In many situations, gag clauses have been written so broadly that any communication between physician and patient could be interpreted to fall within the provisions of this clause, including medical treatment options and whether a given health plan meets the needs of a given patient. These onerous medical "gag clauses" violate sound public policy and should be made unenforceable by Congress.

Types of "Gag Clauses"

Generally, gag clauses are written explicitly in health care contracts. The language is designed to limit the communications between physicians and their patients by prohibiting some or all of the following types of communications:

1) discussion of treatment options which have not been authorized for payment by the plan;

2) making critical comments about the plan, its policies, or quality standards to enrollees or other physicians;

3) communicating with plan patients in the event the physician is deselected (raising concerns of continuity of patient care);

4) discussing financial incentives to reduce care, including capitation and utilization review procedures; and,

5) referring patients to specialists or facilities that are not included in the plan's network.

In addition, more subtle, often unwritten, plan policies and procedures are used to impede physicians from discussing treatment options if the plan does not cover those treatments. Recent media reports have documented the use of a number of these "implied" gag clauses by health plans that value cost containment and financial gain for shareholders over the well being of patients.

Both explicit and implicit gag clauses are designed and implemented with the purpose to control physician behavior and to limit patients' access to the full range of information that is needed to make informed decisions about the proper course of their medical treatment. While we understand the legitimate business interest to control costs and avoid unjustified disparagement of a plan's operations, such efforts should never undermine the quality of care received by patients.

We note that many health plan contracts do not contain "gag clauses." In addition, several plans have voluntarily removed these contract provisions in response to negative media publicity and the enactment of state legislative restrictions.

Gag Clauses Violate Medical Ethics

The fundamental issue that "gag clauses" present is an inherent ethical conflict of interest for physicians, which strikes at the heart of the patient-physician relationship. The ASPRS Code of Ethics states the general rule that "physicians should provide services under terms and conditions which permit the free and complete exercise of sound medical judgment and skill. (*Code of Ethics for the American Society of Plastic and Reconstructive Surgeons, Section 1, Paragraph VI*).

Patients must be able to trust and rely on the information their physicians provide to them regarding appropriate medical treatment and care. Indeed, even setting aside ethical concerns, physicians have a legal duty to make patients fully informed of their options regardless of cost or potential payment limitations. Gag clauses, however, effectively place a wedge between a physician and his or her patients. While a physician maintains an ethical and legal duty to the patient, the plan's contractual language seeks to place an opposing contractual duty on the physician.

Gag clauses erode a fundamental element of the healing process. Trust is the most basic component in the patient-physician relationship, yet these clauses cause doubt in the minds of patients, often at a time when they are most vulnerable.

Physicians find it increasingly difficult to act as patient advocates, our most basic mission. If we advocate zealously on our patients' behalf, we place ourselves in danger of being dropped by the health plan. If we don't press hard enough, we don't live up to our ethical obligations. Physicians need support to act as professionals, not as vendors of a third party to control costs.

The Need for Federal Legislation: The Patient Right to Know Act

Negative reaction to gag clauses on the part of the public and media have resulted in a number of states enacting legislation prohibiting gag clauses in recent months. Legislatures in Massachusetts, Colorado, Georgia, Indiana, Virginia and Vermont have recently passed such laws. Similar bills are pending in several states including California, Illinois, New York and New Jersey. Oklahoma, Tennessee and New Jersey have moved against these provisions through regulatory action.

However, action at the state level is not sufficient to remedy this problem. Many health plans, such as self-funded ERISA-preempted plans, are not be reached by state law. In addition, an increasing number of Medicare beneficiaries have begun to join managed care plans. Because this population often uses a greater number of specialists, managed care gag clauses pose especially acute problems for unsuspecting Medicare beneficiaries.

Federal legislation covering all private and public sector health plans is, therefore, needed in order to ensure that every patient is adequately protected from these contractual provisions.

ASPRS strongly supports the legislation sponsored by Representatives Greg Ganske (R-IA) and Edward Markey (D-MA), the Patient Right To Know Act of 1996 (HR 2976). This bill would render managed care contract "gag clauses" unenforceable and prohibit plans from contractually interfering with "medical communications" between physicians and their patients, as well as taking "adverse actions" against physicians.

The bill would set the above described provisions as a federal floor and thus preempt state law in cases where a state sets a lesser standard. Finally, the bill would cover all health plans, including self-insured ERISA plans and would provide for fines and penalties for violation of the statute. HR 2976 is necessary to rid the health care system of these egregious contract provisions without unduly interfering with the legitimate business practices of managed care companies.

Conclusion

ASPRS submits that gag clauses interfering with communications between physicians and patients should be made legally unenforceable. We strongly support the Patient Right to Know Act of 1996 (HR 2976), legislation designed to prohibit such clauses as an unreasonable burden on the health care system. We appreciate the opportunity to comment and are prepared to work with the committee on this important issue.

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August 12, 1996

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

RE: Committee on Ways and Means, Subcommittee on Health, Hearing on H.R. 2976, the "Patient Right to Know Act of 1996" held on Tuesday, July 30, 1996.

Dear Mr. Mosely,

I am submitting this evidence as an individual who has been through all stages of disgust with the way managed care is being operated.

I do not officially represent any organization but am merely the person who has fought their case the longest and hardest while seeking justice and the truth. However, I believe my case is only one of thousands in the Miami area.

The hearings are all about gag clauses and secret contracts. SECRETS are at the root of the managed care problem and secrets kept from the public are not in the best interests of the people.

I believe that health care cannot be left to profit oriented/cost cutting managers. There must be Federal laws that protect the patient by:

1) Eliminating all gag clauses and secret contracts. The people have a right to know!

2) Eliminating any blocks to a patient suing his HMO and his employer in State Court. The current system too often allows HMO's escape by citing ERISA. Filing a suit in Federal Court is expensive and since attorney's fees are not guaranteed; most Americans cannot afford due process.

3) Requiring that all HMO personnel who make decisions of medical necessity must be licensed as medical doctors in the state where the patient is located. We are trying to clarify this issue through a criminal court case.

4) Holding individuals, not corporations, liable for malpractice, bad faith, and contract compliance. Anything less will not change the corporate behavior.

I am enclosing 25 copies of the evidence I wish to have printed as part of the printed record of this hearing. Please use them in the following prioritized order.

1) Copies required to ensure printing for the record.

2) 13 Copies - One to each member of the subcommittee.

3) Please distribute any remaining copies to media representatives who expressed an interest in this hearing.

PLEASE CONFIRM BY PHONE, FAX, OR E-MAIL THAT THIS EVIDENCE WILL BE PRINTED AS PART OF THE HEARING.

Samuel Brola

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August 11, 1996

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

RE: H. R. 2976, "Patient Right to Know Act of 1996"

Dear Members of Congress:

I am writing to you in an effort to clarify some issues before you. There are many things a patient has the right to know.

1) Patients have both a right and a need to know whether there are treatment plans available other than the one preferred by their HMO.

2) Patients have both a right and a need to know whether their physician has monetary incentives to deny medical care and what they are. The attached "AvMed Bonus Letter" and the summary of experiences with AvMed HMO will show what GREED causes.

3) Patients have both a right and a need to know if their physician is forbidden from telling the TRUTH by their contract with an HMO.

4) Medicare & Medicaid HMO patients also have a right and a need to know what medical care and services the government's contract requires the HMO to provide. HCFA has informed me that the Medicare HMO contract particulars referring to what medical care and services the HMO MUST provide, are confidential. How absurd!! How is a patient/taxpayer supposed to know what they are getting for the billions in tax dollars.

During the Florida Department of Business & Professional investigation of Roger H. Strube, M. D., (former Medical Director of AvMed HMO's Miami Plan) a form letter was obtained by the investigator to show that Roger H. Strube used the M.D. after his name in the conduct of business, without being licensed in Florida. Nobody apparently read the letter until I requested a copy of the investigative file. This letter clearly explains how AvMed uses financial incentives to control their physicians. The fourth paragraph states: **"Patient complaints, member PCP changes, your office's cooperation with AvMed, and your office's compatibility with and support of the AvMed philosophy were used as modifiers which either increased, decreased or did not change the above scores."** To me, that clearly states: **DO WHAT WE SAY OR YOU GET NO BONUS!!**

The results of all this secrecy are a direct threat to the life and health of my son. Even the Dade State Attorney is trying to gag me about what I discovered about AvMed Health Plan. Nobody wants me on the record because I can prove that HMO personnel who are NOT licensed physicians, routinely practice medicine within the statutory definition. If this case were to go to trial, it would set precedent across the country. Those persons making decisions at HMO's are practicing medicine, must be licensed physicians, and are therefore subject to personal malpractice lawsuits. Of course, if an HMO employee can be held responsible for his actions, he will be less cruel and vicious in denying care. That would hurt the bonuses of the HMO executives as well as the CEO's of the major corporate employers who are driving managed care down the people's throats.

Please restore our citizens' rights by passing legislation that will eliminate all the SECRECY that the HMO's use to avoid responsibility for their actions. The current situation is not the type of government I <u>thought</u> I was defending during my 20 years of military service.

Samuel Brola Monika D. Brola

AV-MED

June 28, 1994

Dear Doctor (s),

Congratulations and thanks from AvMed Health Plan! You have been selected to receive a cash bonus as one of AvMed's outstanding Primary Care Physicians (or Practices).

AvMed is continually striving to improve the quality of health services to its members. One way by which this is accomplished is by the recognition of those physicians who consistently provide high quality services in an efficient manner.

In 1993, AvMed improved the mechanism by which physicians were chosen to receive financial incentives. Objective parameters were used for the selection process. Rather than describing in detail the complex formula, I will simply describe the basic criteria which were utilized. They included acceptance of capitation for the year 1993 as part of at least 100 AvMed members, current participation with AvMed, a patient satisfaction survey which looked at such issues as accessibility, availability, waiting time, ease of referrals, and general patient satisfaction with your services. A separate bonus was predicated solely on the basis of patient satisfaction. A second level of measurement was made on the basis of the scores you received on your medical records review. A separate bonus was then predicated on the basis of quality of services as reflected in the scored medical record review.

Patient complaints, member PCP changes, your office's cooperation with AvMed, and your office's compatibility with and support of the AvMed philosophy were used as modifiers which either increased, decreased or did not change the above scores. PCP's may qualify for one or both of these bonuses. PCP's in the upper 50 percentile were included in the distribution of bonuses.

I am pleased to award the enclosed check (s) in recognition of the quality service provided to your AvMed patients. Our thanks and best wishes for continued excellence in the future.

Sincerely,

Roger H. Strube M.D.

Roger H. Strube, M.D.
Medical Director, Miami Plan

RHS/lm

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August 9, 1996

RE: Our history with AvMed HMO, Miami Plan

Patient: David Lee Bissonette, born March 5, 1976

David is unable to walk, stand, or sit alone. He has little or no functional use of his extremities. He is totally dependent on others in all areas. He cannot feed, clothe or bathe himself and cannot speak to ask for assistance or to describe his pain.

Diagnoses: Cerebral palsy, spastic quadriplegia, anoxic encephalopathy, microcephaly, scoliosis (partially corrected by CD rods on spine), esophageal reflux (partially corrected by fundoplication surgery), seizure disorder, chronic pulmonary disease (right lung tested 5% function - no blood circulation).

None of these is curable, nor will they improve substantially. While David is severely physically handicapped, he is not a vegetable. He is very aware of his surroundings and communicates by eye-pointing and answering questions by yes and no head movements. His facial expressions communicate more than most people's words.

HISTORY WITH AVMED:

We are covered by AvMed through my employer, Florida Power & Light, which is self-insured. Our enrollment in AvMed was effective on January 1, 1991. The contract covers all pre-existing conditions immediately and has no financial cap limiting costs. We thought we had found a tremendous blessing. We did not know that a seemingly unending nightmare was just beginning.

1. July 5; Aug 30; Sept 27, 1991 and Jan. 18, 1992 - Letters delivered to us at Miami Children's Hospital on Friday evening stating that David's hospital benefits would terminate either at midnight or the next day. The intent was to coerce families to discharge their children without being able to contact anyone at AvMed, or in some cases, their physician.

ALL OF THE ABOVE LETTERS WERE SENT BY AVMED WITHOUT CONTACTING DAVID'S PHYSICIAN, HIS FLOOR NURSES, OR THE HOSPITAL'S RESIDENT PHYSICIANS TO INQUIRE ABOUT HIS CONDITION!!

2. After one of his many hospital admissions, David was discharged to Greenbriar Nursing Home in Kendall. We were forced to accept this arrangement. After only 12 days at Greenbriar, the situation was:

   a. There was no air conditioning in David's room (approx. 86 degrees), David had a 104.2 degree fever, and he was on oxygen. He was on a heated air bed dressed only in a diaper. He had a huge fan blowing on him. The nursing home's personnel had not called to inform us that he was sick.

   b. Even after four phone calls, Dr. Grijalva, the Nursing Home physician, refused to come. He told my wife that David's blood test (CBC) showed a white cell count in the normal range (approx. 7,000 to 9,000) and that it was

"normal" for "these kids" to "sometimes spike a temperature". My wife informed him that, having raised David at home for 15 years, she knew it was not normal for David. The doctor still did not come. He said he would stop by "later this evening".

c. When I arrived, I called David's pulmonologist, Morton Schwartzman, M.D. He told me to get David to Miami Children's Hospital emergency room right away. I instructed the nursing home's nurse supervisor to call an ambulance to transport David. She REFUSED. I called 911 for an ambulance for transport. When David arrived at Miami Childrens' Hospital, he was evaluated and then admitted to the Intensive Care Unit. His white cell count was now over 20,000, quite contrary to Dr. Grijalva's "diagnosis".

6. In October 1991, after David's hospital admission caused by the nursing home's neglect, AvMed tried to have David discharged to the same nursing home. We refused and David was finally discharged with 12 hours per day of nursing care in our home. We were able to keep him out of the hospital for all of two months.

7. On December 4, 1991, David was again admitted to Miami Children's Hospital with serious pulmonary infection and pleural effusion, including abscesses and fluid in and around the right lung. David failed to respond to many different treatments and, by mid-January, 1992, we thought he would die any day.

8. January 18, 1992 - Letter delivered to us at the hospital stating that David no longer required treatment in an acute care facility and could be discharged to Greenbriar Nursing Center. His doctor said that he was nowhere near ready for discharge AND we would not return him to Greenbriar, since they had nearly killed him.

9. Jan. 30, 1992 - Letter delivered to us at Miami Children's Hospital threatening not to pay for David's care unless we agreed to transfer him back to Greenbriar. They had obtained a "second opinion" about David's suitability for Greenbriar. The so-called "second opinion" was from Dr. Grijalva, the physician from Greenbriar who had refused to come when David was there. We again refused to transfer David to Greenbriar AND refused to discharge him from the hospital.

   After several weeks, AND after obtaining the services of an attorney, AvMed provided David with nursing, respiratory therapy, etc., at home as a substitute for hospital care. David has a RIGHT to high quality care provided by licensed medical professionals. AvMed has continually attempted to curtail care without changes in medical orders and to do so without our prior knowledge. To date, we have kept them from reducing his care to dangerous levels.

10. June 1992 - AvMed attempted to cease providing licensed respiratory therapists by calling the home care agency telling them to stop sending therapists, but not to tell us in advance. We notified the company that there had been no change in the medical orders and that they and AvMed would be liable if care was stopped.

11. Aug. 23, 1992 - David admitted to hospital with pulmonary infection.

12. AUGUST 24, 1992 - HURRICANE ANDREW - My wife, Monika, stayed at the hospital with David while I endured the northern eye wall of the storm in our master bathroom with my daughter, father-in-law, sister-in-law, and my nephew. We all huddled there while most of the rest of our house came apart. We experienced the eye wall of Andrew for hours without injury, but our home, was destroyed.

13. Aug. 31 - Sept. 10, 1992 - When we were finally able to retrieve telephone messages from the Southern Bell message service, we heard AvMed threatening to disenroll us if we did not immediately have David discharged from the hospital. I called to inform them that there had been a hurricane and we no longer had a

home to take him to. They said the hurricane was not their problem, that we should seek public assistance if we had no home, and that they would immediately stop payment for David's care if we did not discharge him. They also stated that Greenbriar was no longer an option. I told them Greenbriar would NEVER be an option and that we would discharge David WHEN we had a home to take him to AND when AvMed had arranged for resumption of his nursing and respiratory care.

14. Sept. 10, 1992 - After days of phoning, found a rental house in North Miami Beach and discharged David with home nursing care and respiratory therapists.

15. Jan./Feb. 1993 - AvMed attempted to curtail respiratory treatments and drug deliveries by phone calls. We demanded a Member Appeals Committee.

16. March 1993 - Result of Member Appeals Committee was that AvMed would NOT attempt to cease providing care without prior written notification to us with sufficient time for us to appeal. We were accompanied by Attorney Arthur Garcia.,

It was around this time that Roger H. Strube, M.D., became the Medical Director of AvMed HMO in Miami. He is licensed in Wisconsin and Indiana but has never been licensed in Florida. His license record in Wisconsin reflects that he accepted a disciplinary entry on his license record that he had improperly prescribed amphetamines over a seven year period. This is on his record with his acquiescence and that of his attorney. It was also placed in his record without the cooperation of the patients involved. The average person would have to question his **ethics** and **judgement**. AvMed may or may not have known about his lack of license or the discipline in Wisconsin.

If AvMed did not know about his past, it means that a huge medical corporation hired a top executive at a large salary and gave him responsibility for the medical care of 110,000 AvMed members in Dade County WITHOUT the most cursory background check. I believe that constitutes: reckless endangerment of the members by IMPROPERLY HIRING an executive with questionable (at best) background. I believe that AvMed did do a background check and decided that Roger H. Strube had EXACTLY the ethical behavior pattern they desired. I stated this belief clearly at our hearing before the Statewide Providers & Subscribers Assistance Panel in early 1995. The Panel was made up of representatives from the Florida Department of Insurance and the Florida Agency for Health Care Administration.

17. July 1993 - AvMed tried to terminate respiratory services without a change in medical orders or prior notice. Mr. Garcia prevented AvMed's action.

18. Oct. 1993 - Unknown to us at the time, a patient filed a complaint against Roger H. Strube with the Department of Business and Professional Regulation, Case No. 93-18811. Roger Strube was notified of the complaint and was requested to sign a Cease and Desist Agreement. The Investigative Report shows Stephen J. deMontmollin to be Strube's attorney. Stephen J. deMontmollin is Vice President and General Counsel of AvMed.

19. Jan. 9, 1994.- The medical home care provider, Infusion Therapies, fired their subcontracted respiratory therapists, Greg Lane and Associates. Mr. Lane received the letter on Saturday which told him to cease providing care to all of his patients on Monday. This incident coincided with the visit to Miami AvMed of Infusion Therapies' Chief Operating Officer from Atlanta.

20. Jan. 12, 1994 - A Mr. Thomas P. Jarrett from Infusion Therapies came to bring a new pulse oximeter. He informed our nurse that he would be taking over David's respiratory treatments the next day.

21. Jan. 13, 1994 - Mr. Jarrett did not show up for David's 8:00 a.m. and 12:00 noon treatments. When he finally arrived for David's 4:00 p.m. treatment, I asked to see

his respiratory license. He showed me a folded up copy of a copy of a copy of a respiratory license. His drivers license picture did not look like him and the license had been peeled open. We wrote down his drivers license number and his respiratory license number. The year of birth in his drivers license number did not match his respiratory license information. We later filed a complaint with the Dept of Business and Professional Regulation in Tallahassee. They refused to investigate even though the local Miami office had expressed an interest, since multiple users of a single license are apparently a large problem.

22. Jan. 1994 - Mr. Jarrett came from Davie to our home in South Dade 3 times a day for the next week, accompanied by a Mr. Hopper of Infusion Therapies, to insist that Mr. Jarrett did not have to show me an original of his license. I agreed but had to remind these people that this is MY home and my son. I will NOT be forced to let just anyone into my house, especially someone whom I consider to be unqualified.

23. Jan. 1994 - We received a visit from an HRS Child Protective Services investigator because of an anonymous report that we were purposely denying David needed respiratory treatments. I am sure that it was Roger H. Strube of AvMed who filed the false and malicious complaint because he threatened in writing to do the same thing to Mr. Dennis Peterson, another AvMed member whose son is chronically ill.

24. March 1994 - At another AvMed Member Appeals Committee, I presented eight pages of facts to the attending AvMed managers and executives. I have their names in their own writing. The result of this meeting was an agreement that NO CHANGES to David's care would be attempted until after a meeting was held among us, David's primary care physician and AvMed's Complex Case Manager.

25. April 1994 - AvMed attempted to cease providing David's feeding formula, feeding bags, and other medically necessary "disposable and consumable" medical supplies. They attempted this in spite of a Member Appeals Committee agreement to make no changes prior to the meeting with David's Primary Care Physician.

26. June 1994- The meeting took place between us, Dr. Jarrett, and Sue Shepper, RN, of AvMed in the doctor's office. The doctor did not examine David. He merely stated that since the current care plan was keeping David as healthy as possible, he did not intend to change it. He also agreed that it was not up to him to decide WHO provided the care, since Florida law specifies the qualifications required to perform various levels of medical care.

27. Sept. 12, 1994 - Roger H. Strube of AvMed sent us a letter claiming to have "recently received updated orders from both Dr. Jarrett and Dr. Gustman," and that the case would be transferred to Roche Professional Service Centers, a home care agency whom we had previously fired for incompetence. What happened is clearly described in a response I received from Karen Nagle, an attorney for Roche Professional Service Centers, Inc. in New Jersey. "RPSC was following the directions of Dr. Strube to create a plan of care for your son and get physician orders in order to be able to follow through on this plan. It is necessary to obtain physician orders before rendering service, so that only care ordered by a physician is rendered."

    Roger H. Strube illegally dictated the orders, (practicing medicine without a license), Karen Martel, R.N., of Roche wrote the orders and illegally obtained signatures. (It is illegal in Florida to obtain medical information/orders without prior written permission of the patient/parent.) Paul M. Gustman, MD, illegally signed a set of the orders (per Karen Martel's statement and Strube's). He had removed himself from David's case in February and had on one occasion refused to order an antibiotic for David when called by the nurse on duty. Is it malpractice for a physician to sign medical orders for a patient he has not seen in eight months and whose case he has given up? We filed a complaint against Karen Martel, RN of

Roche with BPR. They declined to investigate. We filed a complaint against Paul M. Gustman, MD, in May 1995. It has FINALLY been investigated and the report was sent to Tallahassee in February 1996. I wrote dozens of letters to legislators and to the Board of Medicine and BPR. Finally, a legislator told me to call Randolph Collete, an attorney at BPR who had closed all three Strube cases. When his secretary gave me the run-around, I informed her that I had already called the FBI once to accuse AvMed of having undue influence on regulators. I stated I was going to call the FBI again with my belief that Randolph Collette was the contact point for the improper influence. Within three hours, we received a call from a BPR investigator in Miami that had been assigned the case. Case #95-15826 has been assigned to Dahna Schaublin in Miami since Nov. 1995. I have begged the Dade State Attorney to file charges of Criminal Conspiracy against Roger H. Strube, Karen Martel, RN, and Paul M. Gustman, MD. So far, those charges have not been filed although the evidence is clear, documented, and compelling. We have reason to fear retribution from Karen Martel since she is now a Supervisor at Nations Health Care, the medical provider that has David's case.

28. Sept. 22, 1994 - After being told that it was a Federal requirement that employers have an effective appeals process for complaints, I called and then wrote Scott Robinson at Florida Power & Light's Human Resources Department in Juno Beach. I sent him some 60 pages of documentation of the abuse we were taking from AvMed. I also informed him that I believed that Roger H. Strube was practicing medicine without a license. I did not even receive a phone call in response. FPL is self-insured, so this is not a big surprise.

29. Oct. 25, 1994 - When I tried to call Scott Robinson, FPL HRC/JB, I was told that he had been replaced by a Julie Barone. She confirmed that Mr. Robinson had received my complaint. I sent her a copy of BPR's certified statement that Roger H. Strube had never been licensed in Florida. I did not hear from her again.

30. Nov. 2, 1994 - We attended a Member Appeals Committee Meeting at AvMed. We do not believe it met contract requirements. The contract describes a Member Appeals Committee as a FORMAL PROCEDURE. The bold print and capital letters are direct from the contract. We requested that the Case Managers and Karen Martel, R.N. be present. We also requested that we be allowed to bring a Court Reporter to record the minutes and prevent confusion in the future. AvMed refused on both requests, in writing. At this meeting, we obtained a copy of a "Case Summary" dated 10/28/94 which we believe shows that AvMed had already decided to ignore our appeal. I requested that each of the attending executives sign an attendance log and then gave each of them a copy of my eight page presentation. In this presentation we accused Roger H. Strube of Practicing Medicine Without a License and misrepresenting himself as a licensed medical doctor. (We were not yet aware of the 1993 BPR case.) Roger Strube's response was: "You can take it to the top if you want, Mr. Brola, and one of two things will happen, ha ha, either I'll be VERY secure in my position, or I'll get a great severance package." I informed the AvMed executives that he (Roger H. Strube) was "going down" and that it was up to them if they wanted to be accessories to his criminal activities.

31. Nov. 3, 1994 - AvMed sent us the MEMBER APPEALS COMMITTEE DETERMINATION stating: "The Committee determined that the new plan of treatment ... as outlined in the September 12, 1994 letter from Roger H. Strube, M.D., AvMed Medical Director, is appropriate for David's medical condition and AvMed will only authorize payment for that plan of treatment effective January 1, 1995." In other words, we are reducing your son's care in spite of the law.

32. Dec 8, 1994 - AvMed's Vice President & General Counsel, Stephen J. deMontmollin sent us a letter threatening to "seek a legal remedy" if I did not cease informing AvMed's physicians about unlicensed medical professionals in AvMed's Miami Office. It turned out that Marian Carolan, RN (Complex Case Manager) of AvMed,

is really Marie G. Carolan, RN. She was not using her legal name as it appears on her license. I informed Mr. deMontmollin that I would continue educating Floridians to the FACTS about AvMed's unlicensed Medical Directors (E. Leon Cooper, Strube's predecessor, was not licensed, either) and if that proved to be a slight inconvenience for Strube or AvMed, then I would be happy to respond to their threatened lawsuit. I have heard no more on the matter.

33. Dec 16, 1994 - Alise Moss Vetica, Manager, Corporate Member Relations, sent a letter threatening to terminate our AvMed membership on January 1, 1995 if we did not select a new Primary Care Physician for David. (David's PCP, Wentworth Jarrett, MD, had continued David's old medical orders for an additional 62 days, but was forced to remove himself from the case. He told us privately that he could not practice medicine for anyone while AvMed was calling him dozens of times every day, determined to cut David's care, no matter what.) The above-mentioned letter also stated: **"In the event you do select an AVMED PCP by the above time frame, please understand that the new plan of treatment will go into effect on January 1, 1995. This transition of that new treatment plan will not be placed on pending status while you appeal to the State of Florida."** Their intention was to coerce the new physician into signing the orders AvMed and Strube wanted.

34. Dec 27-29 1994 - I called FPL Human Resources to beg for help. It seemed everyone was powerless to prevent the crimes being committed. Scott Robinson called me at home and started spouting quotes from Steven Ziegler, Esq., AvMed's Miami attorney. When he repeated AvMed's LIES about having paid for David's hospital bed and expensive custom wheelchair, I exploded. I then told him I was wasting time with him and hung up. He called back, telling me angrily that he didn't like to be hung up on. I told him I didn't like to ignored when my son's life was threatened, and that if he kept defending AvMed's crimes, I would hang up again.

35. Dec. 30, 1994 - We selected Leonard Askowitz, M.D. as David's new PCP. He renewed the old orders. He has since also removed himself from David's case. Dennis Peterson and I had at that time both filed complaints with the Department of Business and Professional Regulation. Case numbers:9420668 & 9500489. After the BPR inspector observed Roger Strube making medical decisions, all three cases against him were completed. The Chief Medical Attorney of the Florida Agency for Health Care Administration found that in all three cases, probable cause exists to believe that Roger H. Strube was practicing medicine without a license and misrepresenting himself as a licensed doctor. He also finally issued Cease and Desist Orders for all three cases in February 1995.

At approximately this time, AvMed either fired Roger H. Strube or allowed him to resign. This despicable individual was then selected by CareFlorida as their Vice President and Chief Medical Officer for their operations throughout the entire State of Florida. I then convinced the Fort Lauderdale Sun Sentinel to publish an article regarding the Probable Cause findings on Strube. CareFlorida terminated him.

Finally, after dozens of letters to the State Attorney's Office and dozens of phone calls to Katherine Rundle, a single count of practicing medicine without a license has been filed against Roger Strube. It is Police Case # 951592, Court Case # F95032394 and is currently assigned to Herb Andrews at the SAO. His trial has been delayed several times.

Since this case began, our provider, Nations Health Care, and Roche Professional Services have merged. The pharmacist from Roche who always gave our nurses a hard time about everything the doctor ordered, is now the pharmacist at our provider. Karen Martel, R.N., the nurse from Roche who illegally obtained medical orders, is now a supervisor at this company. FPL, my employer, is undergoing "Strategic Review" (layoffs). Being self-insured, FPL could save lots of money by laying me off.

In the Spring of 1995 we had a hearing before the Statewide Providers & Subscribers Assistance Panel. AvMed's attorney, Mr. Cholodofsky, stated that the care being provided for David was not medically necessary. The doctor on the Panel asked Mr. Cholodofsky, WHO at AvMed was qualified to make that decision. The doctor asked FOUR times. He did not get an answer. The nurse on the panel asked Dr. Edelstein of AvMed., WHY anyone would ever consider reducing care to a patient whose conditions will not improve and can only get worse and who has a DO NOT RESUSCITATE order in place. She asked FIVE times and the main response was to complain about how complicated David's case was and that my letter writing made the case even more complicated.

Part of the BPR Case File on Strube is a letter obtained by the investigator simply to show how he signed his letters. Apparently, no one there had read it until I pointed out its contents. In it, Roger Strube clearly described how AvMed controls physicians financially. He states: "Patient complaints, member PCP changes, your office's cooperation with AvMed, and your office's compatibility with and support of the AvMed philosophy were used as modifiers which either increased, decreased, or did not change..." the physician's bonus. To me, that states very clearly, "Do what we tell you or you will not receive a bonus.

AvMed has used financial leverage in other ways. With the cooperation of Nations Health Care, Nursefinders' (nursing agency subcontracted by Nations) payments were delayed by up to six months. At one time the past due amount exceeded $200,000.00. This was a successful attempt to force the nurses to accept several dollars an hour less pay.

The January 22, 1996 TIME Magazine reports on a case in California where an arbitration panel found that telephone calls made to "influence or intimidate" the doctors was interference in the doctor-patient relationship. They decided this constituted "intentional infliction of emotional distress". They also determined that the California HMO's actions fit the legal definition of "extreme and outrageous behavior exceeding all bounds usually tolerated in a civilized society." I believe the actions of all the individuals/entities in our case exceed those described in the magazine and these people should be held legally and financially accountable.

As of April 25, 1996, we learned that AvMed, their Miami Attorney Steven Ziegler and Venturi Investigations have improperly, unethically and probably illegally, been attempting to gather information about me and my family. They have contacted our son's health care providers and used false statements in their efforts to induce cooperation. They have threatened to use subpoenas. AvMed is not charged with anything and therefore cannot subpoena anyone. We believe this is one more attempt to frighten or intimidate us into dropping every available avenue to pursue our rights under the law, and to see that justice is done, finally.

August 1, 1996
We have been told by Assistant State Attorney Paul Silverman that the charge against Roger H. Strube will be dismissed because he is only consulting and because the Florida Agency for Health Care Administration now claims there is no one at that agency to testify that Roger H. Strube's actions constituted practicing medicine. Trial date is still set for August 19, 1996.

August 2, 1996
Sent fax letter to Paul Silverman and a copy to Dade State Attorney Katherine Rundle, citing the Florida Supreme Court decision in Reams v. State, which states: "In prosecuting for practicing medicine without a license, State is required to prove only that defendant is not a licensed physician and that he practices within the statutory definition and exceptions to the act must be raised and proved by the Defense."

August 4,1996
Sent fax letter to State Attorney Katherine Rundle with a copy to Paul Silverman, citing the Florida Supreme Court decision, Florida Statutes, Black's Law Dictionary, and the Notice

of Dismissal/Closing Order for BPR Case 95. I stated clear concise methods to convict Roger H. Strube without expert witnesses. It is IMPOSSIBLE for Roger H. Strube to prove that he meets the exception requirements for consultants.

August 6, 1996
Sent fax letter to Katherine Rundle with copy to Paul Silverman, citing the Florida Constitutional Amendment, Article 1, Sec. 16(b) about crime victims having the right to be informed, to be present, and to be heard when relevant, at all crucial stages of criminal proceedings. I demanded to be heard at the motion hearing scheduled for August 19.

August 7, 1996
I called Paul Silverman to ensure the faxes had been received. He confirmed that he had received them and informed me that I would be heard at the hearing. He also informed me that it would probably be rescheduled for August 16 due to a conflict.

August 8, 1996
I called Paul Silverman to request more information about the Motion Hearing. He informed me that now there would be NO hearing at all. He plans to present a Nolle Prosequi to the judge and that will end the case. I asked if I would still be heard. He said probably not, since once he submits the Nolle Prosequi, the case ceases to exist. I informed him that there sure must be a lot of people who don't want me to be heard. Nobody in the State Government wants me "On the Record".

The Statewide Providers & Subscribers Assistance Panel did NOT get a transcript of our hearing. I had to order and pay for it myself. I have offered to meet with AvMed's attorneys. They refused. Roger H. Strube's attorneys have chosen to not depose me because I would then be "On the Record." Now the Dade State Attorney plans to further deprive me of my rights. Not only has Katherine Rundle REFUSED to file all charges against all persons/entities I have accused (and provided documentation for), she now plans to completely drop the only charge filed without my having a chance to be heard. Paul Silverman informed me that not only didn't he have to tell **me** why they were dropping the case, he didn't have to tell the Court and did not plan to.

Nobody wants my case to go to court because that will require a court ruling that the HMO medical director IS practicing medicine when he tells physicians what care to order or not to order. Most state laws are similar in defining "practice of medicine" and this decision would have national consequences. If the HMO medical directors, case managers, etc. are practicing medicine, then they must be properly licensed under the laws of the state where they are located. But the big thing the HMO's are afraid of is this. Those persons who would now have to be licensed physicians would also now be personally liable for malpractice civil suits. When a person is personally responsible for his actions, they are less likely to be as vicious in denying care as the HMO's want.

It sure seems like the criminals have all the rights while the victims have none. This is especially true if the criminals are huge corporations, managed care lobbyists, and high government officials.

That is why the "powers that be" are determined to shut me up.

Is this still the United States of America?

STATEMENT OF RENEE MCLEOD, MSN, RN, CS, CPNP
PRESIDENT
NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS

As president of the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP), I am submitting testimony on behalf of over 5,000 Pediatric Nurse Practitioners (PNPs). We are health care providers dedicated to the care of children. We urge your swift action in support of legislation to prohibit "gag rules," restrictions on communication between health care providers and patients.

It is imperative that providers be allowed, if not encouraged, to share all treatment information with patients, even treatment options which may not be "covered" by a certain health plan. This is particularly important when children are concerned because children represent so much potential for life.

The Patient Right to Know Act, H.R. 2976, would prohibit health plans from having a policy which restricts medical communications between providers and patients. The bill would protect the right of the health care providers to speak freely and openly about the patient's physical and mental condition and/or treatment options. While we also believe that the patient has a right to know information relating to the financial arrangements between health plan and provider, we strongly support H.R. 2976 as passed by the House Commerce Committee.

Managed care health plans are doing a great deal to address one of the biggest problems in our health care system: rising costs. We recognize this, and agree that managed care can be a very positive option for millions of Americans. However, health care providers have a responsibility to look critically at health care systems, and work to make improvements wherever possible. We must make sure that above all else, the health and well-being of patients are given the highest priority and quality of care. The Patient Right to Know Act is a necessary step toward putting patients first. Communication between provider and patient is the first part of high quality care.

PNPs specialize in providing prevention education, routine physical exams and sick care for children. When a child has an illness that may require a specialist, communication with parents is critical. We have the benefit of experience and knowledge, and what we share with these parents about the kind of treatment options available can be the difference between life and death. Our efforts to share all the information available should not be affected by the health plan which employs us. If we cannot share information because a treatment option is not covered by the patient's plan, but may be covered by another, we are not fulfilling our commitment to that child, to those parents who put their trust in us. Communicating openly and freely with patients and parents is perhaps the greatest power we have as PNPs.

Communication is so important, not just for PNPs, but for all providers, patients, consumers, and for the future of the greatest health care system in the world. Yes, it is important to cut the rising costs of health care, but we must never forget the mission of health care providers, to provide the best care possible for patients.

The Patient Right to Know Act will ensure that the needs of patients come first, and that health care providers can fully address those needs regardless of health plan. We strongly support this legislation, and thank the Committee for holding this hearing. We urge you to move quickly in support of this important legislation. Patients, providers, and health plans all agree that open communication between providers and patients on medical treatment is in everyone's best interest. Please act on this opportunity to bring the Patient Right to Know Act one step closer to law.

RURAL HEALTH CARE ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

SEPTEMBER 12, 1996

Serial 104–89

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HEARING ON RURAL HEALTH CARE ISSUES

THURSDAY, SEPTEMBER 12, 1996

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

The Subcommittee met, pursuant to notice, at 10:06 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 5, 1996
No. HL-23

CONTACT: (202) 225-3943

Thomas Announces Hearing on Rural Health Care Issues

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 rural health care issues. **The hearing will take place on Thursday, September 12, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 9:30 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 and for inclusion in the printed record of the hearing.

BACKGROUND:

One-quarter of the U.S. population, about 65 million people, reside in rural areas. Assuring access to health care services in rural areas is an important component of national health care policy. Rural communities have unique characteristics and special needs which pose certain challenges to providing health care services. In general, rural communities have higher concentrations of elderly persons, higher levels of poverty, and higher unemployment than urban areas.

Nearly half of all general hospitals in the United States are located in rural areas. Many of these hospitals face financial pressure as a result of declining economies. Many rural hospitals have closed while many rural areas continue to experience shortages of primary care physicians and other health care professionals. Existing physician shortages are expected to grow worse as many of these rural providers retire -- almost 20 percent of physicians practicing in rural counties are over age 65.

States are heavily dependent on the Federal Government for assistance in maintaining and enhancing rural health care resources. These rural resources include personnel as well as maintaining the capital investment in the rural health care infrastructure. Providers in rural areas are also very dependent on the existence of Federal health insurance programs such as Medicare for the financing of health care in their communities.

The Federal role in rural health is carried out primarily through four different types of programs. These programs include: (1) health care financing such as the Medicare and Medicaid programs which pay directly for health care services; (2) health block grants which allocate funds to States to spend on any variety of programs in a general topic, which include the Maternal and Child Health block grant, and the Preventive Health and Health Services block grant; (3) Federal programs for which enhancing rural health resources is an explicit goal, such as the National Health Service Corps, Community and Migrant Health Centers, and the Rural Health Care Transition Grant program; and (4) the coordinating, undertaking, and funding of research on rural health topics.

Congressional concern over the special health care needs in rural areas over the years has prompted the creation of numerous programs designed to address some of the special needs of rural communities. Congress has created programs, demonstration programs, and studies aimed at ensuring continued rural access to health care. These programs are authorized under Medicare, Medicaid, the Public Health Service Act, and the U.S. Department of Agriculture.

FOCUS OF THE HEARING:

This hearing will focus on these Federal programs and demonstrations created to address the special needs of rural communities. The hearing will specifically highlight the programs operated under the Medicare program, while providing an overview of the many programs that currently exist in other areas of the Federal Government. Key issues include the lack of health care resources in rural America, trends in the delivery of medical care in rural America, and the coordination of rural health initiatives specifically targeting rural health needs or predominantly serving rural areas under the Medicare programs as well as the Public Health Service programs.

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, September 26, 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 on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/' or over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

*****

NOTICE -- CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 11, 1996
No. HL-23-Revised

CONTACT: (202) 225-3943

Time Change for Subcommittee Hearing on Thursday, September 12, 1996, on Rural Health Care Issues

Congressman Bill Thomas, (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on rural health care issues previously scheduled for Thursday, September 12, 1996, at 9:30 a.m., in 1100 Longworth House Office Building, **will begin instead at 10:00 a.m.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL-23, dated September 5, 1996.)

* * * * *

Chairman THOMAS. The Subcommittee will come to order. This morning's meeting will focus on rural health care issues and the effectiveness of Medicare demonstration programs, reimbursement modifications, and block grants under the Public Health Service in providing assistance to rural communities.

A number of us, including myself, represent rural areas. Mine is largely dependent upon agriculture. There is a shortage of providers, as is usually the case, and I therefore understand the importance of providing assistance to rural communities.

I just make note of the fact that in working with the Justice Department's newfound flexibility after the passage of the most recent health insurance legislation dealing with antitrust provisions. We have been able to secure a waiver for Ridgecrest, California. It would be interesting to you only that it is a community of 42,000 people with one hospital and the nearest acute care hospital is over 100 miles away. That is stretching the rural definition and that is why I often want to talk about frontier rather than rural.

But, this hearing gives us the opportunity to highlight the major problems facing rural America regarding access to quality health care and will provide us with direction on how to best address these issues.

It is noteworthy that there have been a number of initiatives over the past decade which try to address these access issues. Some of them have worked; others have not. What these initiatives have done is provided us with insight and guidance on what direction to take in the future with regard to these rural health care programs.

I think, we need to stop and think of our goals. To me, it is to bring access to health care to rural communities rather than to enable financially strapped hospitals to remain open in rural communities. If we can do both, so much the better.

The Subcommittee welcomes Representatives Steve Gunderson and Glenn Poshard, the cochairs of the House Rural Health Care Coalition, to our hearing this morning and we welcome their testimonies on these important issues. And I might add, that for years Pat Roberts, our colleague who is attempting to move over to the Senate, has also been extremely interested and involved in, these areas.

Additionally, I would like to express my appreciation to Harry Foster, chief operating officer of the Family HealthCare Network, who comes from Porterville, California, in my district. He has a unique perspective on bringing quality health care to a rural community that, in a microcosm, represents virtually all of the problems in terms of economic level, language barriers, and distance that we are focusing on.

[The opening statement follows:]

OPENING STATEMENT OF HON. BILL THOMAS

This morning's hearing will focus on rural health care issues and the effectiveness of Medicare demonstration programs, reimbursement modifications, and block grants under the Public Health Service in providing assistance to rural communities. I represent a rural area largely dependent on agriculture with a shortage of providers, so I understand the importance of providing assistance to rural communities.

This hearing gives us the opportunity to highlight the major problems facing rural America regarding access to quality health care, and will provide us with direction on how best to address these pressing issues. It is noteworthy that there have been

a number of initiatives over the past ten years which try to address these access issues. Some of them have worked; others have not worked. What these initiatives have done is provide us with insight and guidance on what direction to take in the future with regard to these rural health care programs. Most importantly, we need to stop and think if one of our goals is to bring access to health care to rural communities or is it to enable financially-strapped hospitals to remain open in rural communities.

The Subcommittee welcomes both Representatives Gunderson and Poshard, the Co-chairs of the House Rural Health Care Coalition to our hearing this morning, and we welcome their testimonies on these important issues.

Additionally, I would lie to express my appreciation to Harry Foster, the Chief Operating Officer of Family HealthCare Network has made the long trip from Porterville, CA to provide his unique perspective on bringing quality health care to a rural community.

Now, I would like to turn to the ranking member of the Health Subcommittee, Representative Pete Stark for his opening records.

Now, before I recognize our colleagues, I will ask the gentleman from California, the Ranking Member, Mr. Stark, if he has any comments he wishes to make.

Mr. STARK. Thank you, Mr. Chairman.

I claim very little rural area in my district, but I would claim, along with our former colleague, Mr. Gradison, the authorship of EACH, Essential Access to Community Hospitals and PCH, the Primary Care Hospital Programs and many programs during the past 10 or 12 years to aid rural hospitals and rural medical delivery.

But, it would be fair to comment that the difference between a rural hospital not having as much margin or profit as it would like and closing is great. Quite frankly, very few rural hospitals have closed in the past 10 years. In the State of Wisconsin, for example, the last study we have, unfortunately, is 1988 to 1993, there were three or four hospitals that closed. None in Illinois closed in that period of time.

I am afraid that what is more the problem, and I understand this is the same problem we had in Wisconsin, in the thirties, before Mr. Gunderson was there, when the Kindergarten through grade 12 schools consolidated into regional high schools. It was a good idea but everybody wanted the regional high school in their town. Crandon wanted the high school, Leona did not get it and there was hell to pay. We have that same problem. There has never been a hospital in Leona, and they have a big lumbermill there that cuts off lots of hands and feet and the injured go to Rhinelander. That has been the way for a long time.

There is a local political inertia here to us doing what would be best, and in many cases, that means consolidating because so many of the rural hospitals are of such a size that they cannot afford the modern equipment that you have to have. A 10-bed hospital cannot afford a CAT scan or an MRI machine.

So there are a lot of things that we could do, but we do come up against local pride. I understand that. I am sure Chairman Thomas understands it. Our hope has always been that the Rural Caucus could, in the broad sense, help us with that.

I am going to ask that my two colleagues take a look at this fairly short study, the 1993 study by, I think, the OIG on rural hospital issues and give me some comments on it. We will continue, I think, on this Subcommittee to try and help. But, it is interesting to note that in the rural hospitals that closed, and this is in the

period of 1987 to 1991, three-quarters of those communities had another acute care hospital within 20 miles and there were emergency care facilities available to 82 percent of those communities within 20 miles, and that 20 miles gets to be less and less of a burden as we get more highways and more modern transportation.

So we will try, I am sure, on this Subcommittee to do what we can, but my plea to the Rural Caucus has always been to figure out a way for us to get offstage. Some hospitals will have to what is called consolidate or change to become more of a skilled nursing facility and less of an acute care facility. What we have to figure out is a way to make them proud to do it and not get into this fight where there are six little local communities in each of your districts and each one wants to have the facilities of a 100-bed hospital but they cannot afford it.

So we have a political problem that you can help us—it is not partisan, it is geographic—to solve. I am sensitive to the fact that when it is in your district, it is a big problem, and when it is in the other guy's district, it gets very academic. But, your help in that regard would help this Subcommittee take the limited resources we have and more fairly distribute them.

Thank you, Mr. Chairman.

Chairman THOMAS. With that admonition, in a bipartisan way, I would ask either of you gentlemen to address us in whatever manner you see fit to focus on what I and the Ranking Member had to say.

STATEMENT OF HON. STEVE GUNDERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN; ON BEHALF OF THE RURAL HEALTH CARE COALITION

Mr. GUNDERSON. Thank you very much, Mr. Chairman, and I want to thank you for allowing myself and Mr. Poshard to testify on behalf of the Rural Health Care Coalition. This is a bipartisan group of over 100 members dedicated to improving the access and health care in rural areas.

I think the opening statements of both of you are, frankly, moving in the right direction, and I think you will find a lot of support from both of us, from the Rural Health Care Coalition and from the legislation we are advocating, which is trying to, frankly, recognize realities, give these local institutions the flexibility they need to change their mission in order to operate under a very different environment today than they have had in the past.

This Subcommittee and this Full Committee has been very patient with the Rural Health Care Coalition, as we have been here before asking for things, as you all well know, especially in the area of Medicare reimbursement formulas. To the credit of this Subcommittee, you have responded in kind with some very strong, positive legislation that was included in the Balanced Budget Act, as you all know. I will not go into that in the interest of time today, but I want to thank you for that. Unfortunately, as we all know, that legislation was vetoed, so we are back here again today looking at a different approach.

It was in June of this year that we introduced H.R. 3753, the Rural Health Improvement Act which is a consensus bill that tries to deal with these issues one more time. I will talk about limited

service hospital designations and networking, whereas my colleague will talk about the rest of the bill in depth.

As you both have articulated, in rural America, 25 percent of our population faces a very different kind of delivery system than suburban and urban America. Most importantly, however, you cannot make changes in this area unless you deal with the reality of Medicare reimbursement. In rural health care facilities, someplace between 50 to 70 percent of our rural hospital revenue comes from Medicare. So we have to deal with eligibility for Medicare in the process of dealing with flexibility, and this really is the key, gentlemen.

Number one, we have to allow rural America and rural hospitals to respond to the changing realities of the marketplace in their communities. However, in doing so, it is essential that we allow them to remain Medicare eligible because otherwise they simply economically cannot make those changes and survive.

I would point out to Mr. Stark that, yes, the hospital in my hometown is still open. It is open, frankly, because the city council is subsidizing it, because it simply cannot survive on its own. Until we can give that community, and they keep asking me every year, you keep telling us you are going to do this and it never gets done. Until we give them the flexibility to respond to the economics and the realities of that geography, they simply cannot shut down the existing facility because they will then lose the emergency room and they will lose those lifesaving, stabilizing elements which are essential before patients can be moved to the more urban areas.

I hate to tell you this, but I have had a coroner in my district recently indicate that there was a person who died in my district because they could not get them to an emergency room in time to get them stabilized. Frankly, that was in an area not far from home where a rural hospital was closed during my time in Congress. This is unacceptable in the nineties, I think we would all agree. That is why we are trying to respond.

What are we suggesting? We are suggesting a number of measures which we believe are flexible in nature and, frankly, very low cost. As you all know, H.R. 3753 is paid for, so we are not coming here asking for new money or anything of that sort.

First, we want to advocate something known as rural emergency access care hospitals. What is this? It would be a limited designation to allow a rural hospital to downsize to an emergency room facility with a 24-hour limit on inpatient care. A REACH facility would be designed to stabilize patients until they can move to a full-service facility.

That kind of a vehicle would allow my hometown to become a 24-hour acute care clinic with an emergency room. That, we can financially maintain, and that will serve the needs of my community. But we cannot do that today, because, frankly, the present definition does not allow that to happen. So those are the kind of changes that we need.

The second change——

Chairman THOMAS. Excuse me. Can those acute care clinics be staffed with paramedics and physician assistants?

Mr. GUNDERSON. The criteria is that a physician has to be on call and available over the telephone.

Chairman THOMAS. On call?

Mr. GUNDERSON. Right. That is the criteria that we have established in the legislation itself. There would also have to be a written affiliation with a nearby full-service hospital to coordinate the needs, after stabilization. We also have a criteria from a funding mechanism that this has to be the sole provider in that community so that we are not getting into any kind of overlap or duplication, and a midlevel practitioner must be on site at all times. So those are the four criteria we have articulated in the legislation.

A second designation is a little bit broader, the rural primary care hospital. This designation, much like the critical access hospitals provisions that were passed as a part of the Balanced Budget Act. It would consolidate existing limited service reimbursement demonstration programs, EACH/RPCH, you are all well aware of those, to allow HCFA a more streamlined process, similar to the RPCH that I just mentioned, however, a bit more broad. HHS could designate a RPCH under these new circumstances if it found the hospital was located in a rural area more than 20 miles from another hospital or certified by the State as being a necessary provider of health care, makes available 24-hour emergency care, has no more than 15 acute care inpatient beds, provides inpatient care for a period not to exceed 96 hours.

So this is just one step above the REACH, requiring a State certification that this must be done in order to make inpatient care available for those who need it. So we have tried to deal with the two realities of rural America as we have seen them.

Let me quickly move on, in the interest of time. You all would, I am sure, not like me to spend a lot of time on AAPCC reimbursement because I know we are not going to get into those changes yet this year.

But, I do want to articulate quickly one other issue that we are trying to deal with that is a problem for us as we deal with the appropriation bills, and that is the whole transition and networking process. Rural America is trying to do what both of you have articulated. That is to downsize, to network, to outreach, and so forth.

The problem is, as you know, our outreach and transition grants have not been reauthorized. As a result, neither the House or Senate appropriations Subcommittees will fund them. They have both articulated to us that if these were authorized, the money would be there and they would fund them, but they simply, as you know, are not going to fund unauthorized programs.

I could go into at length, as my written statement does, the experience we have had just in Wisconsin in responding to this area. How have we tried to deal with this? We have tried to deal with it in the interest of streamlining by simply creating a new grant program established under this bill which would provide a planning grant for underserved areas. These would be 3-year grants to States to develop networking plans for chronically underserved rural areas. We would provide technical assistance grants or we would provide development grants for networks with limits and very strict criteria on each of these particular areas.

I will conclude my remarks there, Mr. Chairman, and simply turn it over to Mr. Poshard for the remainder of our testimony.

Mr. Poshard.

[The prepared statement follows:]

STEVE GUNDERSON
...
MEMBER
AGRICULTURE COMMITTEE
ECONOMIC AND EDUCATIONAL OPPORTUNITIES COMMITTEE

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Congressman Steve Gunderson

Testimony Before the Subcommittee on Health

House Ways and Means Committee

September 11, 1996

Statement Summary

Thank you, Mr. Chairman, and Mr. Stark for providing me and my colleague Glenn Poshard with the opportunity to testify before you today. As you know, Congressman Poshard and I serve as Co-chairs of the House Rural Health Care Coalition, a bipartisan organization of over one hundred members with a keen interest in rural health issues.

Just over a year ago, I sat before you as we considered changes to Medicare in the context of a balanced budget. I am pleased that with your help, Mr. Chairman, the Medicare portion of the Balanced Budget Act included key provisions to provide for a flexible rural health infrastructure and to attract qualified personnel to underserved areas. Unfortunately, we were unable to get the package signed into to law, and we must come back again, with a similar, but slightly different approach.

As you know, on behalf of the Rural Health Care Coalition, I introduced the Rural Health Improvement Act of 1996, H.R. 3753, in late June to address rural health issues. While I will discuss all parts of the bill in context of the needs of rural communities, the key to the future of rural health is medicare-eligible reimbursement. Consider these statistics:

- Twenty-Five percent of the United States population lives in rural areas.
- The Rural health infrastructure varies greatly by state and geographic location. This makes developing comprehensive rural health legislation difficult.
- Rural residents are more than twice as likely as their urban counterparts to travel more than 30 minutes to reach their usual source of care. This is partly due to dwindling local providers and the influence of managed care.
- Medicare represents between 50 and 70 percent of rural hospital revenue. However, with limited exceptions, only full-service hospitals are eligible for Medicare reimbursement.
- In Wisconsin, hospitals receive only 88% of their costs of providing service. That number is projected to drop to 86% by the year 2000, under current law.

What inferences can we draw from these facts? The mechanisms of providing health care are changing, just as rural demographics are changing. Many rural hospitals need to eliminate excess capacity to stay in business. The role of Congress is clear: (1) Congress must provide the flexibility necessary to allow rural hospitals to respond to these changes by assuming limited service roles. (2) Given rural hospitals' dependence on Medicare, once Congress provides flexibility, we must ensure that the

downsized facilities continue to remain eligible for Medicare reimbursement. Although I understand that changing reimbursement formulas outside of Medicare reform is not likely, we should provide for medicare eligible limited service hospitals as soon as possible.

My home town hospital provides a good example of why flexible hospital designations are necessary. The Osseo Area Hospital is struggling to stay afloat. Many area residents are members of HMOs, where the provider is at least one-half hour away and as far away as a two and one-half hours drive. Obviously, I support the movement toward more cost-effective health care. However, what do residents in and around Osseo do when immediate emergency service is needed? For now, they can go to the Osseo Hospital. But as the utilization rate of the hospital continues to drop, Osseo must downsize.

Two New Limited Service Hospitals

As part of the Rural Health Improvement Act, we have constructed two limited service designations which preserve a local emergency room without maintaining long-term inpatient services. One is the Rural Emergency Access Care Hospital, which was included in the Balanced Budget Act. The other, the Rural Primary Care Hospital is a variation of the Critical Access Hospital section that was included in the Balanced Budget Act.

Rural Emergency Access Care Hospitals (REACH) -- This is a more limited designation which provides the Department of Health and Human Services to waive the Federal Medicare conditions of participation to establish a limited service category hospital for facilities in danger of closing due to low inpatient utilization rates and net operating losses. Conversion to a REACH facility could occur if the Secretary finds:

1) Access to critical services would be severely limited to residents in the community if the sole community hospital were to close or closes;

2) There is a written affiliation with a nearby full service hospital to coordinate patient referrals and other service needs;

3) a physician is available by telephone and is on-call to provide emergency services.

4) a mid-level practitioner is on site 24 hours.

REACHs would only be allowed to keep patients for a maximum of 24 hours. The intent is to have an emergency facility stabilize patients and then transport them to a full-service facility. The only exemption is where bad weather prevents immediate transport to a full-service facility.

Rural Primary Care Hospitals (RPCH) -- this designation would allow for a consolidation of existing limited service reimbursement demonstrations, while providing a slightly extended version of the REACH. The idea is very similar. The Department of Health and Human Services could designate a Rural Primary Care Hospital if it found the hospital:

1) Is located in a rural area that is:

   - more than a 20-mile drive from a hospital or another facility
   - is certified by the State as being a necessary provider of health care services because of local geography or service patterns.

2) Makes available 24-hour emergency care.

3) Provides not more than 15 acute care inpatient beds.

4) Provides inpatient care for a period not to exceed 96 hours.

5) Each Rural Primary Care Hospital must have an agreement with at least 1 other hospital for patient transfer, electronic data, telemetry and emergency/nonemergency transportation between the facility and the hospital.

Although the Rural Primary Care designation allows for an extended time of patient stay over the REACH, it does provide for an increased incentive for rural hospitals to network. It is broad enough to encompass the EACH/RPCH program and the Medical Assistance Facility (MAF) program to fall under an umbrella designation, reducing the bureaucracy required to administer these programs. This is always useful at a time we are trying to balance the budget.

AAPCC Adjustment: An Issue of Fairness

It is difficult to discuss hospital designations without making mention of actual reimbursement formulas. Many of you are familiar with the Average Annual Per Capita Cost formula, used to set the monthly payment rates. I realize that this issue is more properly considered within the context of comprehensive Medicare reform, but I believe it is so important that I need to mention it briefly.

The AAPCC formula is used to set monthly payment rates for Medicare managed care providers. Although managed care will not reach all rural areas, we must even out the disparities in the capitation rate if we expect managed care to appear in any rural communities.

The numbers say it all:

- The 1996 Highest payment, in Richmond, NY = 758.53
- The 1996 National Average = $400
- 1996 Lowest Wisconsin County (in my district) Vernon County = $237.09

- 1996 Lowest Payment, in Fall River, SD $207.31

By correcting these disparities in a revenue neutral fashion, we can ensure that managed care, especially preferred provider organizations, begin to take root in rural areas.

Rural Health Network Grants: Creating Economies of Scale

Mr. Chairman, another mechanism to bring managed care into rural areas more quickly is to provide limited support for rural health networks. Because rural health infrastructures vary so widely among states and geographic areas, there is no set definition of what is included in a rural health network. However, the concept behind a network is to develop a consortium of doctors, full or limited service hospitals, rural health clinics and other rural health providers and link them together. The purpose behind the network grant section of the Rural Health Improvement Act is to provide a federal incentive to plan and implement such networks.

The network grants would replace the Rural Health Outreach and Transition Grant programs that have served rural america well over the years. However, the authorization for these programs has long run out, and no new grants were funded in FY 1997 in the House. Especially in latter years, a portion of both outreach and transition grants have gone for networking purposes.

In my state, many of the Rural Health Transition Grants have been used to develop innovative networks among the state's rural areas. For example, Berlin Hospital Association used a Transition grant to plan and implement a spoke and hub network with the Hospital acting as a hub and four affiliated clinics providing outreach services. Eagle River, Reedsburg and Tri-County Memorial Hospitals received a grant to develop a new type of coordinated health provider, the Rural Medical Center. An Oconto Memorial Hospital and Bay Area Medical Centers used a grant to develop a rural health network plan and implement the network.

The rural health network grants in H.R. 3753 are based on the concept that in an era when managed care is taking over, rural areas need limited federal assistance, along with state and local assistance, to secure coordinated delivery systems. In keeping with the notion of state-based solutions, the Rural Health Improvement Act provides a system of three grants to mirror the basic phases of designing and implementing a network: planning, technical assistance and implementation grants.

A. Planning Grant for Underserved Areas Under this grant, states designate chronically underserved areas based upon criteria set by the Secretary. Chronically Underserved Areas are determined by a lack of basic health care providers for local residents and a lack of assistance from other private, state and federal sources. The grant is used to plan a rural health network.

These grants provide for 3-year grants, 100%, 50% and 33% each year, not to exceed $100,000 per year.

B. Technical Assistance Grants for Networks -- Provide technical assistance for a state or a consortium of three entities within a proposed network.

These grants are 1-year, $50,000 per grant area.

C. Development Grants for Networks -- This is a 3-year, $250,000 per year limit grant for the development and implementation of a rural health network. The Department of Health and Human Services is directed to give priority to entities with a comprehensive network plan. The purpose is to allow rural health clinics, hospitals, physicians and other providers to network.

We believe that these grants will provide a boost for the physical development of managed care in rural areas. In fact, these grants are an extension of the networking grants that were part of the Critical Access Hospital section in the Balanced Budget Act.

Personnel -- an Essential Rural Resource

Mr. Chairman, it may seem a bit ironic that at a time we are trying to downsize the rural health infrastructure we are also providing incentives to attract qualified personnel. This should not be all that surprising. Few medical programs are located in rural areas, and few rural areas offer the latest techniques or the newest technology. In order to provide an incentive to practitioners, the National Health Service Corps (NHSC) provides scholarships and loan repayment assistance to those who agree to serve a Health Professional Shortage Area for two years in return for each year of scholarship or loan repayment.

Prior to the 1986 tax reform act, the Scholarships and loan repayments did not count as part of NHSC members gross incomes. However, following 1986, with the great increase in student debt load, it has become obvious that including these amounts in gross income provides a significant barrier to participation. In fact, the tax burden to a professional student could be up to 39 percent of the annual amount

awarded, effectively reducing the value of the scholarship by 39 percent. If the federal government has decided that providing the incentive through a scholarship is a priority, why should it blunt that incentive through taxes? Obviously, we are in an era of declining appropriations, but we must make the best use of limited resources.

The Rural Health Improvement Act of 1996 would exempt both scholarships and loan repayments from income, thereby allowing the full effect of those amounts to be used by the medical professionals. The bill also requests that the Secretary conduct a study of allocation of Corps members among shortage areas and to grant priority in assigning members to areas planning or implementing a rural health network.

The bill would also increase the Health Professional Shortage Area (HPSA) bonus payment from 10 percent to 20 percent. Hospital administrators and other health professionals believe strongly that an increased bonus payment is the key to attracting full-time professionals to rural areas.

Rural Health Center Grants

The geographic diversity of the United States means that not every program will work for every area. Community Health Centers (CHCs) have served the country well. Unfortunately, CHCs are not located in many areas. For that reason, the Rural Health Improvement Act allows the Secretary of Health and Human Services to give priority in making new health center grants to a project where a CHC is not already located. The bill then makes a provision for health centers located in or adjacent to a community hospital. The rationale here is simple. Most areas that do not have CHCs, have community hospital. Distributing new grants to downsizing hospitals ensures continued rural health access.

Antitrust

A quick word about antitrust. The RHCC has been very concerned about the heavy handed approach of the Justice Department and the Federal Trade Commission toward hospital mergers and networking. Last month, these agencies jointly released a new, more flexible approach toward these combinations. The full effect of their promise to provide "more flexible antitrust treatment" has yet to be analyzed, but represents an important first step toward providing the flexibility our rural
areas need.

Conclusion

On behalf of my colleagues in the RHCC, I again thank you for holding this hearing, Mr. Chairman. In closing I would stress that access to health care in rural areas should not be underemphasized. While people are certainly more mobile today than they were thirty years ago, there is a limit to how far people will travel, especially among the older rural populations. As we move toward the finale of the 104th Congress, I urge the Ways and Means Committee to consider the proposals that we have laid forth in the Rural Health Improvement Act of 1996, and to work with the RHCC to provide access to care and a flexible rural health infrastructure as quickly as possible.

Chairman THOMAS. Thank you very much, Mr. Gunderson.

STATEMENT OF HON. GLENN POSHARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS; ON BEHALF OF THE RURAL HEALTH CARE COALITION

Mr. POSHARD. Mr. Chairman, Members of the Subcommittee, I, along with Congressman Gunderson, want to thank you for holding this hearing. As co-chairman of the Rural Health Care Coalition, it has been a pleasure working with this Committee over the years on the many health care issues that affect our Nation.

I represent a district in Central and Southern Illinois, a rather large rural district, one that is almost exclusively rural, in fact, and during my travels throughout the district, I witness all kinds of distresses that Steve articulated on our rural health care system today, from communities without the services of a primary care physician or an OB/GYN to small hospitals facing closure due to their increasing dependence on Medicare and Medicaid reimbursements. The distress in our rural communities in terms of trying to ensure quality and affordable and accessible health care services is greater, I think, than it has ever been.

Of the 2,100 rural communities or rural counties, in this nation, 1,400, that is fully two-thirds, are in federally designated primary care provider shortage areas. This number should not be surprising, because only 16.5 percent of our primary care providers choose to practice in rural areas. Additionally, over 400 rural hospitals have closed, with many facing the same fate, should we allow a disproportionate share of reductions in Medicare and Medicaid spending to be directed toward our Nation's health care providers, that is, our hospitals and our physicians.

Let me say before I go on that I think every member of our Rural Health Care Caucus realizes that it should be Congress's top priority to balance our Federal budget. I may disagree with some of my colleagues in how we achieve that goal, but I believe it is a goal that all of us on both sides of the aisle have to embrace.

I also understand that in order to achieve a balanced budget, the Congress will have to make some very tough decisions and realign our priorities. However, I also believe that with 22 million Americans living in health professional shortage areas, the closure of 400 rural hospitals across the country in the last 15 years and a significant lack of managed care services available to rural Americans that rural health care has to be a top priority for this Congress and for the country.

Many of our federally funded rural health programs and initiatives are working well and we are obtaining the goals that we set out when we designed them. However, the Rural Health Care Coalition recognizes that we must continue efforts to balance the budget. We must do all we can to get the maximum return for every dollar that Congress appropriates.

For this reason, we introduced the Rural Health Improvement Act of 1996. The legislation includes provisions that not only move rural health care into the 21st century, but reform and consolidate a number of federally sponsored rural health care initiatives.

While I do not believe that managed care is the simple solution that some believe it is to the problems that our rural health care

delivery system currently faces. I do believe it has the potential to increase access of care in rural communities and improve the continuity of care for our rural citizens. However, the introduction of attractive and affordable managed care into rural America depends greatly on our rural communities' willingness to adapt to new and innovative delivery systems and on Congress's willingness to pass legislation that gives incentives for managed care to competitively enter into these markets.

Because the coalition sees the delivery of health care moving in the direction of managed care, especially with regard to Medicare and Medicaid, we included changes to the adjusted average per capita cost in the Rural Health Improvement Act that would have the effect of raising the Medicare capitation rates in most rural areas, thus reducing the current rural-urban differential. While our proposed change is relatively small, we do believe it is a step in the right direction, a step that has to be taken if managed care is to survive in rural America.

It does not seem just to me or even logical that in the 27 rural counties that I represent, when managed care enters into our counties and tries to deliver services, that we get an average cost for a managed care person in Medicare of less than $300 per month per person when just 200 miles away in Cook County in Chicago, that same person gets an average cost of over $530 a month paid on their managed care. How can we expect managed care to move into the rural areas if there is such a differential in our payments between the rural and the urban areas?

There is a question here that has to be addressed, and I know we are not going to do it this year, but I hope next year, when we fully address Medicare reform and include rural health care reform in that, that we seriously take a look at the AAPCC and the way it affects rural areas and the unjust nature of that reimbursement formula.

The Rural Health Improvement Act also works to foster the networking of rural health providers. We believe the rural health care community has a greater understanding of the need and advantages to working together. Whether it is sharing of physician services or medical equipment to communicating through telemedicine, providers are finding that they can offer more quality services in a more cost-effective manner through health care networking.

Mr. Stark, I went through years ago in my rural communities a consolidation of schools, too, and I learned one thing. Every time you talk about consolidating something in rural communities, 1,000 red flags go up because the schools, other things are the glue that hold them together. I learned something pretty simple in that process. If you talk about sharing resources, not as many red flags go up.

We think that, fundamentally, we have to change the approach for hospitals in rural America. We know not every hospital can stay, not every hospital can provide a full range of services. What we are advocating is that hospitals perform the service that they can do well and cost effectively and that we help them with that. We know that some hospitals are going to have to become urgent centers or emergency care centers. They are going to have to convert some unused bed space to long-term care or swing beds.

We know that we are going to have to strike some of the antitrust laws that currently prevent our hospitals from sharing technology or human resources and these kinds of things because those are outdated in our rural areas now. No one is dominating rural health care.

There are many changes that have to come about and we have to do it in a cost effective, efficient way, but it is going to mean the changing role of hospitals. I do not think we have to do away with every hospital but we have to find a way that it fits a particular niche and delivers a cost-effective service to its people. That is our key here, in the next few years, and that is what Steve and I and the other members of the caucus or the coalition have tried to draft.

So, I am going to leave it at that and then hopefully we can discuss some of these things.

[The prepared statement follows:]

Statement
of
Representative Glenn Poshard
19th District of Illinois

September 12, 1996

Chairman Thomas and members of the Subcommittee, along with Congressman Gunderson, I want to thank you for holding this hearing. As Co-Chairmen of the Rural Health Care Coalition, it has been a pleasure working with this Committee on many of the health care issues affecting our nation's rural communities.

I represent a district in central and southern Illinois, the third largest congressional district east of the Mississippi River and one that is almost exclusively rural. During my travels throughout my district, I continue to see the serious problems that plague those trying to meet the health care needs of our families living and working in rural America. From several communities being without the services of a primary care physician or an OB-GYN to small hospitals facing closure due to their increasing dependence on Medicare and Medicaid reimbursements, I witness the distress our rural communities face in insuring quality, affordable and accessible health care services are available to all.

Of the 2,100 rural counties in this nation, 1,400 are in federally designated primary care provider shortage areas. This number should not be surprising as only 16.5 percent of primary care providers choose to practice in rural areas. Additionally, over 400 rural hospitals have closed with many more facing the same fate -- especially should Congress allow an disproportionate share of reductions in Medicare and Medicaid spending to be directed toward our nation's health care providers -- our hospitals and physicians.

Before I go on let me state -- it should be Congress' top priority to balance our federal budget. Though I may disagree with some of my colleagues on how we achieve that goal, I believe it is a goal all of us, on both sides of the aisle, must embrace. I also understand that in order to achieve a balanced budget, this Congress will have to make some very tough decisions and realign our priorities. I believe, however, that with 22 million Americans living in Health Professional Shortage Areas, the closure of 400 rural hospitals across this country over the last 15 years, and a significant lack of managed care services

available to rural Americans, rural health care must be a priority of this Congress and this nation.

Many of our federally funded rural health programs and initiatives are working well and are obtaining the goals we set out upon their design. However, the Rural Health Care Coalition recognizes that as we continue efforts to balance the budget, we must do all we can to get the maximum return for every dollar Congress appropriates. For this reason, the Coalition introduced the Rural Health Improvement Act of 1996 earlier this year. This legislation includes provisions that not only move rural health care into the 21st century, but that reform and consolidate a number of federally-sponsored rural health care initiatives.

While I do not believe managed care is the simple solution to the problems our rural health care delivery system currently faces, I do believe it has the potential to increase access of care in rural communities and improve the continuity of care for our rural citizens. However, the introduction of attractive and affordable managed care into rural America depends greatly on our rural communities willingness to adapt to new and innovative delivery systems and on Congress' willingness to pass legislation that gives incentives for managed care to competitively enter these markets.

Because the Coalition sees the delivery of health care moving in the direction of managed care, especially with regard to Medicare and Medicaid, we included changes to the Adjusted Average Per Capita Cost (AAPCC) in the Rural Health Improvement Act that would have the effect of raising the Medicare capitation rates in most rural areas, thus reducing the current rural-urban differential. While our proposed change is relatively small, we believe it is a step in the right direction -- a step that must be taken if managed care is to work in rural America.

I look at Illinois and the fact that a manage care plan serving a Medicare beneficiary in Cook County, Chicago, would be eligible to receive a monthly capitation rate of $528 -- while at the same time a managed care plan providing the same Medicare services in a number of counties in my district would receive less than $350 a month per beneficiary. There is no question of whether there is a problem in the AAPCC formula that needs to be addressed. In fact, last year both the Republican Budget Reconciliation Act and the Blue Dog Balanced Budget bill made great strides in decreasing the variation in payments. We

must continue our commitment to finding a solution that will allow managed care to offer meaningful and affordable benefits to rural families.

The Rural Health Improvement Act also works to foster the networking of rural health providers. We believe the rural health care community has a greater understanding of the need and advantages to working together. Whether it is the sharing of physician services or medical equipment to communicating through telemedicine, providers are finding they can offer more quality services in a more cost-effective manner through health care networking.

First, our Act provides financial and technical support for planning and developing community rural health networks through a grant program that consolidates a number of current rural health care programs, including rural transition and outreach grants. The Coalition also promotes the formation of health networks in the Medicare Rural Primary Care Hospital designation, which Congressman Gunderson earlier described, by requiring that the designated hospital have an agreement with another hospital for patient transfer and referral, telemetry, sharing of patient data, and emergency services.

The Rural Policy Research Institute stated in its analysis of our Act that "it serves a very important function of targeting limited federal support to the development of network structures in underserved rural areas that will help these areas sustain accessible and financially viable health services." The Coalition believes that with limited federal dollars available, we must use them to assist in achieving the goals leaders in the rural health care community have set for themselves.

The Rural Health Care Coalition commends the work of the National Health Service Corp. -- a program that has been extremely successful in encouraging providers to practice in rural communities. Through its scholarship and loan repayment programs, the Corp. has been able to have a direct impact on the health care services available to many once underserved communities. Studies now demonstrate that a significant number of Corp. participants continue to practice in rural areas after completion of their work requirements. However, because the Corps.' funding is limited, many rural communities continue to express concern regarding the recruitment and retention of physicians and other health care practitioners, especially those providing primary care services.

The Coalition supports allowing for the tax deductibility of payments for National Health Service Corp. scholarships and for payments under the Loan Repayment Program. We believe that the greater financial incentives we give to Corp. members, the more attractive it will be for providers to participate and locate in a rural community.

We also have included in our legislation an increase in the Medicare bonus payment to physicians practicing in rural areas. I recognize the fact that some argue the Medicare bonus payment has not been effective in the recruitment and retention of primary care physicians, but instead specialists have taken advantage of the incentive. I would say the bonus payment has not been as successful as predicted because it is not high enough, nor does it target primary care providers who are needed by our communities the most.

Our legislation increases the Medicare bonus payment to 20 percent, and more important limits the payment to primary care services provided by not only physicians, but physician assistants, nurse practitioners and nurse midwives. While we limited the scope of services that were eligible for the payment to primary care, the Coalition recognized the need for other levels of providers to deliver primary care to those in rural areas. Additionally, we direct the Secretary of Health and Human Services to study the statutory criteria used by the Corp to insure its participants are being placed in areas that are truly underserved. However, it is our understanding the Department is already undergoing the very study suggested in our legislation -- a move that will assist the Corp. in better allocating its resources.

Before I conclude, I would like to address the future of many of the rural health initiatives I spoke of this morning. First let me emphasize, that the Rural Health Care Coalition and its 115 members believe government has a role to play in insuring rural Americans have access to quality and affordable health care. During this Congress, we have seen many federally-funded rural health programs attacked -- programs that have made considerable differences in my district, and I am sure many of yours. For example, the House passed a budget resolution that calls for the elimination of the Federal Office of Rural Health Policy and an appropriations bill that zeros out the rural hospital transition grant program and nearly eliminates the rural outreach grant program. Do I recognize the need to

reform or restructure these programs? Yes, but to eliminate them before we have a chance to make them work better for our rural constituents is a mistake.

I understand this Committee does not have jurisdiction over all of these and some of the other programs that will be addressed today. I bring them to your attention, so you realize how important it will be for your Committee to not only support, but to be an advocate for those rural health care initiatives such as changes in the AAPCC formula or an increase in the Medicare bonus payment for rural physicians over which you have jurisdiction.

As Co-Chairman of the Rural Health Care Coalition, I plan to continue to push for passage of the Rural Health Improvement Act during the 105th Congress. I believe it is inevitable that Congress and the President will debate and pass substantive Medicare reform legislation that puts solvency back into the Medicare system. At the same time, we must make the necessary changes to make the Medicare program work better for rural Americans.

I believe this Coalition has demonstrated the bipartisan support for a partnership between the federal government and those trying to make accessible, quality and affordable health care a reality in their rural communities. We stand ready to move legislation, like the Rural Health Improvement Act, and support initiatives, such as the restructuring of the Federal Office of Rural Health Policy, in Congress that will continue to make federally-supported rural health programs work for our rural constituents. Some of the Coalitions goals for the future of rural health care in this nation may be easier to achieve than others -- but I know the Coalition and this Congress is ready to meet the challenges necessary to providing security that the health care needs of those of us that call rural America home.

I want to again thank the Committee for allowing Congressman Gunderson and me to testify today. I look forward to answering any questions you may have, and to working with you during the remainder of this Congress and more importantly the 105th Congress in passing legislation that will make a difference to the delivery and future of rural health care in America.

Chairman THOMAS. Thank you very much, both of you. We would appreciate it, more so than most members' testimonies, if we can ask you some questions, because you do represent a significant chunk of folk. Not just in the rural areas do we need to have a dialog and an understanding of the need for change, but among some of our members, we also need to understand the nature of change and the possibility of that change.

In looking at your legislation, in title VIII, I hope all of us are pleased with what appears to be a willingness on the part of the Justice Department in the Antitrust Division to begin to change. I mentioned briefly the legislation which just passed, H.R. 3103, which moved some of the criteria from the rule of reason and I feel very good about the Ridgecrest area. Virtually, there are 98 percent of the doctors in a single hospital are creating a managed care structure, and in looking at the consequences, the Justice Department has felt with one-third party management, there would not be the concerns about collusion on prices that seem to concern them.

It is that kind of creativity, working with a supportive and nurturing Antitrust Division, that will allow us to be as creative as we can be. What we have to do is provide as many models as possible for folks to find one that they are comfortable with.

We went through an analysis of the AAPCC funding structure and looked at some alternatives, like moving to a metropolitan statistical area rather than the counties. A lot of those switches really did not move us forward. In some ways, they created problems.

It is true that there is a maldistribution, but when you go back in and try to figure out what is a fair distribution with intent, and that is what is the purpose for trying to put more money into those areas that perhaps have a lower payment, the argument obviously is to try to create more of a competitive marketplace and perhaps attract managed care structures. It does not make a lot of sense to me to up the AAPCC if all we do is increase those who are under the current fee-for-service structure, since they are there and operating anyway.

I personally am quite disappointed in our inability, to take what I thought was a real opportunity when there was a 10-percent increase in the AAPCC and not redistribute it as a first step forward. In fact, this administration simply sent it out on the straight 10 percent rate. So, Dade County at about a $600 rate got the 10 percent multiplier and the counties in Wisconsin or in some of the other Midwestern States, especially in Iowa, which would be at about a $220 or $250 rate, got their $25 rate and we did not get an adjustment which would have been a significant first step forward.

Let me ask you a question about title V. There is some concern about the administration's recent reclassification for payment purposes doing away with the old urban, rural, and other categories, and creating only two categories, urban and other, denying payments that otherwise had been made on the Medicare disproportionate share payments. I know some of our concerned colleagues are in the audience. Bob Inglis from South Carolina, for one. Your legislation would not allow for what in essence has occurred. There

is obviously a cost factor there. Have you been able to cost that out at all?

Mr. GUNDERSON. Just a second here. According to CBO's advisory draft statement, it is de minimis and it falls under their basic guidelines for illustrating a particular number.

Chairman THOMAS. Which is usually $50 million, I believe. It is an asterisk if it is $50 million.

Mr. GUNDERSON. Actually, there is nothing on this sheet that shows any cost projections on title V for the whole bill. If you do not have this, we would certainly be willing to share this. This is an informal CBO report.

Chairman THOMAS. I have it. We think the number, if we have not firmed it up, is $37 million in 1997 and then revenue neutral after the adjustment has been made.

I guess these are the kinds of arrangements we are talking about, which may make a significant difference in particular areas. But, when you look at the larger picture and the dollar amounts that need to be shifted, they are not significant, other than de minimis amounts of money are significant.

Mr. GUNDERSON. Sure. In the broader context of comprehensive Medicare reimbursement reform, this may not be a justifiable provision and something I think you correctly articulate you would want to look at in a much more comprehensive fashion. What we are frankly trying to do here is survive until that day comes.

Chairman THOMAS. Thank you very much.

Mr. Stark.

Mr. STARK. I just want to thank the gentlemen for their offer of cooperation. I would like further, Mr. Chairman, just to point out that during the time that this hearing was scheduled, the Democrats have a caucus scheduled. I believe the topic is to discuss changing your title from Chair to Ranking Member. [Laughter.]

In finding out what is going on, I am sure Congressman Poshard and Congressman Gunderson will excuse me. I would like to get over and find out what they are talking about in that secret session. I assure the gentleman that the absence of my fellow Democrats does not signify a lack of interest in your problem.

I also wonder whether there will be any witnesses here from Health and Human Services, after reading about all the resignations there were in the paper yesterday, so this may be a much shorter hearing than you think.

But, I appreciate the Chair's indulgence in letting me sneak away to find out what is going on.

Chairman THOMAS. As long as you will inform us when it is over.

Mr. STARK. You will be the first to know. [Laughter.]

Chairman THOMAS. We have with us someone who is not a Member of the Subcommittee but obviously a Member of the Full Committee and has a significant interest in legislation of this type, the gentleman from Iowa, Mr. Nussle. I believe he wants to inquire.

Mr. NUSSLE. First of all, I appreciate the Chairman allowing me to come and visit the Subcommittee. I just have two observations.

First, just to let everybody know of how tough a negotiator you were last year with us and how fair you were with us on the whole area of AAPCC. We believe that we made some significant reforms

last year and it was because of your leadership, Mr. Chairman, that we were able to get that done. That is not to suggest that it was easy and that you were not a tough negotiator in the process, because, as we all know, there is a finite pool of money and if you push down on one side to raise the other, it means that somebody else is discouraged or concerned.

So, as the leaders of the Rural Health Care Coalition were working with you, and I had the honor of observing that and participating in that, I just wanted to thank you for your leadership. It was done very fairly and with the concerns of rural areas in mind.

Then just a final observation about Mr. Gunderson. I really believe that if a farmer falls off a tractor today because he has a heart attack in Southwest Wisconsin or if a mom needs to go and deliver a baby today in Iowa or even in Illinois, that they have a much better chance of finding a hospital open and rural health care delivered for them because of your leadership in the Congress over the last many years. I want to thank you for that service.

I have had an opportunity to watch both of you, but because you are leaving, I wanted to single you out, Steve, and just say thank you for that leadership, because we are not done yet. We will not be done when I am done here, I am sure. This is an issue that will continue to be at the forefront. But, I wanted to single you out and say thank you for that service, because I really believe that.

I think much of what we were talking about today is not so much once you get in the front door of the hospital as it is, where is the hospital? How long does it take you to get there? Is there going to be an ambulance to get you there, and how far do you have to go? The closing of one hospital is not just a 20-mile issue. It means 40 miles, because it just doubled the amount of time and minutes that it takes you to get there.

So, I really believe that with harvest season coming and all the different things that are going on in your area and in mine, I wanted to thank you, because I think there is probably a better chance that the people are going to get assistance because of your leadership over the last few years.

Mr. MCCRERY. Would the gentleman yield?

Mr. NUSSLE. I would be happy to yield.

Mr. MCCRERY. I just want to say that as a person who has been here for several years, and interested in health care ever since I got here, I want to associate myself with the remarks of the gentleman from Iowa about Steve Gunderson. Steve has been a leader as long as I have been here in fighting for rural health care. He has not been a member of a committee of jurisdiction as far as I know, but he has been a true leader in bringing to light the problems of rural health care, and coming up with solutions that fit within the framework of what we are all trying to do here.

So, I want to add my commendation to the gentleman's efforts and urge Mr. Poshard to take up where Mr. Gunderson is going to leave off and continue his battles, because they are worthwhile.

I thank the gentleman for yielding.

Mr. GUNDERSON. Mr. Chairman, if I might respond——

Chairman THOMAS. Certainly.

Mr. GUNDERSON [continuing]. I want to thank both my friends for their kind eulogies. I hope you will also give me a going away present known as H.R. 3753. [Laughter.]

Chairman THOMAS. I will tell the gentleman that oftentimes in those negotiations, the Rural Caucus looked a lot like the Agriculture Committee, and as an alumnus of that Committee, my concern always is not that we can come to an agreement, but that what we agree on can pass the House. That is a secondary requirement on anything that we come up with. So, usually my exhortations were to the fact that we would be taking it away from someone else and we could only take so much away.

In that regard, I thought we had put together an excellent working package. That does not mean we will not be able to recreate most of the pieces. It is pretty obvious in the timeframe that we have left, it may not be possible, but the groundwork that you folks have laid in rethinking, restructuring, and sensitizing certainly will not be wasted, notwithstanding the fact you may not be able to vote for the final change, Mr. Gunderson, you will be there in spirit, clearly.

I want to thank both of you for your continued leadership. Thank you very much.

Mr. GUNDERSON. Thank you.

Mr. POSHARD. Thank you, Mr. Chairman.

Chairman THOMAS. And now, apparently two individuals who have not yet resigned from the Health Care Financing Administration, as per Mr. Stark's comments, Jeffrey Human, Director of the Office of Rural Health Policy, and Kathleen Buto, Associate Administrator for Policy at HCFA.

I want to welcome both of you and, obviously, your written statements will be made a part of the record and you may inform us in the time that you have in any way that you see fit. Thank you very much for coming.

STATEMENT OF JEFFREY HUMAN, DIRECTOR, OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HUMAN. Thank you very much, Mr. Chairman. I am real pleased to be here as a part of this important hearing.

There are two major components of the unique problems rural Americans face in getting health care. First, there is a shortage of physicians and other health care professionals in rural areas, as you have alluded to yourself, and second, rural hospitals have been closing at a disproportionate rate.

With respect to physician shortages, on a per capita basis, there are almost twice as many primary care physicians practicing in urban areas as there are in rural areas. There are also documented shortages of nurses, psychiatrists, dentists, social workers, psychologists, and other health professionals in rural areas.

The other problem is the viability of rural hospitals, and we have already had a good bit of testimony on the number of rural hospitals that have closed over the past 15 to 20 years. About 25 percent of the remaining 2,100 rural hospitals have negative operating

margins. That is, they are losing money and may be at risk of closure.

More than a few urban hospitals also have closed during this period, but the consequences of the closure of a rural hospital are frequently more difficult for local people than the consequences of the closure of an urban hospital. Many of us who live in the Washington, DC area have several hospital choices. Hospitals that closed in rural areas may leave local people with no choice or a very long distance to travel.

Any strategy to improve health care in rural America will also benefit rural viability. Towns without physicians usually cannot attract employers or even hold the employers they already have. Rural hospitals are typically the second or third biggest employer in a town. When the rural hospital closes, the local physicians typically also leave, and the prognosis for the economic viability of the community darkens considerably and immediately. The availability of health care in America's smaller communities and the economic viability of those communities are inexorably entwined.

We can count many Federal initiatives that assist rural people to get health care. We must, however, resist the temptation to define rural health as a Federal problem that requires a Federal solution. It is a national problem that cannot be solved without the involvement of the States, the local governments, and the private sectors. What we do in government at any level merely compliments the efforts of the thousands of dedicated physicians and other health professionals who serve rural areas.

Through the years, the Congress has passed a number of acts designed to assist rural populations to get the health care they need and to support the health professionals who serve them. Some of these public laws fall under the jurisdiction of this Committee. Kathy Buto of the Health Care Financing Administration will discuss those programs and I will move on to the office I direct, the Office of Rural Health Policy.

We administer some programs which I describe, but our principal roles are to serve as a voice for rural health in the Federal establishment and to develop information and policy alternatives that help rural America. Most of the rural health programs under this Committee's jurisdiction are reimbursement programs under title XVIII. A number of other programs, including some we administer, compliment these reimbursement programs with direct assistance to rural communities in need.

Among these are Community and Migrant Health Centers in rural areas. Over 3.7 million Americans in 1,100 of the poorest communities in this country receive their day-to-day primary care from these private medical clinics. Federal support from the Health Resources and Services Administration allows these clinics to offer discounted fees to the poor and the near-poor, who are the bulk of the centers' patients.

Another is the National Health Service Corps. Under the Corps programs, physicians receive their medical education at government expense, either through scholarships or later by loan repayment, and pay the country back by serving in the communities that experience the greatest difficulty recruiting physicians. Currently,

about 1,300 of the 2,200 physicians and other health professionals in Corps service are in rural areas.

Area Health Education Centers in 36 States link medical schools and teaching hospitals with rural communities and help them recruit physicians, as well as provide continuing medical education to those who already are there.

Rural Interdisciplinary Training Grants prepare health profession students for rural practice.

My office supports the Rural Information Center Health Service, we call RICHS, in collaboration with the U.S. Department of Agriculture. By dialing 1-109-800-633-7701, rural communities can get information on such diverse topics as how to recruit a doctor or how to build a community water and sewer system.

We fund grants to communities for rural health outreach projects to help each community develop unique solutions to its particular problems. Under outreach rules, the projects must be directed locally, the money must be spent locally, and the patients served must be local people. A consortium of three or more organizations need to coordinate the services provided. Thus, our grants help local community groups work together to build self-sufficiency and economic viability while improving health care. More than 70 percent of our grantees have been able to continue their projects after the 3-year period of Federal support has ended.

We also provide grants for rural health research centers. These centers are exploring many important issues, such as policy options for increasing the number of health professionals in rural areas.

We administer the Rural Telemedicine Grant Program, which is designed to systematically evaluate rural telemedicine. We currently fund 12 projects in 11 States, all of which also are facilitating the development of rural health networks.

The office helps to shape departmental policies and programs on rural health care by reviewing regulations and legislative proposals that affect rural health care providers and rural populations. For example, we review Medicaid waiver applications from the States from a rural perspective.

The office also staffs the Secretary's National Advisory Committee on Rural Health, which is chaired by former Iowa Governor Bob Ray. Over the past 6 years, the Committee has produced a wide array of recommendations on rural health care financing issues and ways to improve access to health care in rural communities.

We help the 50 States each fund rural health offices, much like our own. State efforts have led to the placement of more than 1,000 physicians in rural practices in recent years.

Madam Chairman, there are other rural health problems that are pervasive, such as EMS shortages, mental health shortages, and occupational health problems. There are also other Federal programs I have not had the time to describe and thousands of State, local, and private efforts that help, as well. Thank you very much.

[The prepared statement follows:]

STATEMENT OF JEFFREY HUMAN, DIRECTOR
OFFICE OF RURAL HEALTH POLICY,
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning,

Mr. Chairman, I am pleased to be here to be a part of an important hearing on the availability of health care in rural communities. This is a significant problem that has plagued the Nation for many years. We are appreciative of the support the House Ways and Means Committee has provided through the years in addressing rural health care concerns.

There are two major components of the unique problems rural Americans face in getting health care. First, there is a shortage of physicians and other health care professionals in rural areas. Second, rural hospitals have been closing at a disproportionate rate for the past 15 years.

With respect to physicians shortages; on a per capita basis there are almost twice as many primary care physicians practicing in urban areas as there are in rural areas. When we consider all physicians, not just those practicing primary care, there are well over twice as many physicians - on a per capita basis - practicing in urban areas.

If we look at the problem on a county basis, about 1400 of the nation's 2100 rural counties are classified as Health Professions Shortage Areas, because of a shortage of primary care physicians. For the most part these are the more remote counties, those that are farthest away from the Nation's cities. Most of the counties on the Great Plains, for example, are shortage areas and more than 100 have no physicians at all.

There are also documented shortages of nurses, psychiatrists, dentists, social workers, psychologists and other health professionals in rural areas.

The other problem is the viability of rural hospitals. According to the Office of the Inspector General, there were 2,489 rural hospitals in 1987. By 1995, the number had declined to 2,141 -- a 14% decrease. The rate of closure has slowed during the past five years and the average total margin for rural hospitals was 5.5% in 1994, the highest in over a decade. Despite the improvement in the average rural hospital margin, however, about 25% of the remaining 2141 rural hospitals have negative operating margins - that is they are losing money and are at risk of closure.

More than a few urban hospitals also have closed during this period, but the consequences of the closure of a rural hospital are frequently more difficult for local people than the consequences of the closure of an urban hospital. Many of us who live in the DC area have several hospital choices. Hospitals that close in rural areas may leave local people with no choice, or a very long distance to travel.

Before we talk about solutions to these problems we should put them into a broader context. In 1900 over 60% of the nation's population lived in rural areas. Today that figure is under 25% and falling. It is not only the hospitals that are closing but also the schools, grocery stores, farms, and manufacturing plants. There are not only shortages of health professionals, but of professionals of all stripes.

And any strategy to improve health care in rural America will benefit rural viability as well. Towns without physicians usually cannot attract employers, or even hold the employers they already have. Rural hospitals are typically the second or third biggest employer in a town. When the rural hospital closes, the local physicians, typically, also leave. And the prognosis for the economic viability of the

community darkens considerably and immediately. The availability of health care in America's smaller communities, and the economic viability of those communities are inexorably entwined.

There is also a close relationship between rural poverty, uninsurance, and health care. In 1994, 16.3% of rural people were below the poverty level, compared to 14.9% of urban people. This is approximately 8 1/2 million rural people. About 17% of all rural Americans are uninsured.

As we look at the problem of accessability to health care in this country's more remote areas we can count many federal initiatives that assist rural people. We must, however, resist the temptation to define rural health as a federal problem that requires a federal solution. It is a national problem that cannot be solved without the involvement of the States, the local governments and the private sector. What we do in government at any level, or in foundations or associations, merely compliments and helps fill in the gaps for the thousands of dedicated physicians and other health professionals who serve rural areas, despite lower compensation. They need and deserve our support.

Through the years the Congress has passed a number of acts designed to assist rural populations to get the health care they need and to support the health professionals who serve them. Some of these public laws fall under the jurisdiction of this committee. Let me just mention some of these. Ms. Kathy Buto of the Health Care Financing Administration, the next witness, will discuss some of these programs in more detail:

- The Medicare Resource Based Relative Value Fee System (or RBRVS) pays primary care physicians more than used to be the case. These are the physicians rural areas depend on most.

- Primary care physicians in rural areas that are classified as Health Professional Shortage Areas receive a 10% bonus for each service paid for by Medicare.

- Medicare certified Rural Health Clinics receive cost based reimbursement in shortage areas for the physicians, nurse practitioners and physician assistants they employ.

- Several special reimbursement programs for rural hospitals have helped many survive that might otherwise have perished. These include the Swing Bed Program which allows rural hospitals to use some beds for long term care when necessary, and the Sole Community Hospital reimbursement program, which pays higher Medicare rates to many of the most isolated and remote hospitals. Rural Healthcare Transition Grants also are under the jurisdiction of this committee. These grants help rural hospitals re-examine their roles in the community, change their service mix, or offer new services as necessary.

- The office I direct, the Office of Rural Health Policy, is authorized under section 711 of the Social Security Act, even though we are located administratively in the Health Resources and Services Administration (HRSA), so we also fall under this committee's jurisdiction. While we administer some programs, which I will describe, our principal roles are to serve as a voice for rural health in the federal establishment, and to develop information and policy alternatives that help rural America.

Most of the rural health programs under this committee's jurisdiction are reimbursement programs under Title XVIII. A number of other HRSA programs, including some we administer, compliment these reimbursement programs with direct assistance to rural communities in need. Among these are:

- Community and Migrant Health Centers in rural areas. Over 3.7 million Americans in 1,100 of the poorest communities in this country receive their day to day primary care from these private medical clinics. Federal support from HRSA allows the clinics to offer discounted fees to the poor and near poor who are the bulk of the centers patients. A reimbursement program under this Committee's jurisdiction known as Federally Qualified Health Centers (FQHC) helps these centers receive cost based reimbursement for Medicare and Medicaid patients.

- The National Health Service Corps. Under the Corps' scholarship program physicians receive their medical education at government expense and pay the country back by serving in the communities that experience the greatest difficulty recruiting physicians. The Corps also repays the educational loans of other young physicians at up to $20,000 per year in return for service in underserved areas. Currently about 1,300 of the 2,200 physicians and other health professionals in Corps service are in rural areas. Three quarters of a million people receive their care from Corps' practices as well as many more in community and migrant health centers served by Corps professionals.

- Area Health Education Centers in 36 states link medical schools and teaching hospitals with rural communities and help them recruit physicians as well as provide continuing medical education to those who already are there. More than one and a half million health professionals have received AHEC sponsored training, most of them in rural areas.

- Rural Interdisciplinary Training Grants train students to work effectively in multi-disciplinary teams that enhance the capability of every member of the team to help the patient. More than 55% of the 1,700 students who have participated in this program now practice in rural areas. This program thus serves as a recruitment program for rural areas.

- My office supports several important rural programs including the Rural Information Center Health Service (RICHS), in collaboration with USDA. By dialing 1-800-633-7701 rural communities can get information on such diverse topics as how to recruit a doctor or how to build a community water and sewer system. RICHS operates a World Wide Web Site that is hyperlinked to many rural health programs throughout the country. RICHS also publishes monographs and bibliographies on topics of concern to rural leaders and health providers.

- We fund grants to communities for Rural Health Outreach projects to help each community develop unique solutions to its particular problems. Thus we fund an Alaska tribal consortium that brings itinerant physician services to two remote villages, an elementary school district in Arizona that brings preventive and primary care to school children in eleven school districts and a hospital in Iowa that is providing training to nurses, paramedics and emergency medical

technicians. We currently fund about 150 projects in 48 states and three territories.

Under outreach rules the projects must be directed locally, the money must be spent locally, and the patients served must be local people. A consortium of three or more local organizations need to coordinate the services provided. Thus our grants help local community groups work together to build self sufficiency and economic viability while improving health care.

One of the key criteria by which we evaluate the Outreach Grant applications is the ability of the applicant to maintain the health care services funded by the grant after the federal support is completed. Results to date indicate that more than 70 percent of our grantees have been able to continue their projects after the federal grant has ended, often through third party payments, local tax support, community contributions, or a combination of these and other strategies.

We also provide grants for rural health research centers. These Centers are exploring many important issues: how market driven reform is affecting rural areas; barriers to the formation of rural networks and rural-based managed care organizations; policy options for increasing the number of health professionals in rural areas; and how to provide rural people with access to mental health services.

Our office administers the Rural Telemedicine Grant Program, which is designed to create the information base necessary for a systematic evaluation of rural Telemedicine. We currently fund 12 projects in 11 states, all of which also are facilitating the development of rural health networks. In addition, the office also funds an additional 18 Telehealth/Telemedicine projects under its Outreach Grant Program. Most projects also involve distance education. In addition, the Office also has just completed the first comprehensive survey of rural Telemedicine. A report describing the survey findings will be available by early October. Later this month, we will be entering into a cooperative agreement with the Telemedicine Research Center in Portland, Oregon, to create an ongoing system for evaluating Telemedicine. Development of the system will be coordinated with other federal agencies sponsoring Telemedicine demonstrations, including the Health Care Financing Administration.

Finally, my Deputy Director chairs the Joint Working Group on Telemedicine, an interagency committee under the Vice President. Federal agency representatives meet twice a month to coordinate various Telemedicine programs of the Executive Branch to ensure the best use of Federal dollars. The working group will be providing an update to Congress in January which describes all of its activities to date, including development of a joint evaluation strategy for Federal Telemedicine program.
The report will also include findings from current Federal projects and a discussion of strategies for overcoming the barriers to the cost-effective use of Telemedicine, such as cross-state licensure barriers and reimbursement. A group sponsored information base on federally funded Telemedicine projects will be available on the World Wide Web in late Fall.

The Office helps to shape Departmental programs and policies on

rural health care by reviewing regulations and legislative proposals that affect rural health care providers and rural populations. For example, we review Medicaid waiver applications from the states and provide HCFA with comments on the potential effects of state plans for bringing Medicaid managed care to rural areas.

- The Office also staffs the Secretary's National Advisory Committee on Rural Health. Over the past six years the Committee has produced a wide array of recommendations on rural health care financing issues and ways to improve access to health care in rural communities. Some of the recommendations have been of interest to Congressional Committees involved with rural health care issues.

- We help the 50 States each fund Rural Health Offices much like our own and work with them to develop joint programs such as a 44 state project to facilitate and coordinate the recruitment and retention of physicians, using an 800 toll free number and the existing staffs of the participating states.

  State office efforts have led to the placement of over 1,000 physicians in rural practices in recent years. All state offices serve as information clearinghouses for their state, coordinate state based rural health activities, and help local communities find financing for their activities.

I haven't discussed the various block grant programs out of HRSA, SAMSHA, and CDC because its difficult to disaggregate the various rural programs given the wide array of state programs.

It should be noted that the reimbursement programs and the grant programs compliment each other. The reimbursement programs create a general eligibility for groups of institutions and populations, and the grant programs provide resources to specific high need areas or populations.

Mr. Chairman, there are other rural health problems that are pervasive, such as emergency medical systems shortages, mental health shortages and occupational health problems. There are also other federal programs I have not had time to describe and thousands of state local and private efforts that help. These however are most of the federal programs that are most important to rural areas. Thank you for allowing us to introduce them to you and the committee.

STATEMENT OF KATHLEEN A. BUTO, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION

Ms. BUTO. Good morning. I am Kathy Buto. I am the associate administrator for Policy. I am very pleased to be here today to discuss rural health care, particularly in the Medicare Programs, which are targeted at improving access to health care services for Medicare beneficiaries living in rural areas.

Although 83 percent of the United States is rural, only 26 percent of the Medicare population, or about 8.8 million individuals, live in rural areas. Rural areas are different from urban areas in a number of ways that affect the supply and demand for health services. For example, rural areas have higher unemployment, lower average incomes, lower average health status, and a higher proportion of residents who are uninsured.

Medical care providers in rural communities face unique challenges. Hospitals located in rural communities are, on average, smaller, have lower occupancy rates, are more dependent on long-term care units, and are financially more fragile. Between 1987 and 1994, 249 rural hospitals closed. Rural communities have difficulty attracting and retaining physicians because of a lack of complete medical facilities, professional isolation, limited support services, insufficient continuing medical education, and excessive workloads and time demands.

Both Congress and HCFA have used the Medicare Program as an instrument for helping to address these issues. Since Medicare is the dominant payer in rural areas, it plays a major role in shaping the rural health care delivery system. In 1993, 23.4 percent of Medicare payments, or about $30.3 billion, went to rural areas.

The Medicare Program has a significant interest in assuring the ability of beneficiaries to obtain needed services, regardless of their geographic setting or location. We have worked with Congress and States to develop and administer a number of programs which target providers in rural settings in order to support the local health care delivery systems. However, in working to stabilize and support the rural delivery systems, Medicare cannot act alone. As Jeff said, we believe it is necessary for the other payers, provider groups, and affected parties to actively support the rural delivery systems and work to implement innovative service delivery programs.

Certain elements of our broader payment policies for hospitals and physicians are designed to provide additional financial support for rural areas. Second, there are special classifications for certain types of rural providers which qualify for preferred payment. Third, HCFA oversees several demonstration projects designed to improve health care delivery in rural areas. I will briefly describe examples in each of these categories.

The first category includes smaller pieces of Medicare's broad payment system for hospitals and physicians, the PPS, or prospective payment system, and the physician fee schedule, respectively. The pieces provide preferable support for rural areas, such as equalizing the base payment amount for rural and small urban hospitals in fiscal year 1995. Our proposals to raise reimbursement for evaluation and management services under the physician fee schedule which also will benefit rural areas.

In the second category, Medicare has preferential payment policies for sole community hospitals and specialty hospitals known as rural referral centers. It also provides additional flexibility for rural hospitals through the Rural Primary Care Hospital Program, a program which originated in this Committee, and the swing bed program that supports outpatient services in rural areas through the federally qualified health clinics and through rural health clinic designations. Medicare provides bonus payments to physicians who work in medically underserved areas, most of which are rural.

One area in which rural providers do not receive preferential payment, as was mentioned in the earlier panel, is in the area of managed care. Managed care payments are based on the same formula, a formula stipulated in the statute, whether the organization serves beneficiaries in urban or rural areas. It has been suggested that one reason managed care organizations do not contract in rural areas is because of low payment rates.

The President suggested changes to those rates in his latest balanced budget proposal in an attempt to address this problem, and I should point out that these changes are very similar to those contained in the conference agreement.

However, even without these changes, we are making progress. For example, HCFA recently approved a Medicare risk HMO contract that is expected to increase access and reduce costs for beneficiaries in rural Arizona. Premier Health Care is a consortium of rural provider-sponsored networks serving eight Arizona counties. Premier Health Care, which began enrolling Medicare beneficiaries in July, greatly expands the health plan options available to Medicare beneficiaries in that service area.

In the third category, HCFA oversees several grant and demonstration programs that specifically target improving access to services in rural areas and encouraging development of rural networks. The demonstration projects include the MMAF, Montana Medicare Assistance Facility Program, which is similar to the RPCH, Rural Primary Care Hospital Program, an upcoming demonstration on telemedicine services, and the upcoming Medicare Choices demonstration that will have 4 plans out of 25 that will be predominantly in rural areas. Grant projects have included the RHTG, Rural Health Transition Grant Programs, telemedicine, infrastructure grants, and the State Rural Health Care Network Reform Initiative.

HCFA has devoted considerable resources in supporting existing health care providers in rural communities and assisting rural communities to reconfigure their delivery systems to better match their needs through the programs that I have already described. The following are our four primary conclusions.

Recent evidence suggests that although payment changes for rural hospitals have resulted in better financial performance on the part of rural hospitals, the biggest problem affecting those hospitals is their declining utilization levels. Inpatient hospital utilization has been declining for both urban and rural hospitals, but the decline has been especially dramatic at rural hospitals. With Medicare payments on a per case basis, some rural hospitals simply cannot generate the volume of services necessary to remain viable.

Second, while the RHTG Program was designed to help hospitals respond to changing markets by diversification of services, physician recruiting and other methods and evaluation of the programs suggests that the grants did not have a major impact on the overall long-term financial stability of the participating hospitals.

Third, on a positive note, programs that take a more aggressive approach and assist hospitals to transition to alternative facilities appear to be more promising. Evaluations of the MMAF, Montana Medical Assistance Facility Demonstration and the Essential Access Community Hospital/Primary Care Hospital Program, or the EACH/RPCH program, suggest that these programs have had some positive results.

For instance, the presence of the inpatient medical assistance facility unit appears to boost the image and utilization of associated ambulatory and long-term care services provided by those hospitals. The EACH/RPCH Program appears to have been a significant catalyst in development of rural provider networks.

Finally, we need further research on the effectiveness of specific programs directed to increasing access to care. Ensuring access remains a primary goal of HCFA and we continue to study it and support programs that ensure appropriate access to health care services for Medicare beneficiaries.

I would like to summarize and comment quickly, and I will do this very quickly. The President has sent his balanced budget plan to Congress and it includes many Medicare provisions, many of which I have already touched on, to strengthen incentives for health care providers to locate and provide needed services in rural areas.

The conference agreement included a number of these provisions or provisions that were very similar in targeting rural providers. I just want to point out that the REACH, Rural Emergency Access Care Hospitals and CACH, Critical Access Care Hospital provisions that were mentioned earlier, we believe, would be more than included in the President's broader initiative to expand the EACH/RPCH program. Those kinds of institutions would be included, and many others up to 15 beds.

So, we think that there is a lot that we have in common. There are a number of provisions where we have concerns, and those are in our testimony submitted for the record, so I will stop there.

[The prepared statement follows:]

STATEMENT OF KATHLEEN A. BUTO
ASSOCIATE ADMINISTRATOR FOR POLICY
HEALTH CARE FINANCING ADMINISTRATION

Introduction

I am pleased to be here today to discuss rural health care, particularly the Medicare programs which are targeted at improving access to health services for Medicare beneficiaries living in rural areas.

Rural areas make up 83 percent of the United States, but contain only 23 percent of the general population and 26 percent of the Medicare beneficiary population (approximately 8.8 million individuals). Although rural and urban distinctions are less clear today than they were in the past, rural areas are different from urban areas in a number of ways that affect the supply and demand for health services. The unemployment rate in rural areas is higher; rural areas are poorer on average, and people living in poor rural areas have lower health status.

Rural Americans are more likely to be uninsured because of the different employment opportunities (many jobs in rural areas do not provide health insurance). Medicare is the dominant payor in rural areas, and thus plays a major role in shaping the rural health care delivery system. In 1993, 23.4 percent of Medicare payments ($30.3 billion) went to rural areas.

The Medicare program has been concerned with the ability of beneficiaries to obtain needed services, regardless of their geographic setting or location. We have worked with the Congress and States to develop and administer a number of programs which target providers in rural settings in order to support the local health care delivery systems.

Hospitals located in rural communities are, on average, smaller, have lower occupancy rates, are more dependent on long-term care units, and are financially more fragile. Between 1987 and 1994, 249 rural hospitals closed. Rural communities have difficulty attracting and retaining physicians because of a lack of complete medical facilities, professional isolation, limited support services, insufficient continuing medical education, and excessive work loads and time demands. In an effort to alleviate these problems, Medicare has operated specific programs to aid rural providers financially.

Medicare has a very significant role in supporting the health delivery systems operating in the country. Its primary focus is the provision of needed health services to the Medicare beneficiary population. However, in working to stabilize and support the rural delivery systems, Medicare cannot act alone. It is necessary for the other payers, provider groups, and affected parties to actively support the rural delivery systems and work to implement innovative service delivery programs.

Medicare Payment Policies Sensitive to Rural Concerns

In addition to specific programs and payment policies designed specifically for rural providers, I would first like to describe the changes in payment policy for hospitals and physicians that have served to increase payment rates to rural providers. In part, these policies were developed specifically to address the financial problems of rural providers and to encourage providers (particularly physicians) to locate in rural areas.

HCFA currently pays hospitals on the basis of a prospective payment system (PPS). Hospitals are paid a predetermined amount per discharge, adjusted for the severity of a patient's condition (casemix), the labor costs in the local area, and other factors such as whether the hospital operates a teaching program. In the early years of PPS, separate base payments were established for large urban, other urban, and rural areas. However, the differential in the base payments between "other urban" and "rural areas" has been phased out as of last year. This was accomplished through higher annual updates for rural hospitals, dramatically increasing payments to rural hospitals relative to urban hospitals.

HCFA currently pays physicians on the basis of a fee schedule with limits on the amounts physicians can charge beneficiaries. The physician fee schedule is based on a system of relative values for all procedures, a geographic adjustment factor, and a dollar conversion factor. The design of the fee schedule geographic adjustment factor resulted in increased payments to rural areas relative to urban areas.

Of significant importance to rural physicians, HCFA has moved to equalize payments between rural and urban localities, although Medicare payments still vary among geographic payment areas. There are presently 210 payment localities under the Medicare physician fee schedule, including 22 statewide localities. HCFA has proposed a further consolidation to 89 payment localities in a July 2 Proposed Rule, including an increase in the number of statewide localities to 34. This change would further equalize payments between urban and rural areas.

In a May 3, 1996 Proposed Rule, HCFA also proposed relative value changes in accordance with a 5-year review of all physician work relative value units. A significant element of the proposed changes would increase relative values for medical visits and consultations. This change should benefit rural areas since those services represent a larger share of rural physician practices than do procedural services.

Medicare programs affecting rural areas

Over the past twenty five years, HCFA has developed and administered a number of legislatively authorized programs to provide extra financial support to rural providers to enable them to continue to provide needed services to rural communities.

The rural hospital is often the centerpiece of rural communities' health care delivery systems. A

number of special programs have been implemented to provide enhanced payment for rural hospitals.

The Sole Community Hospital (SCH) program was implemented under the 1972 amendments to the Social Security Act. Under this program, special payment protections are provided to hospitals that are the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. Hospitals can qualify to be an SCH if they meet certain criteria including: distance from other hospitals, travel time to other hospitals, and their market share in the local area. Payments for SCHs are based on 1982 or 1987 costs (updated to the present), if either of these base amounts are more favorable than the Federal rate that determines payments for all other PPS hospitals. Currently, 744 rural hospitals are designated as SCHs.

The Federal legislation which authorized the implementation of the prospective payment system for Medicare hospital payments in 1983 also implemented the Rural Referral Center (RRC) classification. The RRC classification identifies certain hospitals in rural areas that provide care at a volume and in a manner that is more comparable to urban hospitals than to their rural counterparts. These hospitals serve as "referral" sites for rural physicians and community hospitals that may lack the resources or expertise to handle cases outside the norm. Currently, there are 131 rural hospitals designated as RRCs.

Originally, payment for RRCs was higher than for other rural hospitals because RRCs were paid the standardized amount for "other urban" areas instead of "rural" areas. RRCs were also able to qualify for disproportionate share (DSH) payments and reclassify for a higher wage index under easier criteria than other rural hospitals. Since FY 1995, however, when the standardized amounts for rural and other urban areas were equalized, the financial benefit of being a RRC has decreased relative to other rural hospitals.

Congress also authorized the Swing Bed Program in the early 1980's to help meet rural residents' needs for long-term care services and to provide additional flexibility in service and bed use options to small rural hospitals. Under this program, certain hospitals can use the same bed for both acute care and skilled nursing care, depending on the needs of the patient. Currently, there are 1,356 hospitals participating, almost half of the eligible rural hospitals.

OBRA 1987 implemented the Rural Healthcare Transition Grant (RHTG) program to assist small, rural hospitals and their communities by strengthening the capability of these facilities to provide high quality care to Medicare beneficiaries. Grants can be used to plan and implement projects that modify the extent and types of services that hospitals provide in response to changing market pressures. Hospitals can apply to receive a grant of up to $50,000 per year for up to three years.

A wide variety of activities have been funded under this program. Common projects include physician recruitment, development of clinical and social services (e.g., prevention programs, rural health clinics, home health and hospice, and transportation), and development of management services (e.g., strategic planning and board and staff training.) Since the beginning of the RHTG

program, HCFA has awarded approximately $135 million to over 1,000 small rural hospitals. Approximately 40% of all eligible hospitals have received grant funding under this program.

In addition to these programs which assist individual hospitals, HCFA also supports programs that address broader rural health delivery system issues (e.g., assist hospitals to transition to alternative facilities, encourage development of provider linkages, etc.).

The Montana Medical Assistance Facility (MAF) demonstration provides funding for creating limited service hospitals in Montana. The design, development, and implementation of MAFs and rural health networks is directed by the Montana Hospital Research and Education Foundation (MHREF), which also receives grant funds for its activities. In 1990, the Congress authorized Medicare to pay for MAF services provided to Medicare beneficiaries on the basis of reasonable cost. In 1993, the Congress extended this authorization until July 1, 1997. Funding began in 1988, and the first MAF opened in 1991.

The medical assistance facility model is a limited service hospital that: (1) provides an option for rural communities that can no longer support a full service hospital; (2) preserves local access to primary care and emergency services; (3) more appropriately matches services to community needs and provider capabilities; and (4) expands the use of midlevel practitioners to augment/substitute for physician services. There are nine MAFs currently operating in Montana, and other rural hospitals continue to express interest in the program.

The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is similar to the MAF program except that it provides the permanent authority to reimburse limited service hospitals in certain states. This Subcommittee developed the original EACH/RPCH legislation. Subsequently, the EACH/RPCH program was authorized in 1990 in section 1820 of the Social Security Act. It is designed to assist States and rural communities in maintaining access to health care services through the creation of limited service hospitals, the establishment of rural health networks, and the development of State rural health plans. The EACH/RPCH program consists of: (1) a permanent operating program that establishes the RPCH as a new type of health care facility and the EACH as a new hospital category, and (2) grants to provide funds to States and hospitals to assist in the development and implementation of the program. The statute limits the program to seven states. HCFA chose the following states based on a competitive grant process: California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia. Grant funding began in 1991, with the first RPCHs certified in 1993.

RPCHs must meet several criteria covering size, scope of services, length of stay, and other criteria encouraging the formation of networks. They are reimbursed on a reasonable cost basis. EACHs are larger hospitals that agree to accept referrals from RPCHs and provide other types of support, and they are reimbursed like sole community hospitals. Currently, there are about 20 EACHs and close to 30 RPCHs participating in the program.

Based on the significant success of the MAF and EACH/RPCH programs, the Administration has developed a proposal to incorporate the best aspects of each program into a new program that is eligible to all states.

The Rural Health Clinic (RHC) benefit was enacted into law on December 13, 1977 in the Rural Health Clinic Services Act of 1977 (Public Law 95-210). Medicare and Medicaid coverage was extended to primary and emergency care services furnished in RHCs located in rural, medically underserved communities by physicians and nonphysician medical practitioners (including physician assistants, nurse practitioners, and certified nurse midwives). Medicare provides coverage of medical services by non-physician practitioners even when a supervising physician is not permanently on-site. The scope of services provided in RHCs is comparable to those provided in physicians' offices.

Between 1987 and 1993, Congress passed several amendments to the Act which were intended to overcome obstacles to participation in the program. Consequently, HCFA began paying for RHC services in 1992, with a rapid expansion of RHCs in the early 1990s. HCFA estimates that there were about 2,530 RHCs in October 1995, almost double the 1,350 RHCs that existed in January 1994.

At the time the RHC law was passed, independent clinics and a small number of rural hospitals which operated RHCs already existed. HCFA accommodated the provider-based clinics in order to achieve administrative simplicity and authorized a different payment method for provider-based RHC services than the one used to pay independent RHCs.

HCFA will be proposing to modify the payment method for provider-based RHCs in order to achieve uniformity and equitable treatment of both freestanding and provider-based RHCs. We have been consulting with the industry, and have considered their views. Under this proposal, HCFA would level the playing field for all RHCs by applying the same payment limitations and productivity screens that currently apply to services furnished in independent RHCs to provider-based RHCs. HCFA believes that the impact of this proposed change on providers is negligible, and that a new, uniform payment methodology for all RHCs will eliminate concerns of many independent RHCs who currently claim to be at a competitive disadvantage compared to provider-based RHCs.

In response to the accelerated growth in the number of RHCs and questions about their success in increasing access to care, HCFA has contracted for an independent evaluation of the RHC program. This study will be completed next year. This evaluation will focus on a number of issues, including: reasons for the rapid growth of RHCs; the impact of the program on rural populations; and the cost of the program to the Federal and State governments.

The Federally Qualified Health Center (FQHC) benefit was enacted by section 4161(g) of OBRA 1990 to provide Medicare coverage and payment for outpatient services furnished by clinics approved under the Public Health Service (PHS) Act. There are four categories of FQHCs:

Migrant, Community, and Homeless Health Centers, (including entities which the PHS determines meet the requirements for receiving such a grant, but which do not receive any grant funds), and outpatient programs operated by tribes, tribal organizations under the Indian Self-Determination Act, or by urban Indian organizations receiving funds under Title V of the Indian Health Care Improvement Act. This last category was added in OBRA 1993.

Payment for FQHC services is through an all-inclusive rate based on costs. Recognizing the primary mission of these health centers is to serve low income groups, there is no Medicare Part B deductible applicable for FQHC services, and the FQHC is authorized to bill the beneficiary for coinsurance based on a sliding fee scale.

Congress responded to the physician shortage problem in medically underserved areas by providing for a physician incentive payment in rural areas beginning in 1989; the legislation delayed urban bonuses for two years. A 5% bonus payment was provided to physicians treating Medicare patients in geographic health professional shortage areas (HPSAs) designated by the Public Health Service. Subsequent legislation extended the incentive to all HPSA shortage categories and raised the bonus to 10%.

Advances in telecommunications technology have also made possible the provision of increased consultation by specialists to rural areas. HCFA uses the term "telemedicine" to refer to two-way, interactive video systems over which medical consultations take place. Typically, a telemedicine encounter involves a primary care physician and a patient located at a remote, rural site, and a medical specialist or consultant located at a medical center. HCFA has funded five telemedicine demonstration projects to develop the infrastructure for telemedicine networks and perform preliminary evaluations of the effects of telemedicine services. The next phase of the project, which we plan to begin next month, will be to assess the feasibility, accessibility, costs, and quality of providing services through the use of telemedicine. A provision in the Health Insurance Portability and Accountability Act directs HCFA to complete its ongoing study and submit a report with a proposal for reimbursement for telemedicine services, although we recommend waiting for the results of the upcoming study before payment policies are set.

As this Subcommittee is well aware, many more Medicare beneficiaries are choosing to enroll in Medicare managed care plans. However, to date, enrollment in rural areas has been limited in part because many managed care plans do not operate in rural areas. However, some plans that have commercial operations in rural areas have opted not to contract with Medicare, reportedly because Medicare's payment rates in rural areas tend to be lower than payments in urban areas.

Under Medicare statute, risk contracting Medicare managed care plans are to be paid 95% of the Adjusted Annual Per Capita Cost (AAPCC), defined as the estimated amount that Medicare would have paid in a geographic area if plan enrollees had received service in Medicare's fee-for-service program. The AAPCC computations start with a projection of national per capita costs, which is then adjusted for each county's historical costs relative to these national average per capita costs. The AAPCC rate book has county-specific rates for each of the over 3,000 counties

nationwide. The payment for an individual beneficiary enrolled in a risk plan is the county rate (95% of the county's AAPCC) multiplied by a demographic factor representing the beneficiary's age, sex, institutional status, and Medicaid status.

The lower AAPCC rates in rural areas are the result of the statutory requirement that AAPCC rates reflect Medicare's cost experience in the local fee-for-service program; in general, fee-for-service costs in urban areas are higher than those in rural areas. Long-standing concerns about relatively low payments in rural areas, as well as concerns with wide variation in rates in urban areas, led both the Administration and the Congress to propose changes to the payment methodology. The Administration's FY 1997 budget proposes paying plans the greater of three amounts: (1) a blend of an area-specific and national rates; (2) a minimum payment amount ($325 per month in 1997); or (3) a minimum percent increase. This methodology would immediately increase rates in many rural areas, and it would also reduce the extreme variation in payment rates in general. We note that the Administration's proposal is similar in some respects to the payment methodology included in the 1995 budget reconciliation conference agreement.

HCFA recently approved a Medicare risk-HMO contract that is expected to increase access and reduce costs for beneficiaries in rural Arizona. Premier Health Care is a consortium of rural provider-sponsored networks serving eight Arizona counties. Premier Health Care, which began enrolling Medicare beneficiaries in July, greatly expands the health plan options available to Medicare beneficiaries in the service area.

The Medicare Choices Demonstration is designed to give Medicare beneficiaries expanded choices among different types of managed care plans and to test new ways to pay for Medicare managed care. The project is aimed at areas with low Medicare managed care penetration and was targeted to nine metropolitan areas and rural areas. Of the 25 plans selected as final candidates for participating in the demonstration, we are working with four which would serve predominately rural areas. These rural sites will provide an opportunity to test payment and delivery systems. while also providing a manage care option to beneficiaries in those areas for the duration of the demonstration.

Results of Research

HCFA has devoted considerable resources to supporting existing health care providers in rural communities and assisting rural communities to reconfigure their health care delivery systems to better match their needs through the programs I've just described.

Recent evidence suggests that the payment changes we have instituted for rural hospitals -- both the changes in PPS as well as special payment policies for distinct groups of rural hospitals -- has resulted in better financial performance on the part of rural hospitals. However, it appears that the biggest problem affecting rural hospitals is their declining utilization levels. Inpatient hospital utilization has been declining for both urban and rural hospitals, although the decline has been especially dramatic at rural hospitals. With Medicare payment on a per case basis, some rural

hospitals simply cannot generate the volume of services necessary to remain viable.

The Rural Health Transition Grant Program was designed to help hospitals respond to changing markets by diversification of services, physician recruiting, and other methods. However, an evaluation of the program suggests that the grants did not have a major impact on the overall long-term financial stability of the participating hospitals.

Programs that take a more aggressive approach and assist hospitals to transition to alternative facilities, however, appear to be more promising. Evaluations of the Montana MAF demonstration and the EACH/RPCH program suggest that these programs have had some positive results. For instance, the presence of the inpatient MAF unit appeared to boost the image and utilization of associated ambulatory and long-term care services provided by the hospital. The EACH/RPCH program appears to have been a significant catalyst in the development of rural provider networks.

There is a lack of evidence, however, regarding the effectiveness of specific programs on increasing access to care for Medicare beneficiaries. However, access to needed care remains a primary goal of HCFA, and we continue to study it and support programs that ensure appropriate access to all health care services for Medicare beneficiaries.

Future Directions

The problems facing rural providers are complex, and we have not yet developed the perfect solution to ensure their financial solvency. Because of this, proposals to address rural health care needs are necessarily piecemeal. Each proposal is designed to address a specific discrete problem.

Last May, the President sent his Balanced Budget Plan to Congress. The plan included Medicare provisions to strengthen incentives for health care providers to locate and provide needed services in rural areas. For example, the Plan included a provision to combine the best elements of the Montana MAF and Rural Primary Care Hospital programs and expand them to all states. It also included improvements to the SCH payment policy; permanently grandfathered RRCs and provided for special geographic reclassification standards; and reinstated the Medicare-dependent, small rural hospital program. The Plan also included provisions to reduce the variation in capitated payments to Medicare risk plans, and to increase the AAPCC in rural areas. Finally, the Plan included a grant program to promote the use of telemedicine.

The Conference Agreement also included a number of provisions targeted to rural providers. It created two new categories of rural providers -- Rural Emergency Access Care Hospitals (REACHs) and Critical Access Hospitals. While the Critical Access Hospital provision is identical in many respects to our PRCH program, the REACH provision creates a limited-service rural hospital with more restrictions than the RPCH program. In addition, the Conference Agreement would have increased the bonus payment for primary care services furnished in rural health professional shortage areas to 20% (from the current 10%).

The Rural Health Improvement Act of 1996 (H.R. 3753), introduced by Representative Gunderson and others, includes a number of provisions which are analogous to the Administration's proposals. Foremost among these are reducing variation in capitated payments to Medicare risk contractors and increasing the AAPCC rates in rural areas, and expanding the RPCH program to all states and modifying its requirements in ways that are similar to the President's expansion plan. It also contains other provisions that were in the Conference Agreement, including the establishment of rural emergency access care hospitals, and increasing bonus payments for primary care services to 20 percent. Finally, the Rural Health Improvement Act includes a provision for a new grant programs to encourage the development of community health networks in chronically underserved areas.

HCFA has specific concerns about some of the provisions that are in both the Conference Agreement and the Rural Health Improvement Act. In particular, we are concerned about provisions that are poorly targeted or that have no demonstrated benefit in increasing access to care. For example, we are concerned that the RRC provision is not sufficiently targeted to focus on RRCs with low wages compared to other hospitals in its area. Expanding direct payment to non-physician professionals would create yet another situation for billing Medicare on a fee-for-service basis. There is no compelling evidence for providing additional opportunities for non-physicians to bill Medicare directly, especially outside rural shortage areas. While all the plans allow for greater flexibility for certain rural hospitals, we believe that, given our successful experience with the RPCH program, the Administration's provision to expand that program would meet the needs of rural facilities better than the creation of two new limited hospital providers. In fact, the REACH program is redundant to the RPCH, i.e, the RPCH offers everything that the REACH does and more.

In spite of our concerns, we note the similarities in a number of provisions. We are looking forward to working with Congress to ensure that all Medicare beneficiaries have access to medical services.

Mrs. JOHNSON [presiding]. Thank you. I thank the panel for their excellent testimony. It was very helpful to get such a thorough review of the rural policies that are already on the statutes and how they are working.

Ms. Buto, I have been a strong supporter of REACHs and RPCHs, the REACH and RPCH grant programs to help rural hospitals restructure themselves to be economically viable and to provide the quality of services and the type of services that rural communities need. I am increasingly concluding that the difference between those grants is artificial, that to have one grant completely focus on emergency services is not useful for us, that really, we need much more flexibility. Those moneys need to be packaged and you need a lot more flexibility to respond to the specific needs of specific rural communities.

Would you agree with that? Is that something we should be moving toward, merging those grants?

Ms. BUTO. The RPCHs are the urgent care model or the critical care model that was mentioned earlier. Yes. We think that it is better to have a broader provision, as you state, that would allow the EACH/RPCH program to expand, or the RPCH program to expand up to 15-bed hospitals, give them entire flexibility to use those beds either for long-term care or acute care, or emergency services, so the whole spectrum.

Mrs. JOHNSON. Why is it that the RPCH program looks at creating the possibility for hospitals to offer inpatient services with a patient stay of up to 72 hours? What is the rationale behind the 72 hours?

Ms. BUTO. That is in the statute. I think the rationale at the time was to really look at what seemed to be a reasonable time to stabilize individuals. As you probably know, our proposal would expand that up to 96 hours, so that we have more time. We are looking at demonstrations up to 96 hours in Montana, and we think that is a reasonable timeframe.

Mrs. JOHNSON. This is probably the biggest problem that we face. I have a hospital, not categorized as rural, because nothing in Connecticut is categorized as rural because of our payment need, but they are certainly facing exactly the problems. I looked into REACHs and RPCHs for them, and certainly, the more narrowly focused of those programs is useless.

But, we do need more flexibility in thinking through whether it should be 23-hour stabilization or 72-hour stabilization or 96-hour stabilization, and as medical practice changes, those issues are going to change. So, I hope that in the next session, we will actually rethink these two grants and the amount of flexibility that communities need in restructuring.

Ms. BUTO. As you were talking, I wondered if you were referring to the EACH part, which is the hospital that gets referrals from the primary care hospitals, and for those, we agree. We think it is more appropriate to let those smaller hospitals have more flexibility as to where they refer patients, and they can then enter into payment arrangements to pay those referral hospitals. Then we do not need this other designation.

Mrs. JOHNSON. Mr. Human, I appreciate your review very much and was interested in your comments about the community health

centers, because they are not common in the rural areas and yet they really can provide a sense there, the missing piece in our health care system until we are able to do more.

In my urban areas, seniors who cannot afford copayments can go there and on a sliding scale fee they can get things that Medicare does not offer. For uninsured families, you do not have to be on welfare to go to a community health center, and, in fact, they are usually about as nice as the doctors' offices nearby. They are furnished the same way, the same examining rooms, and so on, and the service corps program has been very helpful in the community health center movement.

I would ask you, though, to begin looking between now and the next session as to why so many who have been involved in establishing community health centers now are doing it without Federal money because they find our money too restrictive. So, I now have a chain of community health centers, only the first of which was established with Federal money, and every one of the others thereafter, have not been established with Federal money—some State money, some private sector investment, because they feel they can respond to people's needs more effectively.

So I think what we need to look at, in the modern era, is the program structured as it was about 15 or 20 years ago still the program we need now? The concept is certainly important and the American people do not understand that it is there, that it is incredibly high quality, and that it serves everybody. But, I think we need to look at which pieces need to be redeveloped, refined, and expanded, versus trying to do quite so many things and particularly controlling so much of it from Washington.

Mr. HUMAN. We would be very interested in your comments on what specific changes ought to be made, to look at what we can do from an administrative standpoint. I can tell you that it still is a very popular program in terms of the communities that would like to be added to the list that are receiving the Federal funds to establish community health centers. There has been no lack of new applications, but we would still be very interested in those comments.

I would add one thing, just if I could go back to the last discussion for just a second. Another reason for the flexibility that you and Kathy Buto were talking about with respect to these limited service hospitals is that more than 20 States are currently involved in either licensure changes or contemplated licensure changes to redefine what a limited service hospital is. So, it is particularly important at the Federal level that we allow the flexibility for this incubation that is occurring nationwide, until we understand what works best.

Mrs. JOHNSON. I would hope that as you look toward the legislation for the next session, that you would think about the fact that a lot of these definitions do not fit anymore. My hospitals do not fit in the right definitions anymore. They did when they applied for that category. They fought hard to get out from rural, because at first, we treated rural hospitals so badly and costs are so high in Connecticut. Now, the resources they need are actually in the rural programs and they are not in the rural programs.

We have to think more effectively about how we do localize this and eliminate a lot of the definitions and regulations from Washington. I do not want to be too simplistic in the language, but it is not working and we have the money in the system.

Of course, communities want community health centers, but we are not able to staff them and to make them work the way they should, and yet other people in the movement are creating those models. I cannot believe I am the only one who has told you that the community health system also is spinning off all kinds of other community health centers out from under Federal law. I will try to work on that, but I would hope that I am not the only voice that is telling you that. I cannot believe I am.

I just do want to close my questioning by saying that a number of times, Ms. Buto, you mentioned that things were in the conference Committee. I am not sure that that is clear enough. The fact is that there is an enormous overlap between how the Republicans see health care problems in America and how the Democrats see them, also how the President and how the Congress see them, and it is really terribly unfortunate that given that broad commonality, we could not have been at the same table these last 2 years, because now we are 2 years behind on the Medicare problem. We will have 3 instead of 5 years to deal with a system that is extraordinarily important to each one of us in our lives of every age, and its impending bankruptcy.

So, I am glad you did note that in the conference agreement, which is the agreement between the legislation passed by the Senate and the House and primarily now Republican thinking because of the political problem that developed around Medicare premiums that prevented the legislative process from looking at where do we agree and how do we move forward.

There is so much we could have done, because there are so many areas of agreement. It is really a tragedy for the seniors of America that, in fact, we have not been able to move forward on so many things we should have moved forward on because of the politics of premiums.

We had others from your office, from HCFA, in here talking to us about how they wanted to develop Medicare Plus plans. We call them Medicare Plus plans. I do not care what you call them. They are Medicare managed care options. They were saying to us, but we need the law more flexible. We need the law to change. We should have done some of that changing. The world's pace of change is so much more rapid than ours and we have to find a way to keep up so that the health care resources can constantly be reconfigured to meet the access and quality demands of the American people of all ages.

Mr. Ensign, I understand, is in a meeting, and my colleague has no further questions, but I thank you for the quality of your testimony. It was very interesting. It will be very useful to us. Thank you.

Ms. BUTO. Thank you.

Mrs. JOHNSON. If the next panel will come to the front, and if Mary Wakefield will begin. Mr. Christensen will chair for a few minutes while I take a phone call. Thank you.

Mr. CHRISTENSEN [presiding]. Dr. Wakefield, will you go ahead and give us your testimony?

STATEMENT OF MARY K. WAKEFIELD, DIRECTOR, CENTER FOR HEALTH POLICY, GEORGE MASON UNIVERSITY

Ms. WAKEFIELD. Good morning. I am Mary Wakefield, the director of the Center for Health Policy at George Mason University in Fairfax, Virginia.

With 65 million Americans residing in rural areas and massive changes underway in health care, the Subcommittee's interest in this population is important, timely, and much appreciated.

Before briefly commenting on specific Federal programs, I would like to describe rural America. About one-quarter of the U.S. population lives in rural areas which are diverse and often as different from each other as they are from cities. The most remote rural counties are classified as frontier, with fewer than seven people per square mile. Other rural counties are adjacent to urban areas and offer easier access to many goods and services. Frontier Wyoming, then, poses very different challenges to providing health care than does rural Texas.

Rural areas have higher concentrations of elderly than urban areas and higher rates of disability and chronic illness which necessitate greater need for health care services. Yet rural residents have less access to health care services and rural Medicare beneficiaries have lower utilization rates for hospitals and physicians than their urban counterparts.

Poverty rates are higher among the rural population, yet fewer of them qualify for Medicaid. However, interestingly enough, rural health care providers are more dependent on Medicaid and Medicare for their income than are urban providers.

Meanwhile, health care has been a vortex of change in recent years. This may seem most noticeable in metropolitan areas, but rural America also has been caught up with changes that I believe are no less stressful or complex. Over the past 15 years, inequitable payment rates for services, difficulty in finding health care providers, and the closure of hospitals have characterized rural America's struggle with issues that are at least as difficult to wrestle with as the problems now facing our urban areas.

With these concerns in mind, I want to comment on a few Federal programs, beginning with Medicare, and specifically the methods used to determine the capitated payment rate, that is, the AAPCC rate. The AAPCC is based on historical cost data and I am concerned that rural areas will receive only the amount needed to maintain minimal services that they may have but not enough to expand access or enhance services or to give rural elderly a choice of health plans, which is one driving force behind Medicare managed care.

To date, managed care plans are not available in the counties with the lowest payment rates and managed care plans that do serve rural counties are concentrated in higher paying counties and located near urban areas.

However, as important as it may be to provide incentives so that rural elderly can access managed care plans if they choose, it is equally essential to ensure that those plans provide quality care

and services that match the needs of the rural elderly. It is not safe to assume that managed care plans based in urban areas and designed to serve a younger, healthier population and to save costs will automatically be appropriate for an elderly, rural population with higher rates of chronic illness and disability.

Particularly over the next few years, while enrollments in managed care plans are increasing, I think it will be critical to assess quality of health services offered by these plans, and I think that health outcomes will need to be evaluated every step of the way to determine what is happening with the health of our rural elderly population.

The chronically short supply of health professionals in many areas of rural America is another major issue, and this problem is bound to worsen, as over 20 percent of rural doctors are older than 65 and existing managed care plans are competing for primary care providers.

Medicare's bonus payment to physicians in health professional shortage areas is helpful in this regard, and I support the provision in H.R. 3753 to provide the bonus for primary care services rather than strictly for physician services. This is particularly important because many rural communities have access only to non-physician providers as their source of health care services. And, in fact, taking it a step further, instead of viewing shortage areas based on the number of certain health care providers, it may make more sense to change the question and ask, what is the availability of primary care services?

Currently, the health professional shortage area designation is based on the ratio of primary care physicians, dentists, and/or mental health providers to population. This means that an area with no primary care providers is considered the same as an area with two physicians' assistants and a nurse practitioner. Yet, I would assert that access to care in those two situations is markedly different.

I also want to express my support for the National Health Service Corps and to encourage you to consider exempting from tax the service-linked scholarships and loan repayment funds that the Corps provides.

Additionally, I want to draw your attention to a training program that I believe has been successful in helping to meet the manpower needs of rural areas, and that is the Interdisciplinary Training Program, which provides grants for team training of at least three disciplines in rural health care settings. The multiskill training the students receive, coupled with practical experience in rural health facilities, prepares them exceptionally well for rural practice.

While these and other training programs are important to rural areas, they are dwarfed when compared to graduate medical education funding of almost $6.7 billion per year. I urge you to consider targeting medicare graduate medical education to train more primary care physicians and fewer specialists. Borrowing ideas proven successful in other rural training programs, I would recommend using GME funds for training in nonhospital settings and for supporting rural clinical experiences.

Medicare education funds for nonphysician providers need to be directed, as well. Seventy percent of these funds go to hospital-

based diploma nursing programs that produce less than 10 percent of the nation's registered nurses. Instead, these Medicare funds should support training of nurse practitioners, certified nurse midwives, certified nurse anesthetists, and other clinical nurse specialists with advanced practice skills.

In rural areas, these advance practice nurses are especially important. For example, certified registered nurse anesthetists are the sole anesthesia providers in 85 percent of rural hospitals.

Bottom line, Medicare education and training funds need to catch up to the needs of today's Medicare beneficiaries and support the new array of facilities and providers who are meeting those needs. Where health services are provided and how health care is practiced today are very different from 30 years ago when Medicare was first established.

One of the ways in which health care practice is different is also one of the most striking innovations in health care now entering the marketplace and that is telemedicine, and I applaud the Federal Office of Rural Health Policy for their efforts to coordinate the work of Federal agencies that are engaged in telemedicine initiatives.

Finally, I think that research should be a priority to monitor quality of care and health outcomes during the transition to new health care systems and methods of service delivery. During these times of tectonic shifts in health care, I believe we must continue to support both the programs and research that most efficiently and effectively meet the unique needs of rural populations.

Thank you for the opportunity to testify.

[The prepared statement follows:]

STATEMENT OF
MARY K. WAKEFIELD, Ph.D., R.N., DIRECTOR
THE CENTER FOR HEALTH POLICY
GEORGE MASON UNIVERSITY

Mr. Chairman, members of the Subcommittee,

I'm Mary Wakefield, Ph.D., R.N., Director of the Center for Health Policy at George Mason University.

With 65 million Americans residing in rural areas and massive changes underway in health care, your interest in this population is important, timely, and appreciated. I want to thank you for holding this hearing and for inviting me to testify.

I will address two major issues in my testimony this morning: first, access to health care in rural areas, and how some of our federal programs address this. Second, and just as important, is the issue of quality.

Briefly describing rural America: about one quarter of the U.S. population lives in rural areas, which are diverse and often as different from each other as they are from cities. The most remote rural counties are classified as "frontier," with fewer than seven people per square mile; other rural counties are adjacent to urban areas and offer easier access to many goods and services. Frontier Wyoming, then, poses very different challenges to providing health care than does rural Texas, Georgia, the Mississippi Delta, or rural Washington.

Rural areas have higher concentrations of elderly than urban areas, and higher rates of disability and chronic illness, which necessitate greater need for health care services. Yet rural residents have less access to health care services, and rural Medicare beneficiaries have lower utilization rates for hospitals and physicians than their urban counterparts. And since rural Americans are more likely to be self-employed, it is thought that rural residents probably have less comprehensive coverage when they are insured.

Poverty rates are higher among the rural population, yet fewer of them qualify for Medicaid. However, interestingly enough, rural health care providers are more dependent on Medicaid and Medicare for their income than are urban providers.

Today, business and government leaders talk quite a lot about "downsizing." Well, rural areas have been "downsizing" since the start of this century. The decline of farming, mining, timber, and other rural industries has caused massive shifts in the rural economy. Rural citizens have had to make do with less.

Meanwhile, health care has been a vortex of change in recent years. This may seem most noticeable in metropolitan areas, but rural America also has been caught up with changes that I believe are no less stressful or complex. Over the past 15 years, inequitable payment rates for services, difficulty in finding health care providers, and the closure of hundreds of rural hospitals have characterized rural America's struggle with issues that are as difficult to wrestle with as the problems now facing urban areas.

If access to care is on a continuum, the preferable end to be on is to live close to health services. Unfortunately, many residents of rural communities are on the other end of the spectrum. Their situation in terms of access to care isn't quite as severe as that facing astronaut Shannon Lucid (currently orbiting Earth in the Mir space station) if she needed health care, but it's still a problem.

Rural communities across the country confront the challenge of access to care daily. The net effect of loss of providers and/or facilities has been a sudden lack of health care, and the odds of finding a replacement provider or creating an alternative facility are very often slim. The impact on the economy is also severe, as rural hospitals often are the largest or second largest employer in the community.

For many years, access to care has been a paramount issue in rural health. The two parts to this puzzle are health professionals and facilities. No matter what payment mechanism or program is under discussion, the question is, how to maintain access to quality health

services and adequate numbers of health professionals?

In these bottom-line-oriented times, small populations that characterize rural areas present a great challenge to ensuring access. Other challenges include poverty, geography, lack of transportation, and cultural barriers. But I believe that the greatest challenge is the chronic under-supply of health professionals, whether it's to staff a solo practice or a tertiary care center.

With these access and supply problems in mind, I'll turn to Medicare.

About 15 years ago, as members of this subcommittee well know, Congress mandated radical changes in Medicare by replacing the cost based hospital payment system with a new Prospective Payment System (PPS). To set the PPS payment rates, HCFA essentially took a snapshot of costs in urban and rural areas, and used these as a baseline.

Then as now, rural areas had mostly primary care physicians and small community hospitals. There were very few large health systems and medical specialists. With providers in short supply, naturally, Medicare utilization rates in rural areas were lower than in urban areas. Simply put, Medicare doesn't get billed for services that beneficiaries can't get.

The same situation existed regarding medical specialists. With very few specialists in rural areas, rural Medicare beneficiaries did not have access to specialists' services, which tend to cost more than primary care.

When the original PPS snapshot was taken, rural Medicare beneficiaries' lack of access especially to more expensive specialists, was reflected as lower costs. While data show that providing health services in many rural areas costs somewhat less than in many urban areas, the snapshot magnified the actual difference in costs.

In the early years of PPS, Congress and HCFA pursued the policy that payment should be based on what had been observed, with a cost of services index based on the same year. An urban-rural differential was observed, then locked into place. And all subsequent adjustments to the rates were made on an artificially low base, which reflected rural areas' under-supply of health providers and low numbers of specialists. While the policy may have seemed logical and even fair, it greatly contributed to maintaining the rural status quo: too few health care professionals and poorly-financed institutions.

The urban-rural differential was a one-two punch: low rural payments resulted in great financial strain, and created a disincentive for providers to practice in rural areas. Lacking adequate funds, rural hospitals could neither enhance services nor recruit staff. This hardship contributed to the closure of hundreds of rural hospitals, which aggravated the shortage of health professionals across rural communities.

Instead of the low payments to rural areas based on their under-utilization, what was needed to address the chronic provider shortages and ensure access to high quality care were higher payments.

There's a lesson in this. Using historical utilization and cost data to set payment rates for rural areas, without appreciating the context in which they occur, perpetuates rural communities' problems: a lack of health professionals and access to health services. This was the unintentional result of the original urban-rural differential.

Eventually, Congress addressed the urban rural differential in PPS payment rates -- but did so in the context of slowing the growth of Medicare spending, and also while protecting large urban hospitals and teaching hospitals. Essentially, rural providers got a slightly bigger slice of a shrinking pie, but not before hundreds of rural hospitals had closed, leaving many communities without any access to health services.

Now Congress is again looking at re-shaping Medicare to avoid a financial crisis in the program. And again, basing AAPCC payments on some measures of historical costs. The problem with this approach is apparent from the situation I've just described.

If the capitated payment is based on historical cost data, I'm concerned that rural areas will receive only the amount needed to maintain the minimal services they have – not enough to expand access or enhance services, or to give rural elderly a choice of health plans, which is one driving force behind Medicare managed care.

In 1995, AAPCC rates ranged by county from a low of $177/month in Fall River, SD, to $678/month in the Bronx. That yawning gap widened even further this year, with rates varying from under $230/month to over $750/month.

It appears that enrollment in managed care plans tracks the payment rates and that lower payments translate into lack of service. Rural counties receive payments about 30% below the national average, and most rural areas do not have managed care plans. To date, managed care plans are not available in the counties with the lowest payment rates. And managed care plans that do serve rural counties are concentrated in higher-paying counties and near urban areas.

If Congress intends to facilitate a choice of health plans for rural Medicare beneficiaries and preserve the health services currently available, then the capitated payment rates must be high enough to allow this.

However, as important as it may be to provide incentives so that rural elderly can access managed care plans if they choose to, and as important as it is to support the development of these and other networks of care, it is equally essential to ensure that those plans provide quality care and services that match the needs of the rural elderly. It is not safe to assume that managed care plans based in urban areas and designed to serve a younger, healthier population and to save costs will be appropriate for an elderly rural population with higher rates of chronic illness and disability. Particularly over the next few years, while enrollments in managed care plans are increasing dramatically, it will be critical to assess quality of health services offered by managed care plans. I believe that health outcomes need to be evaluated every step of the way to determine what is happening with the health of this population.

Now I'll turn briefly to several federal programs that benefit rural areas. Some of these fall under Medicare, others are part of the Public Health Service Act. The common theme in both types of programs is that they seek to address the fundamental problem of access to health services in rural areas.

Congress initiated several programs for rural health facilities, including Sole Community Hospitals and Rural Referral Centers, the Essential Access Community Hospital (EACH) and Rural Primary Care Hospital (RPCH, called "peach") program, and the Medical Assistance Facility (MAF) demonstration. All of these programs were designed to help rural hospitals maintain or enhance access to health services in rural areas.

Other programs focus on health care professionals. The chronically short supply of health professionals is a major issue in rural health care. This problem is bound to worsen, as over 20% of rural doctors are older than 65, and existing managed care plans are competing for primary care providers. Medicare's 10% bonus payment to physicians in health professional shortage areas is helpful in this regard. However, given the tremendous need, I support the provisions in H.R. 3753 to increase the bonus to 20%, continue it for three years after the HPSA designation lapses, and to provide the bonus for primary care services rather than physician services. This is particularly important because many communities have access only to non-physician providers as their source of health care services.

In fact, taking it a step further, instead of viewing shortage areas based on the number of

certain health care providers, it may make more sense to change the question to what is the availability of primary care services. Currently, the health professional shortage area designation is based on the ratio of primary care physicians, dentists , and/or mental health providers to the population. With regard to primary medical care, it doesn't distinguish among areas that fall below a specific physician-to-population ratio. This means an area with no primary care providers is considered the same as an area with two physician's assistants, a certified nurse midwife, and a nurse practitioner. Yet I would assert that access to care in these two situations is markedly different.

I'd like to point out some Public Health Service programs that address provider shortages, and may serve as models for needed changes to Medicare's graduate medical education funding.

The first among these is the oldest, the National Health Service Corps, which was authorized in 1970 and started in 1972. The NHSC was designed to reduce the shortage of primary care doctors in designated rural and urban "health professional shortage areas." The Corps has been a great success -- today, over 2,225 Corps professionals, including nurse practitioners, certified nurse midwives, psychologists, and physician assistants as well as physicians and other professionals, provide health care to four million people who otherwise would not have it. A 1994 survey of NHSC scholarship recipients found that, 6 years after the end of their service obligation, over half the respondents were still in rural practice. (NHSC Funding in FY96 is $115.7 million)

Yet the need for NHSC providers remains, since most rural areas of the nation still don't have enough health professionals. There are 2,677 designated primary care health professional shortage areas (as of 3/31/96). 68% are in rural areas, with a population estimated at 22 million.

One strategy to enhance this solid program is worth this Committee's consideration. The NHSC currently offers scholarships and loan repayment in return for service. The scholarships and loans are taxable. The tax on the NHSC loan repayment funds is paid by the Corps, but the Corps does not have the authority to pay taxes on scholarships. I do not recommend that the program be burdened with assuming the tax liability for scholarships. On the contrary, I question the logic of using scarce appropriated funds to pay taxes on the loan repayment funds. Nor do I think it's advisable to make NHSC students pay taxes on their scholarships, which is a substantial burden and a disincentive to serve in this federal program. Instead, I recommend that Congress exempt from tax the service-linked scholarships and loan repayment funds that the Corps provides.

I also want to draw your attention to two other training programs that I believe have been very successful in meeting the manpower needs of rural areas: one is the Interdisciplinary Training program, which provides grants for team training of at least three disciplines in rural health care settings. The multi-skill training students receive, coupled with practical experience in rural health facilities, prepares them exceptionally well for rural practice. Since the program's inception in 1988, 31 programs in 21 states have received support. 1,067 students participated in the program between 1990-1994. 54% of the graduates are working in rural areas. Through the inclusion of psychologists and other mental health providers, the program also has expanded access to mental health services in rural areas. (FY96 funding = $3.7 mil.)

The other program that's expanding access to health services in rural areas is the Rural Health Outreach grant program, administered by the Office of Rural Health Policy. This program offers grants to consortia of rural health facilities to expand or enhance health and mental health services. Currently funded as a demonstration, rural outreach grants ensure collaboration and foster networks by requiring at least three health providers to participate. Perhaps the program's best feature is that it allows local communities to tailor projects to meet their unique needs – it does not specify which providers should participate or what services should be offered, leaving maximum flexibility to local communities to determine their needs and how to meet them. (FY96 funding = $27.9 mil.)

I believe this kind of flexibility is key to the success of rural health programs, because rural communities are so diverse and have vastly different needs. A "one size fits all" approach is much less likely to succeed. Taking this into account, I agree with the recommendation of the Rural Policy Research Institute that Congress should support community-based primary care clinics that do not meet all of the requirements of Community Health Centers. I strongly believe that rural facilities that cannot offer the panoply of services mandated by the CHC statute should nevertheless be able to compete for funding to provide primary health services.

The programs I've just mentioned all help rural communities, and I urge your continued support of them. However, among them all, FY96 funding for rural training and health services totals just $90 million. (About half of NHSC funds are for urban sites.)

Compare that to Medicare Graduate Medical Education funding of almost $6.7 billion/year.

Congress has a right and a responsibility to direct Medicare GME funds to achieve policy goals. If these include alleviating the shortage of health professionals in rural areas, I urge you to consider targeting Medicare graduate medical education to train more primary care physicians and fewer specialists. Borrowing ideas proven successful in other rural training programs, I recommend using GME funds for rural traineeships, rural rotations, training in non-hospital settings, and rural clinical experiences to give students an honest assessment of the benefits and drawbacks of rural practice. The Area Health Education Centers (AHEC) program within PHS is a good model for this. AHECs train students through rotations in clinics and other non-hospital settings.

Medicare education funds for non-physician providers need to be redirected as well. By the year 2000, Medicare payments to hospitals for nursing education are projected to reach $420 million. But 70% of these funds go to hospital-based diploma programs that produce less than 10% of the nation's RNs. Medicare funds should support training of nurse practitioners, certified nurse-midwives, certified nurse anesthetists, and other clinical nurse specialists with advanced practice skills. In rural areas, these advanced practice nurses are especially important: many of the nation's 35,000 nurse practitioners provide primary care services in rural areas, and CRNAs are the sole anesthesia providers in 85% of rural hospitals.

Medicare education and training funds need to catch up to the needs of today's Medicare beneficiaries and support the new array of facilities and providers who are meeting those needs. Where health services are provided and how health care is practiced today are very different from 30 years ago, when Medicare was first established.

One of the ways in which health care practice is different is also one of the most striking innovations in health care now entering the marketplace, and that is telemedicine. The Telemedicine Grant Program is currently funded by the Office of Rural Health Policy as a demonstration. In addition to that program, several other federal agencies are involved in telemedicine demonstrations to enhance or expand services and training, foster provider networks, and reduce professional isolation.

Recently, the Federal Interagency Joint Working Group on Telemedicine (JWGT) was formed to ensure that the activities are coordinated. This group includes representatives from the Departments of Defense, Veterans Affairs, Agriculture, HCFA, and other agencies. Among other activities, the JWGT is developing a World Wide Web-accessible inventory of federally-sponsored telemedicine projects. While bringing the expertise of multiple agencies to the table, this effort, facilitated by the Office of Rural Health Policy, is a solid example of coordinating federal programs that directly and indirectly impact rural health care through telemedicine initiatives, and making that information available to the public.

Interactive telecommunications technology is currently being used in rural areas by a range

of providers, including dietitians, psychologists, nurses and physicians for home visits, nutrition counseling, psychiatric evaluation and case management, long-distance education, and surgery consultation, just to name some of the federally-sponsored projects. While technology is not a substitute for a basic complement of health care providers, it can be a very useful addition, particularly to enhance services or access specialists. Still, telemedicine is still very new, and we know very little about its costs, effects, and effectiveness. These areas as well as questions of licensure and reimbursement are ripe for evaluation.

This brings me to my final topic. Throughout my testimony, I have called for continuing research of pressing rural health questions, and evaluation of the impact of any major change in the ways health care is delivered to rural populations. I want to reiterate that concern and note how beneficial some of the research and evaluations have been to date.

The Agency for Health Care Policy and Research (AHCPR) has funded health services research on many topics important to rural areas, such as long-term care for the rural elderly, access to rural cardiac rehabilitation programs, rural emergency medical services and trauma outcomes, the effects of rural obstetric care provider shortages, and access to primary care services for persons with disabilities in rural areas.

The rural research centers supported by the Office of Rural Health Policy have produced important front-line research on rural health, which Jeff Human addressed in his testimony. Before this office began funding rural health research, there was no federal support for rural research, and no organized network to disseminate information to rural communities.

The Office of Rural Mental Health Research (of the Substance Abuse and Mental Health Services Administration) funds important research on mental health in rural areas, including development of new and innovative models to provide these services. This information simply was not available in the early 1980's when the farm crisis struck, and Congress was calling for proven interventions to help economically and psychologically stressed farm families.

HCFA's Office of Research and Demonstrations has funded important research on the Medicare programs for rural providers that I mentioned earlier. No other entity has access to the wealth and timeliness of data that HCFA has. I recommend that HCFA continue to support research on high priority rural health issues. For example, given the higher concentration of elderly, poor, and chronically ill in rural areas, research on the quality of rehabilitation and other non-acute care services and its availability to rural populations would be appropriate.

Technology and telemedicine present a host of research questions. What are the unique needs of rural communities and the rural elderly for health and mental health services, and how can the federal government work in partnership with states and local communities to meet those needs? And of course, research could well be directed at determining an appropriate mix of primary care providers for meeting the health needs of rural communities as well as how to increase the supply of health professionals and overcome barriers to access.

I believe the most pressing research task ahead is to monitor quality of care and health outcomes during the transition to new health care systems and methods of service delivery. How can quality health services and positive health outcomes be assured under managed care, with a reduced growth rate in Medicare spending, likely coupled with reduced growth in Medicaid spending?

Research on these and other questions may provide vital information on which to base future health policy decisions. During these times of tectonic shifts in health care, I believe we must continue to support both programs and research targeted to rural populations and their unique needs.

That concludes my testimony this morning. Again, thank you for the opportunity to testify. I'd be happy to answer any questions you may have.

Mr. CHRISTENSEN. Dr. Myers.

STATEMENT OF WAYNE MYERS, M.D., DIRECTOR, CENTER FOR RURAL HEALTH, UNIVERSITY OF KENTUCKY, ON BEHALF OF THE RURAL POLICY RESEARCH INSTITUTE

Dr. MYERS. Thank you. The Rural Policy Research Institute, or RUPRI, appreciates this opportunity to testify again before the Subcommittee.

I represent RUPRI's rural health care delivery expert panel, which is one of several panels assembled to provide research and advisory support on rural implications of Congressional policy alternatives. Three of these panels have presented testimony on various occasions regarding Medicare policy alternatives, including analyses of two legislative packages this season, the Balanced Budget Act of 1995 and the Rural Health Improvement Act of 1996. We appreciate the opportunity to have our written testimony included in the record.

I am a pediatrician. I live in Lost Creek, Kentucky, which is a suburb of Hazard in Central Appalachia. I have spent most of the past 25 years living out in the sticks, working for medical schools, trying to help with rural medical work force issues in Alaska, Montana, Idaho, Washington, and Kentucky.

My written testimony covers quite a range of rural health work force issues. The fundamental work force problem is that there are not enough appropriately trained primary care personnel to recruit, and I do emphasize appropriately trained. The best way I can use my brief time before you this morning is to ask you to consider overhauling in a very fundamental way the Medicare Graduate Medical Education Program.

The GME Program overshadows all other health work force programs. It puts out twice as many dollars each year as the 46 States with medical schools put into their State medical schools. It puts out more money in a year than the Bureau of Health Professions has had to expend in grants in its entire agency lifespan and it out spends the National Health Service Corps each year by 60 to 1. The Medicare Graduate Medical Education Program has never served rural needs, and now it has become a barrier to efforts to develop a more appropriate national medical work force.

The current program has two fundamental flaws as a work force program. First, it is not connected to work force needs in any way. Second, it is dominated by large hospital needs to the exclusion of all other considerations.

As you probably know, this program helps pay teaching hospital salaries and support costs of apprentice or resident physicians. It also pays these teaching hospitals a supplement on the assumption that if they have resident physicians, they must waste a lot of tests and supplies and they must provide a lot more indigent care than other hospitals.

If a hospital can get a residency training program accredited and can recruit some residents from U.S. or overseas, it gets the money. Nobody asks whether anybody needs the graduates of the program, of the residency program, either in terms of specialty or location. So to repeat, the Nation's largest health care work force program has no linkage to the Nation's health care work force needs.

Second, the program serves the needs of large hospitals to the exclusion of all other considerations. The program was designed around the assumption that everything a doctor needs to know can be learned in the beds of the tertiary care hospital. That is an assumption that was suspect in 1965 when the Act was passed and it is completely worn out now.

Rural areas have always needed primary care doctors who could talk to people as equals and members of their own communities, who could use judgment as well as advanced diagnostic technologies, who could help people avoid plugging up their coronary arteries instead of just rescuing them after the damage is done, and who could recognize spouse abuse, substance abuse, alcohol abuse, and so forth and not feel terribly anxious without subspecialists at their elbow.

Training for this kind of practice is simply not to be found in tertiary care hospitals. The hardest thing a physician or a nurse practitioner has to do is to pick out the one patient in 1,000 that is in serious trouble, and by definition, that is something you cannot learn in a teaching hospital. Everybody that is in there has already been identified as being in big trouble and the only way you are criticized is if you overlook the possibility that the person may have not one terrible problem but two, three, or four.

The second point I would make in terms of appropriate training is that the thing that keeps primary care people in the business is the satisfaction of watching people they have taken care of get older, the kid that had meningitis as a baby do reasonably well in the kindergarten plan. These are things of which people in tertiary care hospitals have no inkling, at least as trainees.

So now the stakes are rising. The kind of people that we have needed for decades in rural areas are now becoming precisely the people we need to run managed care, and you cannot learn that in a teaching hospital, tertiary care hospital, or tertiary care dominated training system.

It is easy to overcomplicate this issue. The first thing we have to do is divide the issue into manageable sizes; to divide the GME issue, and money, between hospital needs and training needs. We need to develop reasonable numbers for each but not commingle them anymore. We need to pay the hospital subsidy money to hospitals and the teaching money to training programs. We need to restrict or stop training in glutted specialties. We need to put the training programs and money where people need personnel, not where hospitals need personnel.

The $7 to $8 billion of graduate medical education money in the Medicare budget may be the most highly leveraged money in that budget. How we spend it now largely decides who will be available to provide care for the next 30 years. Sorting out all the claims about complex institutional missions and so forth will take wisdom and courage, but it really needs to be done.

I thank you very much, Madam Chairman, and I will be glad to entertain questions.

[The prepared statement follows:]

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RURAL HEALTH WORKFORCE POLICY ISSUES

Hearing Testimony Presented to

The Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

September 12, 1996

by
Dr. Wayne Myers
Representing the Rural Policy Research Institute (RUPRI)
Rural Health Care Delivery Expert Panel

Thank you, Mr. Chairman. The Rural Policy Research Institute (RUPRI) appreciates this opportunity to again testify before this Subcommittee regarding the rural implications of Medicare reform decisions currently confronting Congress. I am here as a representative of the RUPRI Rural Health Care Delivery Expert Panel, one of several national RUPRI Panels assembled to provide ongoing research and decision support regarding the rural implications of Congressional policy alternatives. As you may know, the RUPRI Health Care Delivery Panel, Rural Medicare Task Force, and Regional Modeling Work Group have all presented Hearing testimony on various occasions regarding the broad range of these Medicare reimbursement and program policy issues. Many of these issues will undoubtedly be discussed before this Hearing today, including specific proposals considered as part of prior legislation this session.

As you may know, RUPRI has already submitted detailed analyses of two legislative packages this Session, the Balanced Budget Act of 1995 and the Rural Health Improvement Act of 1996. These analyses detail our assessments of the rural impacts of specific components within these legislative proposals. Today, I will focus primarily upon the rural health workforce policy issues which must be addressed if significant systemic change is to occur in rural health care delivery and reimbursement.

Overview

In the testimony which follows, detailed attention is given to several critical rural health workforce issues, which are summarized below:

- The Medicare Graduate Medical Education (GME) Program is the nation's largest health workforce program. This program requires thorough overhaul. This process should be guided by national workforce needs, with priority given to primary care for underserved areas.

- Health workforce programs of the Health Resources and Services Administration, including the National Health Service Corps, are important resources for rural America.

- Leveling of the urban/rural Medicare reimbursement differential is essential to system reform.

- Increased federal/state coordination will be essential for development of managed Medicare and managed Medicaid in rural areas, and can contribute to development of more appropriate incentives for health professions education institutions.

- International medical graduate placement programs continue to be helpful in rural America. These physicians should be graduates of primary care residency training programs.

- Educational loan repayment programs are effective tools for improving workforce distribution.

Background

Current restructuring of America's health care system includes a variety of efforts to avoid the continuing costs of surplus capacity and unnecessary intensity. These problems of excess capacity are relatively concentrated in metropolitan areas. As we reported to this committee in our testimony of July 20, 1995, Medicare payments in 1992 were 23 percent higher per urban than per rural enrollee. For part B payments, the urban/rural differential rose to 52%. We suggest the guiding principle that fragile, relatively low cost rural health care not be further damaged in efforts to control problems which are largely metropolitan.

Primary care personnel are the backbone of rural health care. Unlike their more specialized colleagues, they are able to provide a broad range of care, and need relatively small populations to make a living. Thus the size of the national primary care workforce pool is of critical importance to rural communities. About thirty percent of American physicians practice primary care compared to a widely recommended national goal of fifty percent.

Inability to attract and retain adequate numbers of locally credible primary care personnel is the limiting factor for the performance, and even the viability, of many rural care systems. For example, the lack of local medical staff capable of retaining adequate numbers of insured patients is probably the largest single factor in the closure of rural hospitals.

Although about 23 percent of Americans live in non-metropolitan counties, only about eleven percent of physicians practice in such counties. A national "doctor shortage" was largely resolved by the mid-1970's, but an increasing abundance of physicians has been confined to the referral specialties. There have been increases in numbers of family doctors, internists and pediatricians in counties adjacent to metropolitan areas, and in large, rural hub communities. We have not seen a general reduction of rural shortages.

Several prominent health workforce distribution programs were initiated in the early 1970's. These included the National Health Service Corps and the Area Health Education Center (AHEC) program. By 1980 states such as North Carolina which participated in both programs were reporting gain in rural primary care workforce. As the national perception of a doctor shortage receded, support for the Corps decreased while the AHEC Program continued. By 1990, the important contribution of the corps had become clear as perennially underserved areas struggled to cope with the lack of Corps personnel. The Corps has been revitalized. The AHEC Program has been shown to enrich the practice environment in selected communities, and to give health professions students a better understanding of rural practice, but has not been shown to influence student career decisions.

Most Americans live within thirty minutes drive of a primary care physician, but many of these physicians are seriously overloaded. The criterion for primary care shortage area designation of one physician for every 3600 people is about one third the national average supply, and one half the number of primary care physicians used by highly developed managed care systems.

The Practice Acts of many states tie nurse-practitioners and physician assistants very closely to physicians. For this and other reasons, the distribution of these professionals generally parallels that of physicians.

The Nation's medical schools and teaching hospitals have given us the world's most sophisticated medical research and intensive care capacity, but most have not been very responsive to rural and primary care needs. The faculty members of these institutions determine who will be admitted, what they will be taught, and where. Following World War II, NIH funding to medical schools grew explosively and came to play a major role in shaping medical school faculties and their values. In 1965, Medicare accepted a share of the costs of supporting clinical faculty members through Graduate Medical Education (GME) payments. This permitted academic medical centers to expand their full time subspecialty faculties. NIH plus GME payments to academic medical centers now total about fifteen billion dollars per year, of fifty times the annual grant resources of the USPHS Bureau of Health Professions. After several years of recognition of the need to expand primary care training, less than three percent of medical school faculty members are family practice physicians. While the success of Bureau programs in rationalizing the production of our health professions educational

system has been limited, these programs have served an important role in nurturing our academic primary care seed stock through decades of adverse institutional incentives.

Medicare is particularly important to rural care systems. In 1992, the enrollment rate for Medicare Part A in nonmetropolitan counties was 16.2 percent, compared to 12.7 percent of metro residents. Two other factors amplify the importance of Medicare. Older rural people are more likely to choose to remain in their home communities for care than younger people. A greater proportion of rural than urban people live in poverty. Few of the indigent are able to leave their home community for care. Thus Medicare enrollees make up an even larger proportion of the "paying patients" of rural providers than high rural enrollment rates would suggest.

Current Market Driven Trends

The recent growth of managed care, concentrated in urban and urban fringe areas, is influencing the rural health workforce. Recruitment and retention of primary care personnel are becoming more difficult. The services of medical referral specialists are becoming more accessible.

Starting salaries being offered newly trained family doctors and nurse practitioners have increased about fifty percent in the past two years. These raises are being driven by urban managed care systems. Many rural providers are unable to compete in this rising wage market. On the other hand, some areas are seeing managed care systems open new rural primary care facilities and bring in new practitioners to serve and existing or anticipated market..

In contract to the primary care picture, referral care is becoming more accessible to rural people. All over the country, insurance plans are using a variety of mechanisms to reduce the use of subspecialty services. Examples include requirements for preauthorization of various procedures, practice protocol based constraints, requirements for second opinions, etc. In fully developed managed care systems, these controls are much stronger. These measures are creating an actual or anticipated surplus of referral specialty care capacity in most metropolitan areas.

Even in cities with little highly managed care, hospitals and specialists are moving to recruit patients and consolidate feeder relationships in rural areas. Development of itinerant clinics and telemedical consultative ties are common examples.

In metropolitan areas dominated by stringently managed care, referral specialists are being squeezed out of practice. These displaced specialists are relocating to new locations including rural communities. The relocation of subspecialists from metropolitan California to rural Idaho communities is reportedly impressive.

Medical trainees appear to be changing career decisions in the face of the new market conditions. Choices of residency training are hard to interpret since many residents move from general internal medicine and general pediatrics ("primary care") directly into subspecialty fellowships. For many years about a third of medical school graduates said they intended to practice primary care and ultimately did so. By 1990, less than fifteen percent of medical school graduates expressed intent to practice primary care. By 1995, this figure had climbed back to thirty percent. Perhaps more meaningful, however, is the report that this July a substantial proportion of candidates for fellowship positions in internal medicine for subspecialty training failed to accept their appointments.

A national shortage of nurses has been resolved, primarily by rapid expansion of our capacity to provide two year Associates' Degrees in Nursing. This capacity, largely in community colleges, is geographically well dispersed. On the other hand, current changes in health care are increasing the demand for nurses with advance training and preparation for independent decision making and advanced practice. The increase in market demand for nurse practitioners has been mentioned. Similar increases in demand for Certified Nurse Midwives are evident. It has been demonstrated that the quality of nursing care in hospitals relates quite closely to the degree of involvement of nurses in managing nursing services. For these and other reasons, the number of programs for Masters' level preparation of nurse practitioners, midwives, advanced practice nurses and managers is growing rapidly and outstripping the supply of faculty. Although the absolute number of nurses in rural areas

is generally adequate, the number with advanced preparation is not.

Current Policy Context

Managed care, at least in its developmental stages, increases the primary care workload for two reasons; more care stays at the primary care level as less is referred, and the management of care and oversight of referrals takes time. Demand for primary care practitioners is being driven up because the capacity of managed care systems is largely dictated by its primary care capacity. Enrollees cannot be denied care because "the practice is full". Introduction of managed care into governmental entitlement programs converts individual difficulty finding a provider into a system difficulty. As managed care systems mature and patients become accustomed to new patterns, the number of annual visits per patient may decline and the primary care load decrease to some extent.

There is concern in some rural areas, particularly in the southeastern U.S., that there are not enough primary care personnel to meet the demands of managed care, particularly if the introduction of managed Medicare from the federal sector is coincident, but not coordinated, with state introduction of Medicaid managed care. Experienced managed care systems typically expect a primary care physician to take care of about 1800 people. This is twice the physician density threshold (1:3600) for a primary care shortage area. As the proportion of elderly people in the managed care population increases, primary care physician demand increases. Thus, the availability of primary care personnel in rural areas is a serious issue for the introduction of managed care, particularly for Medicare beneficiaries.

Rural communities compete with urban areas for all kinds of health personnel as well as paying patients. Medicare reimbursement formulae with lower rates for rural areas disregard this market reality and put rural health delivery systems at an additional competitive disadvantage for health care workforce recruitment and retention as the urban/rural primary care wage differential widens.

Federal and state governments have not traditionally collaborated to any great extent on health workforce issues. Today there are stronger incentives for such collaboration than in the past. Federal concern regarding Medicare costs are reflected at the state level as Medicaid consumes more and more of state budgets. Health professions education and managed care implementation are two candidate areas for stronger state-federal collaboration.

It will be extremely difficult to reconfigure the health care without sufficient primary care personnel where they are needed. As the nation tries to increase the proportion of primary care personnel in the workforce, and improve geographic distribution, it should be noted that most of the health professions education infrastructure is state owned. National health professions education policy should be based on the citizenry's need for care. State government may be better positioned to modify incentives of state educational institutions to meet these needs.

As the states implement managed Medicaid, and federal Medicare moves toward managed care, these efforts should be coordinated, particularly in areas where key resources such as primary care capacity may have to be strengthened to carry the combined load. Contracts should include performance standards requiring provision of primary care in rural areas.

In moving toward managed care, federal and state governments share a common interest in making it possible for all primary care providers to practice at the level for which they are trained. Thus, the federal government, as a purchaser of health care services, has a legitimate interest in providing incentives for states to permit nurse practitioners, nurse midwives, and physician assistants to practice at full capacity.

Education Issues

The Medicare Graduate Medical Education Program requires thorough overhaul. It should be guided by national workforce needs, with priority given to primary care and underserved area demands.

This program is by far the largest and most influential federal health care workforce program. Federal GME policy is often seen as a large city hospital issue. This perception points up the need for a

comprehensive redesign of the program. Most physicians practice near where they were trained and do what they were trained to do. Current Graduate Medical Education programs and payments lack any linkage to national workforce needs. They are concentrated in areas of greatest physician geographic and specialty surplus and reflect hospital subsidy and service needs, rather than population-based workforce needs.

Rural areas, and the rest of the country, have a compelling interest in the expansion of the proportion of physicians and nurses trained in primary ambulatory as well as hospital care, and prepared to work with less dependence on subspecialists and high intensity diagnostic equipment than is the current norm. This change cannot be achieved within the current federal GME hospital subsidy framework.

Essential subsidies for hospital high intensity care should be separated from educational program support. Educational support funds should go to educational programs rather than to hospitals. Programs in referral specialties deemed to be oversupplied should not be eligible for funding. Distribution among the states should be in proportion to state population. Educational support funding (as opposed to hospital patient care subsidies) should be factored out of the determination of payments to managed care organizations based on the Adjusted Average Per Capita Cost (AAPCC). It is particularly important that any reorganization of the GME Program not lock into place the current geographic and specialty training maldistribution.

The nursing workforce is geographically well distributed, but under prepared. Priority should be given to preparation of the nursing workforce for more advanced practice. Rural areas would be particularly well served by increasing the number of programs which prepare rural, place committed nurses for more responsible roles, using modern telecommunication. Training for allied health professionals, who are in short supply, should be targeted in rural regional hub communities rather than metropolitan medical centers.

Access to Primary Care

The National Health Service Corps is an important workforce resource for underserved areas. Deductibility of Corps payments, particularly for repayments of educational loans, would be helpful. In general, targeted repayment of practitioners' educational loans seems an effective way to provide incentives for people to practice where they're needed. The effectiveness of these programs will be increased if they can be regarded as reliably available for sufficiently far in the future that trainees can plan their careers accordingly.

The Rural Health Research Centers supported by the Federal Office of Rural Health Policy have become important sources of policy-relevant information regarding rural workforce issues.

Community and Migrant Health Centers are important as organizational nuclei for practice in many underserved areas. Lack of funding for new starts has resulted in many well qualified underserved areas being unable to develop such Centers. These Centers will become even more important as managed care eliminates the possibility of the cost shifting which has supported the indigent care "safety net."

As previously noted, rural areas compete with metro areas for personnel. Low rural reimbursement rates are a self-perpetuating burden. Any measure which reduces the urban/rural payment differential will benefit rural health care workforce recruitment and retention. The ten percent Medicare bonus payment for rural primary care in underserved areas has been helpful. It makes sense to increase it to twenty percent. Considering that only about three percent of doctors and nurse practitioners qualify for such payments, this is not a costly adjustment. Medicare cost bases for the AAPCC vary more than three fold from rural to urban extreme. Institution of measures to reduce the variation in AAPCC rates, especially a minimum AAPCC floor, will facilitate development of rural managed care and reduce organizational incentives to restrict system development to areas with redundant capacity.

Performance standards for appropriate local access to care should be developed for both managed Medicare and managed Medicaid. Throughout the country, large urban care systems with surplus capacity are organizing managed care programs to assure themselves of continuing business. In a sense these are market management rather than care management organizations. At least in the

transition to managed care, they may be less interested in buying the best care at the lowest cost, than in covering the costs of sustaining their own hospitals and clinics, even if only marginal costs can be recovered. Eventually this arrangement will fail, as the fee for service indemnity base disappears into highly penetrant managed care. In the meantime, however, lots of low cost, high quality, locally appropriate rural facilities may be eliminated. Medicare managed care, as well as Medicaid plans developed under federal waivers or capitation, should require provision of appropriate services near patients' homes. Provisions requiring accessible services "within thirty miles or thirty minutes" seem reasonable. This approach may be preferable to "any willing provider" provisions or attempts to identify particular categories of providers as "essential."

Access to Referral Care

The evolving surplus of referral specialists should be an asset to rural communities as some relocate and other extend their services through itinerant clinics or telemedicine. The latter has real promise of making referral care more reliably available and convenient for rural people. Properly structured, it may increase the proportion of people staying in their home communities for care (although many of the large urban hospitals sponsoring development of telemedicine links may assess these probabilities differently). Telemedicine is unlikely, however, to help with the fundamental rural problem of too few primary care providers.

International Medicine Graduates

Every year several thousand physicians enter the US on "J-1" visas to secure training and augment teaching hospital workforces. The J-1 visa requires the holder to return to his/her country of origin for two years before seeking permanent entry. The Appalachian Regional Commission has for many years been able to request waivers of the compulsory departure requirement in exchange for a commitment to practice under certain stipulations in an area of need. Recently this source of physicians has been opened to non-Appalachian states through new programs.

The long term experience with this approach in Appalachia has been positive for the following reasons. Most "J-1" doctors have been through several highly competitive selection processes. Most are extremely able and well trained, often having been through more than one residency or fellowship training program. Without them, medical care in many of the poorer parts of Appalachia might have collapsed. Although most move on to urban areas after their obligations have been fulfilled, many other have put down permanent roots and become key people in local professional and community groups.

Negative points include the following: Relatively few international medical graduates come to the U.S. for primary care training. Most are referral specialists who are not entirely comfortable in primary care and revert to subspecialty practice as soon as possible. Some patients complain of communication difficulties which arise when rural American speech patterns intersect a variety of accents from overseas.

The J-1 visa waiver programs for practice in underserved areas should be continued until there is reason to believe that U.S. graduates are prepared to meet rural needs. Eligibility for participation should be limited to physician graduates of designated primary care residency programs.

Thank you, Mr. Chairman, and Members of this Subcommittee, for this opportunity to share these concerns. I would be glad to entertain questions.

Mrs. JOHNSON [presiding]. Thank you very much, Drs. Wakefield and Myers.

Let me turn first to Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Madam Chairwoman.

Dr. Wakefield, I want to thank you for your testimony. I grew up in a rural area, St. Paul, Nebraska, a small town that has a little hospital that faces this dilemma of whether or not we move it to a different type of facility because we are about 25 miles from a larger metropolitan city with full services there, so I am very interested in this whole issue of rural health care.

One of the things that came up during your testimony was the issue of providing improved health care to the States where the RPCH Program has been implemented. What evaluations have you done on the effectiveness of this program?

Ms. WAKEFIELD. Well, I have not personally done any kind of a structured evaluation but I have looked at some of the evaluations that have been done by the Health Care Financing Administration and have talked with HCFA's staff and there are a number of things that are said about the quality and the difference that that particular model makes.

The couple of comments that I would have to say about it are these. I do not think that the way it is structured currently is necessarily the model that will meet the needs of every rural area or of every small community hospital. It is something of a niche program and it works very effectively in some of the areas where it is currently located.

There have been hospital administrators who have looked at that program and have done feasibility assessments, and when they have done that, they have found that when they run the numbers, they do not necessarily come out better if they were part of that program in terms of the way it is currently structured.

So that is a mixed response, saying that in some cases, it would seem to work very well and in others, it may not be the best way to structure a delivery system. The point probably is, and the most important point is probably to look at the unique needs of different rural areas and try to come up with the configuration that best meets the needs of that rural community.

The situation that you described with the hospital 25 miles away from a larger, perhaps urban area are needs that are probably quite different from, obviously, whatever health care facilities might be available to a frontier community. So, I guess the best I could give you regarding RPCH is a little bit of a mixed review.

Mr. CHRISTENSEN. How would you change the RPCH Program so that it has more of a greater service rather than just a niche market?

Ms. WAKEFIELD. I think that looking at different models of care is really a good thing to do. For example, in the legislation that was introduced by the House Rural Health Coalition, they promote the notion of a slightly different structure, taking what I think are some of the strengths of the EACH/RPCH Program and of MAF from Montana and incorporating those in their legislation. That is a slightly different model but another alternative.

Mr. CHRISTENSEN. Also, concerning the National Health Service Corps Primary Care Doctor Scholarship Program, could you de-

scribe for us in greater detail why is this a barrier for attracting primary care doctors, the taxation service linked to the scholarships and the loans repayment program?

Ms. WAKEFIELD. Currently, the National Health Service Corps Program provides scholarships and loans both to physicians and to nonphysician providers, and depending on the load that a student carries while they are in school and their ability to pay for that schooling, it can make a difference, having to pay taxes on their scholarships.

So, while it may not be a high priority need for every single student who comes through a college or a university, it certainly would be true for a number of students, given the cost of tuition, and so forth. Paying for scholarships while students are in school and picking up the tax liability for that can make a difference.

In terms of the loan repayment program, that tax is paid for currently by the National Health Service Corps. So in a way, it is the Federal Government, i.e., the National Health Service Corps, paying the Federal liability on that loan repayment, which is paying the IRS back, paying another part of the Federal Government. So, the government's sort of circulating those moneys, taking away the opportunity to utilize the money to put into loan repayment specifically and instead taking those dollars and putting them into paying off a tax liability.

Mr. CHRISTENSEN. What has your research shown is the average tax paid for these scholarships from primary care doctors?

Dr. WAKEFIELD. I am sorry. I do not have the answer to that question but I would be happy to try and get it for you.

Mr. CHRISTENSEN. Thank you, Madam Chairwoman.

Mrs. JOHNSON. Thank you.

I appreciate the panel's testimony this morning. There are a number of questions that you raised. Dr. Myers, you made some very interesting comments about medical education that I think are very important. What is your opinion of funding consortia training groups?

Dr. MYERS. I think that that is very much a step in the right direction and it opens up some public deliberation about where programs are needed and in what specialties. Much depends on the mandated demography of the consortium, and to the——

Mrs. JOHNSON. Excuse me. Please say that again, a little closer to the microphone.

Dr. MYERS. A lot depends on the mandated makeup of the consortium. If it is constituted to be dominated by teaching hospitals and medical schools, I find that less sound than if it is dominated by someone, say, in the State public health or work force that is primarily driven by public needs rather than institutional needs.

Mrs. JOHNSON. Dr. Myers, I think it would be very unwise to pass legislation at this point that required certain structures to be consortia. Different communities have different resources. In some instances, the hospital might be the very best coordinator of that. I think we want to allow groups to apply to have the consortia as the reimbursable unit rather than the hospital and begin to see how it works. We need a lot more experience before we dictate that one or the other unit be dominant.

Dr. MYERS. The point that I guess I would defend is that there must be strong representation at that table to someone who is responsive to, and uncomfortable if, work force distribution problems and staffing problems in terms of specialty and geography are not getting better.

Mrs. JOHNSON. Yes, I do hear what you are saying. I think one of the points you made that was very interesting to me is that the hardest decision that a physician or a nurse practitioner has to make is to spot the 1 of 1,000. If your general practitioners do not have some training in sophisticated settings, they will not get enough knowledge of specialties to understand where that line is going to be, because they are not trained in some of the complexities that specialists are, nor could they possibly be or retain it. But to know when there might be a problem here, they have to have enough exposure in a hospital setting to be able to make that judgment. So, all of this issue of training settings is not something that you want Members of Congress deciding.

Dr. MYERS. Understood, and I would not disagree with the points you make. I think the point that I am trying to push is the idea that there is a legitimate place for training outside hospitals which has not been provided for in our current framework.

Mrs. JOHNSON. And to that point, I agree with you absolutely. In the Republican thinking on this issue, you may remember that we made a number of stabs at how to control this. In the end, in both bills, there a cap on the number of new residency slots because of the pros and cons of every action that the Federal Government takes in this area.

I also have been very impressed by what is happening out there in the real world in terms of the number of people who are looking now to family practice residencies, internal medicine residencies, as opposed to 5 years ago. So a different choice is being made, and I personally think that as the Bostons, New Yorks, Chicagos, and even the Hartford, Connecticuts, of the Nation integrate their hospitals, as Boston is doing at a dramatic pace, that the practice opportunities are going to be greater in the rural areas.

Dr. MYERS. I agree.

Mrs. JOHNSON. We are going to deal with our rural deficit of professionals in, in a sense, the best way. We are going to make rural practice desirable again.

Dr. MYERS. I would like to mention that there are structured ways to pick out the 1 in 1,000 rather than seeing only the 1 in 1,000 after they are picked, and some of the, say, family medicine training programs in decision matrices and so forth are structured to actually educate people in that skill as a thing to be valued in itself.

Mrs. JOHNSON. And actually, the specialists also need training in that matrix so that they know——

Dr. MYERS. If they want to make a living in managed care.

Mrs. JOHNSON. That is right. Even if they are not, they need to understand how the system perceives symptoms and what the communication is going to be. This is not something we can divide up.

But, I agree with you that our training sites can no longer be the traditional hospital sites alone, that we have to do a far more comprehensive and flexible job of training, and we have had some ex-

cellent testimony before this Subcommittee of things that are going on across the nation that is radically changing the training sites.

Last, I would just like to comment that I hear you speak in support of the J–1 visas. I think we do have to pay attention to the fact that the explosion in residency physicians has been to train non-citizen physicians, and while that is useful from the point of view of world health care quality, there is a limit to which American taxpayers can be asked to support that.

So we are going to have to engage, and I think legitimately so, with who pays for that training and more of the countries need to be paying for it and more of those people need to be going back and carrying the quality of training they got in America back to their home countries. I think that is part of also reconfiguring our care system, so that we have the quality but also have it where we need it.

Dr. MYERS. And I would mention that the support I expressed for those programs was not so much for the basic importation of 6,000 new physicians a year but was to make the point that the U.S. training program has pretty much not served rural areas, and as soon as the U.S. training program can meet rural and underserved area needs, I will be anxious to stem the alternative.

Mrs. JOHNSON. I appreciate that. It is important to remember why our system does not serve rural areas. In modern medicine, isolation is not only a personal problem, it is a professional problem, and so telemedicine and some of the things we have heard here, there is a whole development that has to take place to assure that being geographically isolated does not mean being professionally isolated and therefore compromising your ability to deliver care.

I think that the direction that we are moving is the right direction. We have to move far more rapidly, and I think we have to build in a far more integrated health care delivery system across America, outside of the whole debate about managed care, and it is already happening in an exciting fashion. I will read your testimony in preparation for next year's work because I particularly am involved in the medical education issue and I appreciate the thoughtfulness of your comments here today. Thank you.

We have one more panel. We also have a vote. I am going to recess the hearing for 10 minutes. So in 10 minutes, we will reconvene with the last panel before us. Thank you.

[Recess.]

Mr. CHRISTENSEN [presiding]. If we can ask our last panel to come forward, Dr. Keith Mueller, Wayne Nelson, Harry Foster, and Edward Wronski.

I am going to go ahead and introduce Dr. Mueller. He is a fellow Cornhusker from Nebraska and we are glad that you are with us today. I know you have been here before and we have talked several times. You have quite a history in working with rural health care. I appreciate your testimony today. I know that as president of the National Rural Health Care Association, Dr. Mueller, we would be pleased to hear your testimony at this time.

STATEMENT OF KEITH J. MUELLER, PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION

Mr. MUELLER. Thank you, Mr. Chairman, and, for the record, the other Members of the Subcommittee. I am here as president of the National Rural Health Association, which represents all of rural America, health care providers and consumers alike.

All of our members, hospital administrators, policy analysts, clinic administrators, physicians, and other health professionals, State rural health offices and associations, educators, and general consumers are deeply concerned about the future of health care services in rural areas as well as the continuing Federal commitment to sustaining affordable services that are accessible to all rural residents.

We believe that through both a general moral obligation and a more specific fiduciary responsibility for Medicare beneficiaries, the Federal Government must continue to provide leadership on behalf of rural residents. This does not mean that programs should not change. My testimony today will suggest changes that either warrant immediate adoption or further investigation and demonstration.

As the Medicare Program is changed to encourage greater use of managed care as an option, Congress must act to change the current means of funding risk contracts, the adjusted average per capita cost, or AAPCC. This methodology, based on previous expenditures within each county, results in gross urban-rural disparities that may make it financially impractical to offer capitated contracts in rural counties.

AAPCC payments for 1996 are as high as $692 per member per month in some urban counties and as low as $205 in rural counties. My home State of Nebraska has the dubious distinction of having 8 counties in the bottom 10 for payment, and all 93 of our counties are below the national average of $392. While some variation is appropriate to account for price differences, current differences serve as barriers to managed care for rural Medicare beneficiaries. To be more certain that managed care is a meaningful choice for rural residents, the National Rural Health Association supports a minimum payment of $350 in 1997 dollars.

There are currently several Medicare Programs, discussed in earlier testimony, that recognize the special circumstances of rural hospitals, different reimbursement for sole community providers and rural referral centers, and special programs for rural primary care hospitals associated with essential access hospitals and medical assistance facilities. These programs, meritorious as they are, do not meet all the needs of small rural hospitals seeking to reconfigure services to find an appropriate niche in today's system for health care delivery. The models for reconfiguration are currently limited to seven States with the EACH/RPCH Program and one State with the MAF Program.

Additionally, a financial category of importance for rural hospitals, Medicare-dependent hospitals, has lost its authorization.

The NRHA is committed to creating a single category of limited service hospitals that would include flexible regulatory and reimbursement arrangements for health care institutions to reconfigure in a manner consistent with the needs of their communities rather

than predetermined notions of what a hospital is. We will work with the Subcommittee and others to help craft specific legislative language to accomplish this goal.

Telemedicine holds great promise for rural America and for medicine generally. To the extent patients can use telemedicine to consult with physicians, travel is reduced significantly, as shown in data from its first full year of use in Kearney, Nebraska. Installation of more advanced communication lines to rural communities would help a great deal and may be accomplished thanks, at least in part, to the universal service provisions of the Telecommunications Act of 1996.

The National Rural Health Association supports efforts to encourage the Secretary of HHS to develop Medicare payment methodology for all telemedicine services and also supports the continuing evaluation of existing demonstrations of this technology.

The current mechanisms in place to fund graduate medical education, primarily through Medicare, are fundamentally flawed, as you just heard. Our needs now are for primary care physicians trained in ambulatory care settings with particular training for practicing in managed care systems. Instead, we have the remnants of a system designed to train specialists in large teaching hospitals.

The National Rural Health Association believes that the Medicare payment system to support GME should be altered in ways that support national and regional work force needs. I have submitted for the record a special white paper prepared by the NRHA on this topic.

Federal payment policies designed to favor location to underserved rural areas are an important tool in the struggle to attract and keep health care professionals in rural America. The NRHA favors increasing the current 10 percent Medicare bonus payment to 20 percent for primary care physicians practicing in underserved areas and expanding the scope of that program to include direct reimbursement for other primary care providers, such as physician assistants, nurse practitioners, and nurse midwives.

As both the private and public sectors increasingly adopt tough negotiating strategies to pay providers for services rendered to their beneficiaries, safety net providers who have relied on third party payment to help finance the cost of care for the uninsured are threatened. In rural areas, these providers are often community and migrant health centers. These centers deliver primary care services and other essential services that include transportation, translation, and family care, to rural residents unable to afford care.

The costs of running such centers is often higher than other primary care providers because of the health of the population being served, the full array of services offered, and the inclusion of supporting services. We cannot afford to leave safety net providers without the opportunity to participate in the new methods of financing health care.

The National Rural Health Association has taken the position of creating a set-aside for clinics in any block grants from Medicaid. Consistent with that position, any movement to managed care

choice in Medicare and Medicaid must be coupled with provisions that "level the playingfield" for safety net providers.

Mr. Chairman, I trust this brief description of health care programs of special interest to rural Americans and the suggestions it includes for retaining the best aspects while making some improvements is helpful to the Subcommittee. To reiterate, the following programs are critical to establishing a sustainable rural health care delivery system: Equitable reimbursement in Medicare, creating and supporting a flexible program for limited service hospitals, completing a plan for reimbursing telemedicine services as well as thorough evaluation of what works and why and how, reforming graduate medical education payment, and continuing to support safety net providers.

In this brief presentation, I have not had the opportunity to focus on other programs of importance to health care services in rural America but that are of less direct relationship to Medicare. They include the following: Federal support for health services research related to the health care needs of rural Americans. Federal grant programs, such as the Outreach and Transition grants that help rural providers and systems make the transitions in services and institutions to configurations more capable of participating in the new more cost-effective means of delivering health care services. The importance of maintaining an effective venue for rural health interests to be represented in Federal Government deliberations, particularly within the Department of Health and Human Services. The variety of ways Federal Government policies affect rural health, including transportation policies, agricultural policies, environmental policies, and welfare policies.

Mr. Chairman and Members of the Subcommittee, we can best serve rural America by constantly remembering the purpose of our efforts, to improve and then sustain the health of rural Americans. The National Rural Health Association is here to advocate on behalf of serving rural residents by the best means possible. Creative redesign of existing programs is welcome. Abandoning current programs to achieve savings at the expense of access to health care is not.

I know each of you agrees with this general approach, and the National Rural Health Association looks forward to working together with you to advance rural interests that are consistent with your broader policy objectives. Thank you.

[The prepared statement follows:]

STATEMENT OF
KEITH J. MUELLER, Ph.D., PRESIDENT
NATIONAL RURAL HEALH ASSOCIATION

Mr. Chairman and members of the Subcommittee:

I am here as president of the National Rural Health Association, which represents all of rural America—health care providers and consumers alike. All of our members—hospital administrators, policy analysts, clinic administrators, physicians and other health professionals, state rural health offices and associations, educators, and general consumers—are deeply concerned about the future of health care services in rural areas as well as the continuing federal commitment to sustaining affordable services that are accessible to rural residents. We believe that through both a general moral obligation and a more specific fiduciary responsibility for Medicare beneficiaries the federal government must continue to provide leadership on behalf of rural residents. This does not mean that programs should not change—my testimony today will suggest changes that warrant either immediate adoption or further investigation and demonstration.

Capitated Medicare Payment

As the Medicare program is changed to encourage greater use of managed care as an option, Congress must act to change the current means of funding risk contracts—the Adjusted Average Per Capita Cost, or AAPCC. This methodology, based on previous expenditures within each county, results in gross rural-urban disparities that may make it financially impractical to offer capitated contracts in rural counties. 1996 AAPCC payments are as high as $692 in some urban counties and as low as $205 in rural counties. My home state of Nebraska has the dubious distinction of having eight counties in the bottom 10 for payment, and all 93 of our counties are below the national average of $392. While some variation is appropriate to account for price differences, current differences serve as barriers to managed care for rural Medicare beneficiaries. **To be more certain that managed care is a meaningful choice for rural residents, the National Rural Health Association supports a minimum payment of $350 in 1997 dollars.**

Limited Service Hospitals

There are currently several Medicare programs that recognize the special circumstances of rural hospitals—different reimbursement for Sole Community Providers and Rural Referral Centers and special programs for Rural Primary Care Hospitals networked with Essential Access Care Hospitals (EACH/RPCH) and Medical Assistance Facilities (MAFs). These programs, meritorious as they are, do not meet all the needs of small rural hospitals seeking to reconfigure services to find an appropriate niche in today's system for health care delivery. The models for reconfiguration are currently limited to seven states with the EACH/RPCH program and one state with the MAF program. Additionally, a financial category of importance for rural hospitals—Medicare Dependent Hospitals—has lost its authorization. **The National Rural Health Association is committed to creating a single category of Limited Service Hospitals that would include flexible regulatory and reimbursement arrangements for health care institutions to reconfigure in a manner consistent with the needs of their communities rather than predetermined notions of what a "hospital" is.** We will work with the committee and others to help craft specific legislative language to accomplish this goal, which will satisfy delivery and cost-effectiveness objectives simultaneously.

Telemedicine

Telemedicine holds great promise for rural America and for medicine generally. To the extent patients can use Telemedicine to consult with physicians, travel is reduced significantly, as shown in data from its first full year of use in Kearney,Nebraska. Installation of more advanced communications lines to rural

communities would help a great deal and may be accomplished thanks to the universal service provisions (Section 254H) of the Telecommunications Act of 1996. **The National Rural Health Association supports efforts to encourage the Secretary of the Department of Health and Human Services to develop Medicare payment methodology for all Telemedicine services and also supports the continuation of evaluation of existing demonstrations of Telemedicine technology and use in rural settings.**

Graduate Medical Education (GME)

The current mechanisms in place to fund Graduate Medical Education (GME), primarily through Medicare, are fundamentally flawed. Our needs now are for primary care physicians trained in ambulatory care settings, with particular training for practicing in managed care systems. Instead, we have the remnants of a system designed to train specialists in large teaching hospitals, with an emphasis on becoming referral physicians. **The National Rural Health Association believes that the Medicare payment system to support GME should be altered in ways that support national and regional work force needs.** I am submitting for the record a more detailed paper prepared by the National Rural Health Association that makes the argument for ambulatory site training of primary care physicians, consistent with recommendations of the Council on Graduate Medical Education (COGME).

Other Work Force Issues

Federal payment policies designed to favor location to underserved rural areas are an important tool in the struggle to attract and keep health care professionals in rural America. **The National Rural Health Association favors increasing the current 10 percent Medicare bonus payment to 20 percent for primary care physicians practicing in underserved areas and expanding the scope of the program to include direct reimbursement for other primary care providers, specifically physician assistants, nurse practitioners and nurse midwives.**

Supporting Safety Net Providers

As both the private and public sectors increasingly adopt tough negotiating strategies to pay providers for services rendered to their beneficiaries, safety net providers who have relied on third-party payment to help finance the cost of care for the uninsured are threatened. In rural areas, those providers are often community and migrant health centers. These centers deliver primary care services—and other essential services that include transportation, translation and family care—to rural residents unable to afford care. The costs of running such centers is often higher than other primary care providers because of the health of the population being served, the full array of services offered and the inclusion of supporting services. We cannot afford to leave safety net providers without the opportunity to participate in new methods of financing health care. **The National Rural Health Association has taken the position of creating a set-aside for clinics in any block grants for Medicaid.** Consistent with that position, any movement to managed care choice in Medicare and Medicaid must be coupled with provisions that "level the playing field" for safety net providers.

Mr. CHRISTENSEN. Thank you, Dr. Mueller, for your testimony. Mr. Nelson.

STATEMENT OF WAYNE NELSON, PRESIDENT, COMMUNICATING FOR AGRICULTURE, FERGUS FALLS, MINNESOTA

Mr. NELSON. Thank you, Mr. Chairman and Members of the Subcommittee. We thank you for the opportunity to express our views on rural health care.

My name is Wayne Nelson. I am a farmer from Winner, South Dakota. I live in a rural community of about 3,500 people. I am president of Communicating for Agriculture, which is a national non-profit organization with a membership of farmers, ranchers, and rural small business people in 50 States. Our members are consumers of the rural health care system who believe it is vital that we have access to the same quality health care services that urban communities enjoy.

California has long been an advocate of equality in Medicare reimbursement rates for rural health care providers, institutions, and professionals. Rural hospitals lean very heavily on Medicare, which is no surprise, considering rural areas are home to a higher percentage of seniors than the rest of the country. Typically, rural hospitals receive over half their income from Medicare patients, with one hospital in my State of South Dakota receiving almost 80 percent of their income.

The Medicare reimbursement rates are much too low in rural areas in comparison with their urban counterparts. Reimbursements for rural hospitals received do not reflect their true costs, forcing many hospitals to shift expenses to patients with private insurance. This cost shifting might be necessary for the hospital to stay in business, but it also drives up premiums for rural health care consumers.

Several legislative efforts have been introduced that would help solve the problem of unequal reimbursement rates, including last year's budget agreement and the Rural Health Improvement Act introduced this summer, but unfortunately, nothing has been signed into law that adequately addresses this growing problem.

Hospitals play a very important role in rural communities, not only as health care centers but also in terms of economic activity. In many cases, rural hospitals are the largest employers in town. This is the case in my home community in South Dakota. Losing our hospital would deliver a severe economic blow to my community, a dramatic example of why we need to save as many rural hospitals as possible.

Creating new classifications of rural hospitals under Medicare would be one way to help. Rural primary care hospitals could become intermediate State facilities and rural emergency access care hospitals could be designated emergency facilities, with treatment not exceeding 24 hours. These new categories might enable hospitals that are in danger of closing a chance to stay in operation, thus maintaining more health care options and better access at the local level.

Finding new doctors and keeping existing ones in rural areas is a continuing problem. Many things have been done. One thing in my community was private funds were used to pay part of the ex-

pense of a medical student going to a medical college and then, in turn, he agreed to practice in our community for 5 years. But, more needs to be done than just private participation.

We are lucky in my community that we have doctors available, but they do draw from a 50-mile radius. It is not uncommon for people in Western South Dakota to drive 50 or more miles to get to a health care professional. Physicians' assistants and nurse practitioner programs have helped, but we still need more incentive to attract doctors to practice in rural communities if we are to assure adequate access to quality health care for rural Americans.

Since many of these areas are underserved in terms of health care, you can understand why managed care is not always an option for us. As a result, we believe in the ability of rural people to help control their own health care costs. We have offered an Association-endorsed health plan, similar to a medical savings account, since 1978. It is one way of our members to hold down health care costs.

Recently passed legislation offering a trial on MSAs with important tax savings will make the program work even better. The increase in the deductibility of health insurance premiums for the self-employed is also very important to rural America.

Technological advances have opened up new ways of delivering health care to rural regions. Telemedicine services are offered in many rural areas, including my own. The ability to draw on the diagnostic skills of specialists hundreds of miles away through satellite communication is a tremendous advancement. A method to provide Medicare reimbursement for telemedicine services should be offered.

The Internet also serves to help those in rural areas learn more about health care in general. We have been involved in obtaining local access to health care information and other information to people in rural America, enabling them to review the myriad of data available. As you know, doctors are also using the Internet to communicate with other health professionals throughout the world, including reaching practitioners in remote rural areas.

In addition, we have worked for many years to help establish State risk pools or guaranteed access plans so those considered uninsurable will have an option for insurance coverage. This has helped many rural Americans keep coverage when their health condition normally would have made them ineligible for health insurance. The expansion of risk pools into more States would be an effective way for the uninsurable in rural areas to gain access to health care.

Finally, the last 5 years has shown an increase of 2.6 million people in rural America. Seventy-five percent of rural counties are growing today, compared to only 45 percent that were growing in the eighties. A desirable quality of life in rural areas, we think, is bringing people back to communities that were not growing 10 years ago. But, quality health care services are critical to keep these areas growing. We cannot forget about the areas that are not growing as quickly or may be even losing population.

This simply underscores the fact that rural health care needs and problems are very unique and that rural health solutions require a variety of approaches. We all recognize that a one-size-fits-

all program is not the answer. The Rural Health Improvement Act of 1996 addresses this uniqueness and offers a variety of improvements for rural health care that our Association supports. Thank you very much.

[The prepared statement follows:]

TESTIMONY

Wayne Nelson
President
Communicating for Agriculture
Committee on Ways & Means
Health Subcommittee
September 12, 1996

Rural Health Care

Mr. Chairman and members of the committee. Thank you for the opportunity to express our views on rural health care. My name is Wayne Nelson, a farmer from Winner, South Dakota, a rural community of 3500 people. I am president of Communicating for Agriculture, a national nonprofit organization with a membership of farmers, ranchers and rural small business people in 50 states. Our members are consumers of the rural health care system who believe it is vital that they have access to the same quality health care services that urban communities enjoy.

CA has long been an advocate of equality in Medicare reimbursement rates for rural health care providers, institutions and professionals. Rural Hospitals lean very heavily on Medicare which is no surprise considering rural areas are home to a higher percentage of seniors than the rest of the country. Typically, rural hospitals receive over half their income from Medicare with one hospital in my state of South Dakota receiving almost 80 percent. The Medicare reimbursement rates are much too low in rural areas in comparison with urban counterparts. The reimbursements rural hospitals receive don't reflect true costs, forcing hospitals to shift expenses to patients with private insurance. This cost shifting might be necessary for the hospital to stay in business but it drives up premiums for rural health care consumers. Several legislative efforts have been introduced that would help solve this problem of unequal reimbursement rates, including last year's budget agreement and the Rural Health Improvement Act introduced this summer, but unfortunately, nothing has been signed into law to address this growing problem.

Hospitals play an important role in rural communities not only as health care centers but also in terms of economic activity. In may cases, rural hospitals are the largest employers in town. This is the case in my home community in South Dakota. Losing our hospital would deliver a severe economic blow to Winner, a dramatic example of why we need to save as many rural hospitals as possible. Creating new classifications of rural hospitals under Medicare would be one way to help. Rural Primary Care Hospitals could become intermediate-stay facilities and Rural Emergency Access Care Hospitals could be designated emergency facilities with treatment not exceeding 24 hours. These new categories might enable hospitals that are in danger of closing a chance to stay in operation, thus maintaining more health care options at the local level.

Finding new doctors and keeping existing ones in rural areas is a continuing problem. I'm lucky that we have doctors available in my community but they draw patients from a 50 mile radius. It is not uncommon for people in western South Dakota to drive 50 miles or more to get to a health care professional. Physician Assistant and Nurse Practitioner programs have helped, but we still need more incentives to attract doctors to practice in rural communities if we are to assure adequate access to quality health care for rural Americans.

Since many areas are under served in terms of health care, you can understand why managed care is not often an option for us. As a result, because we at CA believe in the ability of rural people to help control their own health care costs, we have offered an association-endorsed health plan similar to a medical savings account since 1978. This plan offers a higher-deductible insurance policy which has a lower monthly premium. We couple it with a saving plan setting aside money to cover first dollar expenses for health care. It is one way for our members to hold down health care costs. Recently passed legislation offering a trial on MSAs with important tax savings will make the program work even better. The increase in the deductibility of health insurance premiums for the self-employed is also very important to rural America.

Technological advances have opened up new ways of delivering health care to rural regions. Telemedicine services are offered in many rural areas, including my own. The ability to draw on the diagnostic skills of specialists hundreds of miles away through satellite communication is a tremendous advancement. A method to provide Medicare reimbursement for telemedicine services should be offered. The Internet also serves to help those in rural areas learn more about health care in general. CA has also been very involved in obtaining local access to health care information for people in rural America, enabling them to review the myriad of data available. As you know, doctors are using the Internet to communicate with other health professionals throughout the world to make available a large window of information, including reaching practioners in remote rural areas.

In addition, we have worked over the last 20 years to help establish state risk pools or guaranteed access plans so those considered "uninsurable" will have an option for insurance coverage. This has helped many rural Americans keep coverage when their health condition normally would have made them ineligible for health insurance. The expansion of risk pools into more states would be an extremely effective way for the uninsurable in rural areas to gain access to health care.

Finally, the last 5 years has shown an increase of 2.6 million people in rural America. Seventy-five (75) percent of rural counties are growing today compared to 45 percent in the 1980s. The desirable quality of life in rural areas is bringing people back to communities that weren't growing 10 years ago. Quality health care services are critical to keep these areas growing. However, we cannot forget that some areas are not growing as quickly, or may even be losing population. This simply underscores the fact that rural health care needs and problems are unique, that rural health solutions require a variety of approaches. Congress and the Administration must recognize that a one-size-fits-all program is not the answer. Thank you.

Mr. CHRISTENSEN. Thank you, Mr. Nelson.
Mr. Foster.

STATEMENT OF HARRY L. FOSTER, CHIEF EXECUTIVE OFFICER, FAMILY HEALTHCARE NETWORK, PORTERVILLE, CALIFORNIA, ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Mr. FOSTER. Thank you, Mr. Chairman and Members of the Subcommittee. As a resident of the 21st Congressional District of California, I want to thank you for the opportunity to testify today. I also want to publicly acknowledge our appreciation for the leadership that the Chairman, Mr. Thomas, has provided us.

I am chief executive officer of the Family HealthCare Network, a community and migrant health center in Porterville, California. We provide accessible, comprehensive, patient-oriented primary health care services in Tulare County. We are especially oriented toward patients who experience barriers in obtaining health care services from other providers.

In 1995, Family HealthCare Network served 21,498 patients. Of these, 63 percent were Hispanic, 25 percent were Caucasian, and 12 percent were other non-Caucasian. Eighty percent of our patients were below 200 percent of the poverty level.

Tulare County is a sparsely populated rural area about 150 miles north of Los Angeles. It is the second most productive county in the world in annual crop production, with over 2.5 billion dollars' worth of agricultural products every year.

Tulare County is a classic rural area. Poverty is high. Over 15 percent of residents are on AFDC. Over 15 percent are unemployed. Education levels are low. Of the 39.8 percent do not have a high school education.

There are several barriers to accessing health care in the county. Transportation is a significant problem, particularly in Porterville. Many people have to travel on rural roads in excess of 30 miles to a provider. Most of our service area is without a fixed-route mass transit system.

Language is a barrier. Many local Hispanics prefer to communicate in Spanish. Others are fluent only in languages other than English. At the health center, we provide translation in four languages, English, Spanish, Hmong, and Lao.

Financial limits are another barrier. Almost 50 percent of the population is on Medi-Cal or uninsured. Very few new patients at Family HealthCare Network have had any preventive care. We regularly see children with no record of childhood immunizations, women who have never had a pap smear, and individuals who are clearly diabetic or hypertensive who have never been diagnosed or treated. It is not surprising that Tulare County has a higher rate than the State average rate for many communicable diseases.

Tulare County especially needs effective prenatal care. The birth and fertility rates are extremely high, as are teenage pregnancy rates. Every day, our providers see women, especially adolescent and foreign-born, who present in their second and third trimester of pregnancy with no prior prenatal care. Despite all this, we have improved birth outcomes. In 1978, the county infant mortality rate

was 14.8 deaths per 1,000 live births and today it is down to 6.2 deaths per 1,000 live births.

Family HealthCare Network is highly dependent on public sources of funding to pay for the care of our patients. Fifty percent of our revenues are from Medi-Cal, 3 percent from Medicare, 8 percent are from Public Health Service Act grants, 10 percent from private insurance, 4 percent are from State funds, and 25 percent are from uninsured patients.

Of critical importance to Family HealthCare Network is the system of reasonable cost reimbursement which health centers currently receive under Medicare and Medicaid. This system needs modification as rural health centers begin to participate in managed care networks. Managed care plans are unwilling to pay capitation payments which are enough to cover the costs of caring for patients. We do not have a large base of revenues from commercial patients to make up any losses from public programs. In my written statement, we have proposed a change in the Medicare and Medicaid Programs to remedy this problem.

Also important to rural health centers are Public Health Service Act grants for community and migrant health centers. These grants are directed toward serving the uninsured and to provide outreach, transportation, and other support services which help eliminate barriers to care. The House has provided an increase of $44 million for these grants for fiscal year 1997. We sincerely hope that this funding level is maintained in any final funding bill for fiscal year 1997.

Another significant problem for rural health centers is the recruitment and retention of health professionals. Even after recruiting doctors, other providers with significant financial resources try to recruit our doctors away from us by offering higher salaries which we simply cannot match.

A way to attract and retain doctors to rural areas is to provide opportunities for them to train in ambulatory care settings, where they can see the benefits and satisfaction of establishing a family practice. We recommend that any reform in the Medicare and Medicaid Graduate Medical Education Programs provide for payment for the training of residents at health centers and other ambulatory care sites.

Our comments about H.R. 3753 are outlined in detail in my written statement. Our most serious concerns are with section 602 of the bill, which requires the Health and Human Services Secretary, in making community health center grants, to give special consideration to projects involving collaborative agreements between health centers and community hospitals. These agreements must meet several overly restrictive requirements, including one that a health center be located in or adjacent to a hospital.

Health centers believe that while collaboration between providers should be encouraged, many hospitals in rural areas have sufficient resources and reserves to establish collaborative arrangements without the use of scarce health center grant funds. In addition, section 602 would discriminate against rural areas without a hospital, even if their need for primary health care services is greater than that of other rural areas which do have one.

We strongly recommend that the current language in section 602 be deleted and replaced with language allowing greater flexibility on these collaborative efforts. My written statement contains specific language for your consideration.

Thank you for the opportunity to provide our views on rural health care in America. We look forward to working with the Subcommittee on this and other important health care issues in the future.

[The prepared statement follows:]

STATEMENT OF HARRY L. FOSTER
FAMILY HEALTHCARE NETWORK, PORTERVILLE, CA
ON BEHALF OF
THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

My name is Harry Foster. I am Chief Executive Officer of the Family HealthCare Network, a nonprofit community and migrant health center in Porterville, California. I am submitting this testimony today on my own behalf and as a representative of the National Association of Community Health Centers. The purpose of my testimony is to describe the needs for, and barriers to, health care in rural central California and to provide you with my views on H.R. 3753, the Rural Health Improvement Act of 1996.

The Challenge of Providing Primary Health Care Services in a Rural Area

The mission of Family HealthCare Network is to provide accessible, comprehensive, patient-oriented primary health care services to individuals and families in our service area, Tulare County. Family HealthCare Network is especially oriented towards those individuals and families who experience barriers in obtaining health care services from other providers. We provide our care in a culturally sensitive and dignified manner. In twenty years, we have grown from a small gas station facility and attached temporary trailer to three facilities in different localities in the county. In 1995, Family HealthCare Network served 21,498 patients. Of these, 63 percent were Hispanic, 25 percent were Caucasian, and 12 percent were other Non-Caucasian (including Filipino, African-American, and Southeast Asian). Eighty percent of our patients were below 200 percent of the poverty level.

Tulare County is a rural area about 50 miles north of Bakersfield and 150 miles northwest of Los Angeles. It is sparsely populated. In 1990, the total population was 311,921 over an area of 4,863 square miles. The population is projected to grow to approximately 437,000 by the year 2000. The population breakdown is 52.8 percent Caucasian, 40.7 percent Hispanic, 4 percent Asian/Pacific Islander, 1.4 percent African-American, and 1 percent Native American. Over eleven percent of the population is enrolled in Medicare.

Tulare County is in the heart of California's San Joaquin Valley, one of the richest agricultural regions in the world. Tulare is the second most productive county in the world in annual crop production, producing over 2.5 billion dollars worth of fruits, nuts, produce, grain, and livestock every year. Two-thirds of the employment in the area is either directly or indirectly related to the agriculture industry. An important factor in the growth of the county's productivity and population are migrant agricultural workers. These workers have made the smaller communities of the county their "downstream" home, moving about the state to work in agriculture from their base in the community, and finding other work in periods when farm work is unavailable.

Because of the rural nature of the county and the seasonal availability of work, Tulare County has many of the characteristics common to rural areas. Poverty is high -- the total percent of population below the poverty level in the county is 22.5 percent, compared to only 12.5 percent for the entire state of California. Over 15 percent of county residents are on AFDC, compared to only 7.7 percent of the population of the entire state. Unemployment is also high -- 15.4 percent of the population of the county is unemployed, while only 9.3 percent of the state's population is unemployed. Education levels are low -- 39.8 percent of county residents over age 25 do not have a high school education. Statewide, only 23.8 percent of residents over age 25 are not high school graduates.

There are several barriers to accessing health care in the county. Transportation to health services is a significant problem, particularly in our Porterville service site area. Many people have to travel on rural roads in excess of 30 miles to accessible primary health care. A portion of the county is in the Sierra Nevada mountain range, making travel even more difficult. A winter-time phenomenon know as "Tule fog" makes it very treacherous to drive from December through February. And, with the exception of Visalia, the county seat, most of our service area is without a fixed route mass transit system. In Porterville, "Dial-A-Ride" programs are available, but there is usually a two-hour wait each way.

There are linguistic barriers in the community as well. About half of the Hispanic population prefers to communicate in Spanish, and there are individuals who are fluent only in languages other than English. At the health center, we provide translation for four languages: English, Spanish, Hmong and Lao.

Financial barriers make it difficult for county residents to receive care. Almost fifty percent of the population is covered by Medi-Cal or is uninsured. Because of the general lack of economic resources, very few of the new patients at Family HealthCare Network has had any preventive care before they are seen at our centers. Restrictions on the use of their resources are significant -- the small percentage of adults who are on Medi-Cal find that preventive health care is not covered. Generalized poverty means that their income must be rationed between immediate problems (such as food and housing) and more long-term needs such as preventive care. While our providers promote the need for prevention and early treatment, we cannot set financial priorities for our patients.

We regularly see patients coming to us for the first time with every indication of health care neglect -- such as children with no record of childhood immunizations; women who have never had a Pap smear; and individuals who are clearly diabetic or hypertensive, who have never been diagnosed or treated in the past. And it is not surprising that Tulare County has a higher communicable disease rate than the State average rate for hepatitis, measles, shigellosis and tuberculosis, and has a higher death rate than the State average for heart disease, stroke, unintentional injuries, pneumonia and influenza, chronic obstructive pulmonary disease, and diabetes.

Tulare County especially needs effective prenatal care. The birth rate in the county is 22.2 per thousand, higher than the 19.2 per thousand rate for the state. The fertility rate for the county is extremely high -- 103.1 per thousand as compared to 82.7 per thousand for the entire state. There are high educational barriers to effective prenatal care -- 51.1 percent of mothers in the county have less than 12 years of education, while 35.7 percent of mothers across the state are at that educational level. Teenage pregnancy is high in the county -- 17.7 percent, as compared to 11.8 percent for the state. More mothers begin their prenatal care after the first trimester -- 36.1 percent for the county, while only 24.9 percent for the state. Every day our providers see women, especially adolescent and foreign born, who present in their second and third trimester of pregnancy with no prior prenatal care. Improving birth outcomes is one area in which our work is having an impact -- in 1978, when we opened the health center, the infant mortality rate was 14.8 deaths per thousand live births for the county, and today it is 6.2 deaths per thousand live births.

Public Programs Are Critical in Serving the Rural Poor and Uninsured

Like other health care providers in rural areas, Family HealthCare Network experiences problems in meeting the many health care needs of the residents of our service area. Because of the lack of economic resources and high numbers of uninsured in our area, Family HealthCare Network is highly dependent on public sources of funding to pay for the care of our patients. Fifty percent of our revenues are from Medi-Cal; 3 percent from Medicare; 8 percent are from community health center grants under the Public Health Service Act (PHSA); 10 percent from private insurance; 4 percent are from State funds; and 25 percent are from patient payments.

Of critical importance to Family HealthCare Network is the system of reasonable cost reimbursement which health centers currently receive under Medicare and Medicaid. Under this system, Federally-qualified health centers (FQHCs) receive an average payment per visit which approximates the reasonable cost of providing services to a Medicare or Medicaid patient. Making sure that the level of payments are sufficient to cover the costs of services is extremely important for rural FQHCs who treat underserved patients, since there are few other resources from which to make up any losses. This system has worked well for centers under a fee-for-service system, but needs modification as rural health centers begin to participate in managed care networks. Our experience in California is that managed care plans are unwilling to pay capitation payments which cover the costs of caring for patients. As a health center dedicated to serving the indigent, Family HealthCare Network does not have a large base of revenues from commercial patients to make up any losses from public programs, and because of this, an adjustment in the reimbursement system for health centers is needed to accelerate their further integration into managed care systems.

We propose an amendment to the Medicare and Medicaid programs to solve this problem. The reasonable cost reimbursement system would operate slightly differently when a Medicare or Medicaid patient is served through a managed care plan. The FQHC would receive a "wrap-around" payment directly from Medicare or Medicaid that is equal to the difference (if any) between the reasonable cost reimbursement which would be paid to the FQHC under current law and the amount the FQHC receives from a managed care plan for services provided to Medicare or Medicaid managed care patients.

Also important to rural health centers are the grants under the Public Health Service Act (PHSA) for community and migrant health centers. These grants are directed towards serving the uninsured and to provide outreach, transportation, and other support services which can help to eliminate the barriers to care faced by rural residents. At Family HealthCare Network, we use our PHSA grants to subsidize the losses we incur by providing a sliding fee scale (based on income) to our patients.

About 50 percent of the funds appropriated nationally for the PHSA grants are used for projects in rural areas. There are many medically underserved rural areas which could benefit from the establishment of a health center if more funds were appropriated. For each $10 million appropriated, 100,000 new patients can be served and 20 new centers established. Between 1991 and 1995, almost 700 communities were identified as needing health care services, but were unable to receive PHSA grants because of inadequate program funding. Approximately half of these needy communities are in rural areas. In California, 65 new underserved communities in rural and urban areas applied and were approved for PHSA grants, but were not funded due to lack of available funds. Many underserved and interested communities throughout the country were discouraged from even applying for health center grants because of lack of funds.

The House Appropriations Committee has recognized the value of the health center programs in rural areas and has provided an increase of $44 million for PHSA grants for health centers for fiscal year 1997. We recommend that this funding level be maintained in any continuing resolution adopted for fiscal year 1997.

Another significant problem for rural health centers is the recruitment and retention of health professionals, particularly physicians. This problem is especially difficult in Porterville due to the lack of community infrastructure and other amenities which would make an area attractive for a health professional and his or her family. For example, in Porterville, the public schools are not ranked highly for academic preparation. There is only one movie theater and one playhouse, no professional sports, and few professional clubs. There are some local stores on our main street, but the nearest shopping mall is 35 miles away, in Visalia. There is significant pollution from agricultural chemicals. In addition, small town politics are still an important factor in the area. Newly arrived professionals are viewed as "outsiders", with one consequence being that the retention of hospital staff privileges is often a difficult process.

Family HealthCare Network is the main provider of primary health care services for the medically indigent in general and the migrant and seasonal farmworkers in particular. We have 23 medical and dental providers. We have experienced difficulties in recruiting and retaining our providers. Most recently, the district hospitals in our county have formed an exclusive consortium of clinics -- choosing not to collaborate or coordinate with community-based organizations like Family HealthCare Network. The consortium is using their huge financial reserves to try and take our providers from us by offering higher salaries. As a nonprofit provider serving a majority of uninsured and underinsured individuals, it is difficult and sometimes impossible to match their offers.

Retaining providers is a problem throughout Tulare County -- and as a result almost the entire county has been designated a health professional shortage area (HPSA) and a significant portion of the county has been designated a medically underserved area (MUA). One important provider resource for rural areas is the National Health Service Corps (NHSC). The NHSC is one of the very few successful efforts to address the acute shortage of primary care providers and the serious maldistribution of health services in rural areas.

Currently, there are 151 NHSC providers in the State of California, most in rural communities. Family HealthCare Network has been very fortunate to have participated in the NHSC scholarship and loan repayment programs. We have two physician assistants and six primary care physicians who are supported under the NHSC. This has helped us tremendously to relieve some of the provider capacity issues associated with our service area.

The House Appropriations Committee has provided $115 million for the NHSC program for fiscal year 1997. We are hopeful that the Senate Appropriations Committee will provide at least $120 million. **We recommend that the highest possible funding level be maintained for the NHSC in any continuing resolution which is adopted for fiscal year 1997.**

Another way to attract providers to rural areas is to provide opportunities for them to get their residency training in ambulatory settings in rural areas. In many cases, when providers receive their training in health centers or other rural clinics, they see the benefits and satisfaction of establishing a family practice in a rural area before they make a decision to practice in a specialty field in an urban area. As currently structured, the graduate medical education system discourages residencies in health centers and other ambulatory settings because the payment system is designed to reward training in hospitals, particularly urban hospitals. As managed care spreads throughout the country, including rural areas, the demand for primary care clinicians who can work in ambulatory settings will increase. **We recommend that any reform of the Medicare and Medicaid graduate medical education systems provide for payment to health centers and other ambulatory care sites for the training of residents.**

Comments on the Rural Health Improvement Act of 1996

I would also like to provide you with my views on some of the provisions of H.R. 3753, the Rural Health Care Improvement Act of 1996. In general, I support the bill and its efforts to improve health care in rural areas. However, I and many other health centers have serious concerns about several of the provisions of the bill, which I will outline in detail.

Section 101 of H.R. 3753 increases the capitation rate that will be paid to Medicare managed care plans that serve rural areas, and is designed to reduce the current differences between the capitation rates paid to plans in urban and rural areas. Inasmuch as the amendments made in this section to the Medicare managed care provisions of section 1876 of the Social Security Act are expected to heighten the interest of managed care plans in rural areas, **we would strongly recommend that an additional provision be added requiring entities with a Medicare managed care contract (under section 1876 of the Social Security Act) to contract with certain essential providers (including health centers, rural health clinics, community health networks funded under Title II, and others of the Committee's choosing) who are located in or serve residents of their service areas.**

In addition, we would recommend that the Committee consider adding a requirement that any such managed care plans serving a rural area under a section 1876 contract be required to meet certain standards for the accessibility and availability of care. We would recommend that you use standards similar to those in S. 839, a bill introduced by Sen. Chafee last year. In particular, standards regarding geographic access to both primary and other health services by managed care enrollees are vital to ensure the effectiveness of rural managed care systems.

Section 201 of H.R. 3753 establishes grants to States for the development of access improvement plans for chronically underserved areas. We note that, in the designation of chronically underserved areas under section 201(b)(2)(B)(i), one of the factors to be considered is whether the area is (or was previously) designated as a HPSA under section 332 of the PHSA, but not current or previous designation as an MUA or a medically underserved population (MUP) under section 330 of the PHSA. This oversight is quite surprising in view of the fact that the succeeding clauses ((ii) - (vi)) of section 201(b)(2)(B) of H.R. 3753 contain precisely the same elements used to determine medical underservice under section 330 of the PHSA. **We would recommend that you add an additional clause (III) as follows: "(III) is designated as an area with a medically underserved population under Section 330(b) of the Public Health Service Act), or meets the criteria for such designation."** We also have the same concern about section 204(b)(4) of H.R. 3753, which once again utilizes the term 'underserved' yet fails to include rural areas or populations designated as MUAs or MUPs under section 330 of the PHSA.

We strongly support the inclusion of the Community Health Advisors program under section 203 of H.R. 3753, which we have supported since it was first proposed in 1992.

Section 204(a) establishes a definition of community rural health networks that are eligible to receive grants under the provisions of title II of H.R. 3753. We note that other classes of providers, including rural health clinics, are listed as potential participants in community rural health networks, but community and migrant health centers are not. While health centers clearly fit into the "other" category, we believe that they should be clearly included, in particular because they serve 4.5 million rural Americans and will be important providers in many rural networks. **Moreover, we believe that any network funded under this new authority should be required to include all health centers and rural health clinics (and perhaps other essential providers of the Committee's choosing) that are located in or serve residents of the network's service area, as a condition of funding.**

We strongly support the provisions of section 401 of H.R. 3753, which excludes from gross income of a taxpayer any scholarship payment or loan repayment for a member of the NHSC. We have advocated for this provision since 1987, after learning that the Tax Reform Act of 1986 had made NHSC assistance taxable to recipients.

Section 403 of H.R. 3753 would give priority in the assignment of NHSC members to providers in community health networks. We strongly oppose the current language of this section. The National Health Service Corps Amendments of 1990 gave priority in the assignment of NHSC members to those HPSAs with the greatest needs. We firmly believe that this priority should remain in effect. With respect to the type of organizational placements, we strongly believe that organized delivery systems like health centers should have at least equal footing with networks, especially because health centers have for 30 years relied on NHSC as an important source of providers for the underserved, including the more than 4.5 million rural Americans who rely on them for health care today.

Lastly, and most importantly, health centers around the country have serious reservations about section 602 of H.R. 3753, which requires the Secretary of Health and Human Services, in making community health center grants under section 330 of the PHSA, to give special consideration to projects in which community health centers have entered in to collaborative agreements with community hospitals. These collaborative agreements must meet several detailed requirements, including one that a health center be in or adjacent to a hospital. Health centers around the country believe that while collaboration between health care providers should be encouraged, the local community should determine where a primary care center should be located based on all local needs and resources. The current provisions of section 602 are too restrictive, particularly in requiring that the primary care center be located in or near a hospital and requiring that the center use hospital facilities. Moreover, many hospitals in rural areas have sufficient resources and reserves to establish collaborative arrangements with health centers and other providers without the use of scarce grant funds under section 330 of the PHSA. In addition, the provisions would discriminate against rural areas without a hospital, even if their need for primary health care services is greater than that of other rural areas which do not have a hospital.

We strongly recommend, as does the National Rural Health Association, that section 602 be amended by deleting the language in the bill that would add a new subsection (m) to section 330 of the PHSA and include instead the following new subsection (m):

"(m)(1) In making grants in rural areas for new or expanded services for each fiscal year, the Secretary shall give special consideration to projects which demonstrate collaboration with community hospitals or other local health care providers. Such collaboration may include agreements to share facilities and equipment, jointly developed patient triage and referral arrangements, or other agreements which demonstrate efficiency and cost-effectiveness in the use of available resources to increase access to underserved populations."

Thank you for the opportunity to provide our views on rural health care in America. We look forward to working with the Subcommittee on this and other important health care issues.

Chairman THOMAS [presiding]. Thank you very much, Harry. Mr. Wronski.

STATEMENT OF EDWARD WRONSKI, DEPUTY DIRECTOR, BUREAU OF EMERGENCY MEDICAL SERVICES, NEW YORK STATE DEPARTMENT OF HEALTH

Mr. WRONSKI. Thank you. I am Ed Wronski. I am the deputy director for the New York State Department of Health's Emergency Medical Services Bureau. I would like to thank Chairman Thomas and the Members of the Subcommittee on Health of the Committee on Ways and Means for inviting me to speak on this important issue that affects the quality of health care provided to all rural communities.

The Governor and the New York State Department of Health support the passage of H.R. 1757, the Community Ambulance Support Act of 1995, which amends title XVIII of the Social Security Act, allowing coverage under part B of the Medicare Program of paramedic intercept services in support of public, volunteer, or nonprofit providers of ambulance services.

A change in interpretation of Medicare regulations disallows payment for advanced life support medical care provided by a nontransporting ambulance service to patients being transported by a basic life support ambulance service. This change has placed an economic strain on many advanced life support ambulance services, which are continuing to provide this type of care, when requested by their neighboring basic life support ambulance service.

The change in policy has its most dramatic negative effect in rural areas of our State where cooperative sharing of this needed and scarce medical resource is most crucial. The ability to provide prompt and effective medical care in an emergency is an accepted principle of any well-designed emergency medical response system. In order to accomplish this, the system must be flexible in design and fit the needs and resource capabilities of the community it serves. This includes the capability to provide advanced life support services to those patients whose medical condition warrant it.

In the fifties and sixties, the ability to provide advanced life support care would not have been so critical to a system, as prehospital medicine was essentially first aid with rapid transport to a hospital. Developments in the decade since then have brought medical techniques and advanced medicine into the back of the ambulance, including the treatment of cardiac patients, patients in respiratory distress, stroke victims, and others, where advanced life support can make a critical difference in their survival. Failure on our part to support the availability of advanced life support medical care in the rural areas of our country is not acceptable.

In many areas of the country, as in New York State, the ability of rural communities to support advanced life support ambulance service is severely limited by their local financial and human resources. It costs approximately one-third more to operate an advanced life support ambulance service than a basic life support ambulance service. There are also limited numbers of trained and experienced paramedics in rural areas to staff these services. The sharing of advanced life support personnel when needed through

an intercept system has helped overcome this problem in many rural areas of New York State.

The negative financial impact of the current Medicare rule denying payment for advanced life support intercept is increased by the fact that the vast majority of New York State ambulance service in rural areas is provided by volunteers. Under the current Medicare guideline, the only way intercept services may be covered is if the volunteer ambulance service who transports the patient bills for the service. The long history of volunteer ambulance service in New York State has established a community-supported system whose organizational culture cannot support billing. Many of these services are also volunteer fire department services that are prohibited from billing by State law.

The current Medicare policy fails to recognize the existence of a clear cost savings to the public and to Medicare provided by dedicated volunteers. If volunteers were to bill for their services, this would substantially increase billing to Medicare in New York State alone. It would be more logical to allow direct reimbursement of needed advanced life support care that volunteer services cannot always provide.

It is important to understand that while 70 to 90 percent of all emergency patients are adequately cared for by basic life support medical care typically provided by the volunteer ambulance, the critically ill patient is not. This is compounded in rural areas due to long transport time, where advanced life support can often maintain the life of the cardiac victim and other critically ill patients.

Additionally, a 1986 GAO report on emergency services quoted in Health People 2000 objectives states, "Although pre-hospital care provided by personnel trained in basic life support is adequate for most injuries, personnel trained in advanced life support is preferable for care of more severely injured patients."

In order to provide this appropriate level of care to the small percentage of patients that require it, a two-tiered system of response has developed in many parts of New York State. This system resolves around the dispatch of a community-based ambulance to the scene of an emergency and dual dispatch of advanced life support service. That dual dispatch is often provided by a commercial ambulance service based outside of the rural community that sends a paramedic to the emergency scene or meets the ambulance en route to the hospital. In either instance, the dispatch of the advanced care unit is dictated by precise medical protocol.

This model has proven effective not only in rural areas of New York State but also in many other States. It fosters the sharing of existing medical resources. It provides the capability to supply the appropriate level of care to the patient. In many instances, it may result in decreased medical care costs at the hospital or rehabilitation center because early appropriate medical intervention has limited the amount of damage to the body systems involved. It has proven to be a cost-effective model in the rural areas.

We understand that the general cost of this type of system cannot be supported by Medicare alone. In New York State, we have supported the provision of advanced life support care in rural communities by application of both State and Federal dollars to programs that develop rural health care networks, utilizing paramedic

"fly car" nontransporting services. We provide millions of dollars for free training to support the growth and development of advanced life support human resources in rural areas. However, the removal of Medicare payments can and will result in discontinuation of some intercept services which depend on a combination of financial resources to survive.

The continued provision of a high quality pre-hospital emergency medical response system designed to meet rural needs is crucial to the health care of rural communities as a whole. It is not only the elderly Medicare patient who will suffer if advanced life support service is not available. It is also the productive 50-year-old farmer who suffers a cardiac arrest and dies who could have received cardiac medications from the paramedic, the non-breathing child whose life is lost because no one trained to intubate was available, and the diabetic who lapses into a coma and suffers irreversible damage during the trip to the hospital when the simple injection of D–50 by a paramedic might well have revived the patient early and prevented significant damage or death.

In urban and many suburban areas of New York State, the population density results in a larger call volume that creates the financial incentive for an ambulance service to have trained paramedic staff to provide advanced life support care. The rural patient has the same health care needs and should be provided the same level of care. Failure to support financial incentives that will provide the rural patient the same health care as the urban patient will result in unnecessary loss of life in our rural communities.

One of the things we would like to ask in final is that this Committee, besides supporting this bill, works with members of the industry and in the affected States to attempt to work out a dialog with HCFA about its current policy to see if we can come to some sort of compromise and return to a policy where these types of services were paid for by Medicare in the past in rural areas. Thank you very much.

[The prepared statement follows:]

STATEMENT OF
EDWARD WRONSKI, DEPUTY DIRECTOR
BUREAU OF EMERGENCY MEDICAL SERVICES
NEW YORK STATE DEPARTMENT OF HEALTH

I would like to thank Chairman Thomas and the members of the Subcommittee on Health of the Committee on Ways and Means for inviting me to speak on this important issue that affects the quality of health care provided to all rural communities.

The Governor and the New York State Department of Health support the passage of HR1757, the **Community Ambulance Support Act of 1995** which amends title XVIII of the Social Security Act allowing coverage under part B of the Medicare program of paramedic intercept services provided in support of public, volunteer, or non-profit providers of ambulance services.

A change in interpretation of Medicare regulations disallows payment for advanced life support medical care provided by a non-transporting ambulance service to patients being transported by a basic life support ambulance service. This change has placed an economic strain on many advanced life support ambulance services which are continuing to provide this type of care when requested by their neighboring basic life support ambulance service. The change in policy has its most dramatic negative effect in rural areas of our state where cooperative sharing of this needed and scarce medical resource is most crucial.

The ability to provide prompt and effective medical care in an emergency is an accepted principle of any well designed emergency medical response system. In order to accomplish this, the system must be flexible in design and fit the needs and resource capabilities of the community it serves. **This includes the capability to provide advanced life support services to those patients whose medical condition warrant it.**

In the 1950s and 1960s the ability to provide advanced life support care would not have been so critical to a system, as prehospital medicine was essentially first aid with rapid transport to a hospital. Developments in the decades since then have brought medical techniques in advanced medicine into the back of the ambulance, including the treatment of cardiac patients, patients in respiratory distress, stroke victims and others where advanced life support can make a critical difference in their survival. Failure on our part to support the availability of advanced life support medical care in the rural areas of our country is not acceptable.

In many areas of the country, as in New York State, the ability of rural communities to support advanced life support ambulance service is severely limited by their local financial and human resources. It costs approximately one-third more to operate an advanced life support ambulance service than a basic life support ambulance service. There are also limited numbers of trained and experienced paramedics in rural areas to staff these services. The sharing of advanced life support personnel when needed, through an intercept system, has helped overcome this problem in many rural areas of New York State.

The negative financial impact of the current Medicare rule denying payment for advanced life support intercept is increased by the fact that the vast majority of New York State ambulance service in rural areas is provided by volunteers. Under the current Medicare guideline, the only way intercept services may be covered is if the volunteer ambulance service who transports the patient, bills for their service as well. The long history of volunteer ambulance service in New York State has established a community supported system whose organizational culture cannot support billing. Many of these services are also volunteer fire department services that are prohibited from billing by state law. While preventing selective billing is appropriate in most instances this policy fails to recognize the existence of a clear cost savings to the public and to medicare provided by dedicated volunteers. If volunteers were to bill for their services this would substantially increase billing to Medicare in New York State alone. It would be more logical to allow direct reimbursement of needed advanced life support care that volunteer services cannot always provide.

It's important to understand that while 70% to 90% of all emergency patients are adequately

cared for by the basic life support medical care typically provided by the volunteer ambulance, the critically ill patient is not. This is compounded in rural areas due to long transport time where advanced life support can often maintain the life of the cardiac victim and other critically ill patients. Additionally, a 1986 GAO report on emergency services, quoted in Healthy People 2000 objectives, states, "Although prehospital care provided by personnel trained in basic life support is adequate for most injuries, personnel trained in advanced live support is preferble for care of more severely injured patients."

In order to provide this appropriate level of care to the small percentage of patients that require it, a two-tiered system of response has developed in many parts of New York State. This system revolves around the dispatch of a community-based ambulance to the scene of an emergency and dual dispatch of advanced life support service. This is often provided by a commerical ambulance service based outside of the rural community that sends a paramedic to the emergency scene or meets the ambulance en route to the hospital. In either instance the dispatch of the advanced care unit is dictated by precise medical protocol.

This model has proven effective not only in rural areas of New York State but also in many other states. It fosters the sharing of existing medical resources. It provides the capability to supply the appropriate level of care to the patient. In many instances it may result in decreased medical care costs at the hospital or rehabilitation center because early appropriate medical intervention has limited the amount of damage to the body systems involved.

We understand that the general costs of this type of system cannot be supported by Medicare payments alone. In New York State we have supported the provision of advanced life support care in rural communities by application of both state and federal dollars to programs that develop rural health care networks utilizing paramedic "fly-car" non-transporting services. We provide millions of dollars for free training to support the growth and development of advanced life support human resources in rural areas. However, the removal of Medicare payments can and will result in discontinuation of some intercept services which depend on a combination of financial resources to survive.

The continued provision of a high quality prehospital emergency medical response system, designed to meet rural needs, is crucial to the health care of rural communities as a whole. It is not only the elderly Medicare patient who will suffer if advanced life support service is not available. It is also the productive fifty year old farmer who suffers a cardiac arrest and dies ,who could have received cardiac medications from a paramedic; the non-breathing child whose life is lost because no one trained to intubate was available and the diabetic who lapses into a coma and suffers irreversable damage during the trip to the hospital, when the simple injection of D-50 by a paramedic might well have revived the patient early and prevented significant damage or death.

In urban and many suburban areas of New York State, the population density results in a larger call volume that creates the financial incentive for an ambulance service to have trained paramedic staff to provide advanced life support care. The rural patient has the same health care needs and should be provided the same level of care. Failure to support financial incentives that will provide the rural patient the same health care as the urban patient, will result in unnecessary loss of life in our rural communities.

Thank you for the opportunity to speak to this issue.

Chairman THOMAS. Thank you, Mr. Wronski.

To what extent is this in essence a New York problem because of New York State law? I am trying to get a feel for not just the physical inability to get transportation and paramedics and the ambulance service, because we have all fought that, but structured as difficultly as yours. Dr. Mueller, have you looked at this in terms of a nationwide problem? Obviously, it is a New York problem.

Mr. MUELLER. No. I confess I have not.

Chairman THOMAS. Mr. Wronski, do you know of any other States that are in the same predicament you are by virtue of the State law?

Mr. WRONSKI. There are other volunteer States. Virginia, Pennsylvania has a large volunteer population. Connecticut has a large volunteer. New York State law only prohibits the volunteer fire department-based ambulance services from billing. The remainder, and there are hundreds of them in New York State in rural areas, are nonfire based, and I have to say this is also with the fire department-based services. There is a culture that they are unable to bill and they really do not want to and that really does affect New York and a number of other States that have large rural areas.

Chairman THOMAS. Mr. Nelson.

Mr. NELSON. Mr. Chairman, in my State of South Dakota, there are only two communities that are not completely voluntary. I am not sure how the South Dakota State law affects them, but I do know that is an additional State that is all voluntary.

Chairman THOMAS. Understanding they are voluntary, there may be a way to work it out. I do not know. I will have to look at this.

Mr. WRONSKI. It was paid for by Medicare, and then it was changed in a policy in June 1995, so——

Chairman THOMAS. There have been a number of changes in Medicare payment structure that have affected the rural areas. My concern always is, were they aware of it when they did it. Fortunately, oftentimes I have to believe they were not, that they have not thought through the ramifications of their changes.

Basically to all of you, but perhaps some individuals might want to respond on their particular concerns, Mr. Foster, I am familiar with your clinic, but common to all the rural areas is the profile of those physicians who are in the communities are aging rapidly. There is a difficulty in getting replacements. But just the ongoing recruitment of the work force, professionally trained in the rural areas, what have you folks done? What have you learned? What works?

Should we be tying loans, medical school payments, residency arrangements for service in underserved areas, or do those people come into an area somewhat resentful of the fact they have to be there by virtue of having received the largess and never ever blend and focus on the community as a potential permanent location?

Mr. MUELLER. I will begin to answer that. There are two levels of response there. One would be a short-term or immediate response and that would have to do with the National Health Service Corps and its ability to place providers in shortage areas now so

that where, say, a retirement might occur next year, the example that you illustrate, we can put someone in that community to continue the care.

A longer term solution has to do with what was discussed previously by Dr. Myers and others and that is reforming or changing the entire scheme we have in place to train health care professionals so that we utilize ambulatory training sites for graduate medical education residencies so that we have a greater emphasis on recruiting medical students from rural areas, train them in environments that show them the benefits of practicing in rural areas.

The third strategy has to do with how we pay for medical care, and that is on the reimbursement side. We have done a lot to equalize basic formulas in PVS and RBRVS and this Committee has been heavily involved in that. We continue to believe maintaining the bonus payments and even increasing those is helpful, and as we move toward different options in Medicare payment, we need to pay attention to making sure that is equitable in rural areas. As you just said a few moments ago, it is very easy to overlook that in the haste and in the anxiety of getting a formula right so that it affects the overall budget correctly.

So those are three strategies, one short term and two longer term. On the one on graduate medical education, there are examples around the country of programs like the WAMI Program in Washington, the program in Minnesota that have demonstrated successfully some strategies for convincing students to locate in rural areas.

Chairman THOMAS. Now that we have seen the Justice Department's willingness to rethink its antitrust provisions in a general sense, do you think it might make sense to examine the whole question of the rules on antitrust to carve out perhaps some special rules or a focus on rural arrangements?

I mean, we are very pleased that we got virtually 100 percent of the doctors, but I think the thing that sold the Justice Department was the 100 miles to any other acute facility and the entire community in support of it. Those may not be all in place in other areas where you could have other structures that would work, and it bothers me a little bit that the only way you can do this is to go and wait for the entire waiver process to be approved before you can move forward.

Is this an area we could focus on in terms of perhaps separate antitrust rules for rurals, or does it elevate itself to that level?

Mr. MUELLER. It is an area that we should focus on. The National Rural Health Association, for example, has endorsed Representative Hyde's legislation in this session of Congress dealing with that. I think at the beginning, again, sort of a two-level answer.

Level one, going to and using rule of reason rather than per se is a major, major step in the right direction, because, of course, we believe reasonable people would see the light in looking at rural arrangements. But second, anything we can do to create more flexibility for how we structure service delivery systems in rural areas is helpful and I think a focus through antitrust is needed to do that.

Chairman THOMAS. One of the provisions that was more controversial in the recent health insurance legislation was medical savings accounts. Is this something? Obviously waiting for HMOs or other structures to move into rural areas, sometimes it may be a long wait if we cannot speed up some of the antitrust provisions. Have any of you looked at MSAs as a potential possible structure that would have some positive aspect, or is this something that is primarily going to be useful in urban areas? Did anybody look at it that way yet?

Mr. NELSON. Yes. We certainly feel that it is a very important program that hopefully will become more than just a 750,000 policy trial basis and we could improve that, especially in rural areas, as you mentioned, where managed care is not an option and, frankly, in some areas might never be a viable option, that this is one way where we can help bring down our own health care costs. So, we are very excited about it and hopefully it will prove to be a very good program.

We have had an MSA-type program without the tax advantages since 1978 that we have offered as an endorsed health plan to our members and some other groups have, as well, and it has worked out very, very well. We just use——

Chairman THOMAS. Even without the tax advantages?

Mr. NELSON. Even without the tax benefits, and so with the tax benefits, we see this as a great possibility for expansion and offering it to more people. So, we think it really offers some help.

Chairman THOMAS. And working directly with the patient in terms of payment structure, that gives you a great degree of flexibility in terms of how you operate without having to have the bureaucracy dictate method of payment and prerequisites to payment?

Mr. NELSON. It certainly does, and also a great deal of choice, albeit a problem if you do not have the access, the choice is not important, but where you do have the doctors and clinics available, then the choice is important.

Chairman THOMAS. Just as an aside, Mr. Nelson, since one of the focuses and the concerns about MSAs was that it was the fear of giving people choice, because after all, if they get choice, they could make the wrong choice, that is, not spend the money. What has your experience been within the structure that you had? Do people seem to understand what their options are and do they shop value for money and, in fact, do they get it?

Mr. NELSON. I think so, but more importantly, I think they get quality health care from their choices that they make are for quality. The dangers that have been pointed out in adverse selection or in no care, ongoing care, I think those are dangers that have proved to be false, and hopefully, like I said, we could get some permanent legislation to offer this to everyone.

Chairman THOMAS. Any additional comments? If not, does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. Thank you, Mr. Chairman.

Thank you, gentlemen, for being here. It has been a wonderful display of information on care and looking over the next hill to see what is going to be needed here.

I think that Mr. Nelson, when you were talking about the change in the demographics of the rural areas, I really resonate with that, and particularly picking up on what Mr. Mueller was saying about telemedicine. I guess where I am coming from is that being a Representative of a rural area, I want to do everything possible to keep the medical service and facilities alive during this transitionary economic period in medicine. Where it is going, I do not know. But, it is so important that we take the "one-size-fits-all" concept, and throw that away because it does not work.

Tell me a little bit about telemedicine, if you will, Dr. Mueller. You really say that it is important that the government step in and help fund some of it. With the new telecommunications bill, do you think it will be possible to make this something where there will be an incentive privately to do this?

Mr. MUELLER. What the new telecommunications bill does for us is require that the service be made available equitably across all areas of the country, and by that, we mean laying the right telecommunication lines out so that you do not have problems—I know we do in the Western part of our State—of multiple companies, different lines that are not compatible, and so on. It will really help a lot to iron out those difficulties.

That needs to be combined with a strategy, then, to make that infrastructure useful for the delivery of medical care, which takes us to the issues of reimbursement being created for services delivered through telemedicine. It takes us to the issues of evaluation, so that we understand what is the best medical use of this technology that is cost effective so that we do not go down a path of having telemedicine be one more way of demanding that rural residents, in effect, receive their services from some distant urban area but that they receive services from the distant urban area that are only available in the urban site but now we can get the service through telecommunications to the residents where they live.

The example I gave in the testimony from the experience in Kearney, Nebraska, it has been saving people a round-trip driving time of 135 miles by using telemedicine to get their consultation done for behavioral health problems where they live rather than driving in to see the specialist.

So there are some reimbursement issues. There are some issues related to understanding how to use the technology, all of that built on top of what the Telecommunications Act does for us in getting the hardware or the communication line infrastructure available in rural areas.

Mr. HOUGHTON. Are there tax incentives? I can understand the Federal Government and its administrative departments allocating funds for something like this, but are there tax incentives which could be developed by this Congress which would further enhance and speed up the use of telemedicine?

Mr. MUELLER. I have not looked specifically into the use of tax incentives, Mr. Houghton, but it makes sense to look at that, particularly from the view of the providers at both ends of that telecommunication line. Are there ways using tax incentives to get them to utilize that system.

Mr. HOUGHTON. I know that the telecommunications revolution is sort of a two-edged sword. One, it is a tremendous job producer

and tends to link people all over the world. You do not have to live anyplace other than where you want.

However, at the same time, if education and medicine is taken away from those areas where people really want to live, then it does not make any sense at all and it just seems to me that the ability of a small medical unit, whatever you call it, to be able to link to the big research centers and to have instant access to that is really very, very exciting and would enhance much more than just the medical area but would have a real economic impact.

Mr. Chairman, I would like to submit, if it is all right with you, the testimony of two people from the area in which I live for the record.

Chairman THOMAS. Without objection.

Mr. HOUGHTON. They really are responsive and totally supportive of Mr. Wronski and the whole concept of life support systems and the "fly car" area.

[The following was subsequently received:]

Rural/Metro Medical Services

The premier provider of health and safety solutions.

TESTIMONY SUBMITTED FOR THE RURAL HEALTHCARE
HEARING SEPTEMBER 12, 1996
WASHINGTON, DC

SUBMITTED BY: ALAN D. LEWIS SR. GENERAL MANAGER
RURAL/METRO MEDICAL SERVICES
(SOUTHERN TIER)

SUBJECT: PARAMEDIC INTERCEPT (FLY-CAR) PROGRAM
REQUESTING MEDICARE FUNDING

SUBJECT: PARAMEDIC "EXPANDED SCOPE" INITIATIVE
REQUESTING MEDICARE FUNDING

Emergency Medical Services (EMS) has over the past two decades made tremendous advancements in the delivery of Quality Pre Hospital Patient Care.

The EMS system has progressed from the days of a horizontal taxi to a Definitive Care Emergency Department Response System.
Paramedics provide invasive care, administering medications, interpreting electrocardiography following Advanced Life Support (ALS), Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) Protocols.

With New York State being the third largest Rural Population in the Country. Many area's are without ALS services.
The Paramedic Fly-Car program as provided by EMS services from larger communities has reached out to Rural America by providing a non-transporting intercept vehicle equipped with a highly trained skill proficient paramedic and appropriate equipment needed to provide ALS as prescribed by local Pre Hospital Care Protocols.
While most rural areas are blessed with dedicated volunteer BLS services, they are very limited with sufficiently trained ALS providers.

The Fly-Car concept has developed a partnership between rural community volunteer Ambulance Corps and larger more sophistication EMS systems, thus creating a cost effective Two Tiered response system reducing mortality and morbidity in those areas.

Charter Member Southern Tier Regional E.M.S. Council
25 East Pulteney Street Corning, New York 14830
Phone (607) 936-4179 Fax (607) 936-0359

In the Southern Tier of New York State, and areas like Olean, Wallkill, and many others. The Paramedic Advanced Life Support (ALS) Fly-Car program has over the past decade made great strides to provide quality ALS to residents in rural communities.

In the Southern Tier specifically, most rural areas are provided ambulance service by Volunteer BLS services. Those Corps are very limited with sufficiently trained ALS providers.
Fly-Car units are strategically located in Corning, Bath and Wayland to respond and assist local volunteer ambulance corps with seriously ill and injured patients.

Over the past eight years we have provided ALS with Fly-Car units to the following Volunteer Ambulance Corps.

The Corning based Fly-Car provides ALS coverage for the following Volunteer Ambulance Corps:

Addison
Woodhull
Jasper
Tuscarora
Troupsburg

The Bath based Fly-Car provides ALS coverage to the following Volunteer Ambulance Corps:

Avoca
Bath
Wayne
Hammondsport
Cohocton
Wayland
Penn Yan
Pulteney
Prattsburg
Tyrone
Bradford

page three

The Wayland based Fly-Car provides ALS to the following Volunteer Ambulance Corps:

Dansville
Cuylerville
Dansville
Genesseo
Livonia
Lima
Mt.Morris
Nunda
Retsof
Springwater
Naples

reaching Across five counties twenty seven BLS Volunteer Ambulance Corps utilize three Fly-Car units to provide ALS to their community residents as prescribed by Protocols designed by the Southern tier Regional Emergency Medical Advisory Committee (REMAC).

Statistically at the three locations Volunteer Ambulance Corps utilize area Fly-Cars for approximately 15 to 20% of their total annual ambulance calls, which results in 1000 calls annually.
Medicare recipients constitute 55% of patients meeting the ALS protocol criteria to utilize Fly-Car services.

The two tiered system as developed for these rural communities is the most cost effective approach to the delivery of ALS. With the combination of free volunteer ambulance services and the fee of a ALS intercept Paramedic. The total charges remain far below that of proprietary service in nearby communities.

It is important to note that Medicare has recognized the advancement of ALS in Metropolitan, Urban and Suburban Communities with funding of ALS when provided by the transporting services. In many rural communities the availability of transporting ALS providers does not exist.

Unfortunately, Rural America volunteer resources have not and cannot provide The standard of pre hospital care more densely populated areas benefit from with local EMS resources.

Medicare should view the partnership between volunteer and proprietary services as a cost effective patient care delivery system savings to Medicare recipients. For the system to continue providing these services. Medicare must develop an equitable payment structure.

Legislative Changes Required

A. Modify Medicare Funding Regulations pertaining to Ambulance Transportation, to include reimbursement for quality two tiered BLS and ALS patient care services based on partnerships between local N.Y.S. Certified Volunteer, Municipal, and Proprietary Ambulance Services.
The partnership should allow for each provider of the two tiered system to bill Medicare for services rendered, filing under their individual Company Medicare Provider Number.
Further, Medicare should thoroughly review funding the proposed "Expansion of Scope" initiate being presented to fully utilize Paramedics in Rural communities as Physician extenders. The initiative is intended to reduce unnecessary ambulance transports and hospital emergency department visits.
Currently, Medicare will not reimburse Ambulance Service providers unless a actual transport is provided. The Expanded Scope of practice would enhance the Paramedics training level to properly assess the necessity of a ambulance transport, and refer certain patients to report to their physician at an appropriate time.
This iniative, if funded by Medicare will save money with the reduction of ambulance transports and emergency department visits.

There is definitely a pay back for these services in rural America. Not only are many lives saved by the partnership arrangement, many patients have reduced hospital stays (if even admitted) due to the definitive patient care provided by the Fly-Car Paramedics.

The situation is urgent, Paramedic intercept services are expensive to operate, but could be self supporting if Medicare updates the regulations to include Fly-Car Services. Failure of Medicare approved funding will eventually force EMS providers to withdraw their partnerships with rural Volunteer Ambulance Corps, and leave rural America without Advanced Life Support services.

It is the opinion of this writer that the current Medicare funding criteria is outdated, and discriminates against rural America, and if not changed, will result in the unnecessary loss of many lives.

Respectfully submitted,

Alan D. Lewis Sr.

New York State Ambulance Association, Inc.

793 State Street
Schenectady, NY 12307
(518)346-5060 Fax (518)374-8511

PRESIDENT
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DIRECTOR AT LARGE
Marvin Raidman

September 11, 1996

Congressman Amory Houghton, Jr.
U. S. House of Representatives
Washington, DC

Dear Congressman Houghton:

The New York State Ambulance Association is comprised of proprietary ambulance services from all regions of the State of New York.

At our annual meeting held on September 10, 1996, the Board of Directors and members unanimously agreed to support revised legislation that will enable two licensed ambulance providers to jointly provide Advanced Life Support services and ambulance transportation and for these services to be considered covered and reimbursable by Medicare.

We respectfully request that all administrative efforts be utilized in achieving this goal.

Thank you for your consideration of this matter.

Sincerely,

James P. McPartlon
President

TESTIMONY TO THE U.S. HOUSE OF REPRESENTATIVES
WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
HEARING ON RURAL HEALTH ISSUES
SEPTEMBER 12TH , 1996

SUBMITTED BY
WALTER L. REISNER, VICE PRESIDENT
TRANS AM AMBULANCE SERVICES, INC.
1658 OLEAN PORTVILLE ROAD
OLEAN, NEW YORK, 14760
716-372-5871

Implementation of the concept of using specially trained physician extenders to provide out of hospital advanced life support interventions in the emergency setting - paramedics - first began about 30 years ago. One of the first successful programs was developed in Elmira, NY. Economics did not allow this wonderful lifesaving concept, which was spawned in this rural city to flourish and spread throughout the other rural communities. Paramedic programs are expensive to start, and expensive to operate. It is an economic fact of life that any enterprise that is engaged in activities that cost money, needs to have a corresponding source of revenues to offset these costs. In upstate New York other than in the cities, population density is low. The Emergency Medical Services agencies that provide ambulance service in these areas are, as a rule, low volume, low budget providers. Economics dictates that these services can be provided most cost effectively by using volunteer staff. Consequently rural New York State' s Emergency Medical Services are provided primarily by volunteers. Recruiting these volunteers continues to be a major challenge. Accordingly these agencies do not provide service at the paramedic level, they provide service at the level of their volunteers. In Southwestern New York most volunteer ambulance service is provided by volunteer fire departments organized under the provisions of the State's General Municipal Law. This law prohibits them from charging their patients for ambulance service. Contrast this with paramedics who are highly skilled and highly trained health care professionals, who, as a rule, expect to be paid for their services and who may only practice under the supervision of a physician - medical control. Given the low call volume , the lack of medical control, and lack of a mechanism for compensation, significant rural paramedic systems did not develop because they were not economically feasible. Accordingly from the late 60's through the early 90's these services were generally not available in many rural areas of the state.

The need for paramedic level intervention in rural areas continues to exist as visually portrayed by the picture on the cover. The van hit an Amish buggy. The remains of the buggy are integrated into the wreckage of the van. The occupants of the buggy , three teenagers, were all thrown through the windshield of the van and critically injured. Extrication of the third victim from the wreckage took about 25 minutes. He then faced a 20 mile ambulance ride to the nearest emergency room. The Advanced life support intervention provided by our flycar medic contributed significantly to his survival.

The problem is not unique to New York. Rural residents nation wide continue to suffer from trauma as well as medical emergencies - heart attacks, strokes, diabetic emergencies, respiratory distress, seizures, and a host of other medical problems. Rural populations have higher accident rates. Farming is an extremely hazardous occupation, as is logging. These are rural activities. Additionally when a medical emergency occurs in a rural area which requires rapid ALS intervention, and the local squad does not have ALS staff, the length of time that the patient must go without ALS treatment, is a function of the distance to the emergency room. As more hospitals close or become Urgicare centers this distance is increasing. Sometimes this simply adds to the pain and suffering that the patient endures, in other situations, it results in the patients condition worsening with the worst outcome being death. The need for ALS in rural areas is self evident. Through the 80's this need remained unmet. The technology to meet the need existed. The personnel to do the job existed. The desire to provide the service existed. A reliable revenue stream to allow it to happen did not exist.

In the early 90's, an idea was developed which would generate a revenue stream that could support rural ALS paramedic systems. The concept was based upon the premise that prehospital paramedic intervention under the control of a physician is a form of healthcare, and as such should be covered by a patient's health insurance. This idea was supported by the fact that most health insurance's covered Paramedic level ambulance services, and reimbursed providers for their services. It seemed logical that a paramedic in a nontransporting intercept unit or flycar could assist a number of small volunteer units who otherwise could not have the service. Since the insurance carriers paid for transporting paramedic ambulance services, it also seemed logical that they would pay for a less expensive paramedic intercept which did not have the transportation charge built into it.

Depending on the area, one flycar can provide ALS coverage for 10 to 20 volunteer units. This cost effective approach to providing rural ALS was initially implemented in Southwestern New York by the Corning Ambulance Service. The concept was accepted by the medicare intermediary The Upstate Medicare Division of Blue Shield of Western New York. This acceptance was crucial: a.) because about half of the rural flycar patients are Medicare recipients, b.) other insurance carriers reimburse according to medicare guidelines. Now there was an economic incentive to provide the service.

The obvious need, coupled with an economic incentive to address it, lead to the development of a number of flycar systems in the region. By mid 1994 Flycar programs had been developed in Jamestown, Dunkirk, Salamanca, Olean, Bath, Wayland, Hornell, and Corning. There were plans to set up flycars to cover the northern areas in Cattaraugus County , as well as the northern and Western portions of Allegany County. But in June of 1995, The Upstate Medicare Division was instructed by HCFA that they could no longer cover "nontransporting" paramedic services billed by the providers. Only the transporting service or their billing agent could bill for ALS Ambulance services. This ruling has no positive effects, but the negative effects include the following:

1.) It negatively impacts the providers of flycar service by removing the reimbursement mechanism for them to be paid for providing the service.

2.) It negatively impacts the patient financially. These senior citizens, mostly on limited fixed incomes in our area, now have to pay for a service which was previously covered, and that people who happen to live in areas that have paramedic ambulance service receive as a covered medicare benefit.

3.) It negatively effects the health of some patients. Some patients find other inappropriate means of transportation to the hospital, rather than requesting a free ambulance that will call the flycar by protocol resulting in thier recieving a flycar bill.

4.) It negatively impacts the volunteer departments because it forces them to spend time and money analyzing how to meet the publics expectations of paramedic service if the more cost effective flycar programs die.

5.) It negatively impacts the Medicare system financially because it has encouraged squads that provided BLS ambulance service with out charge to Medicare or the patient, to reorganize and begin charging for all of their services.

6.) It negatively impacts the more than 40,000 people in Cattaraugus and Allegany counties, and I estimate millions nationwide, who do not yet have this service available, because it removes the economic incentive to provide it

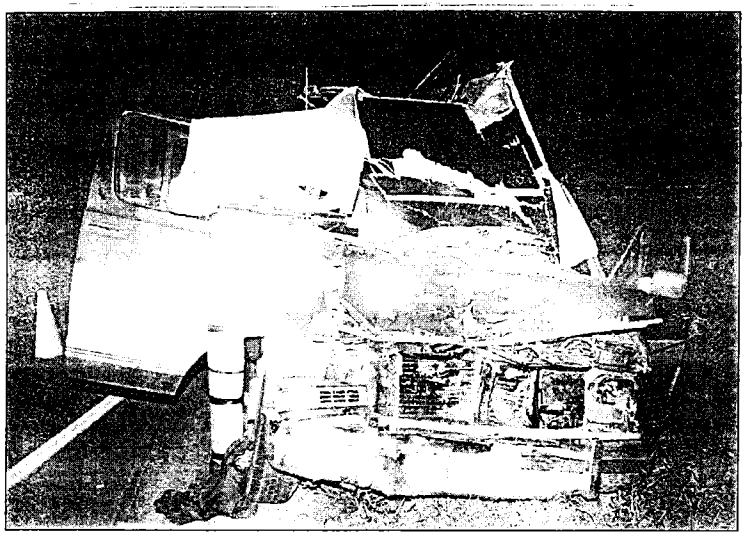
Today the need to provide fycar services continues to exist In fact recent closures and changes at small rural Hospitals enhance this need. HCFA has removed the economic incentive necessary for providers to step up and meet these needs. The flycar providers across the Southerntier, WCA Services Corp., Trans Am Ambulance Services Inc., and Rural Metro Corning continue to absorb these operating losses. We continue to provide flycar service to all who need it without regard for the patients ability to pay. Yet the fact of the matter is, since the service is not covered by medicare, most medicare patients can't afford to pay, and don't. We will not be able to continue to absorb these losses indefinitely. Without a Medicare reimbursement mechanism, some, if not all of these services face extinction. The senior citizens of our area should not be burdened with the total cost of their medically necessary flycar bills, while their urban counterparts get as this service as a covered Medicare benefit. It makes good sense to allow a needed and cost effective program to survive. We need your help so we may continue to provide rural residents with the level of prehospital health care that nonrural residents receive and which they all deserve.

I respectfully submitt the following suggestions for the Subcommittee's consideration:

1. Review the rationale for the HCFA order to no longer allow nontransporting flycar providers to bill for their services. If a HCFA rule change is possible ; consider this course of action as it applies to rural area flycar services, especially those involved in coordinated Rural Healthcare Networks.

2. If no HCFA consideration can be obtained and a legislative change is needed, develop legislation which will allow for medicare coverage of nontransporting flycar services provided in rural areas that are part of rural health care networks or other state defined criteria .

3. As medicare managed care programs are developed be sure that provisions for coverage of nontransporting flycar services are included for rural residents.



AMISH BUGGY VS VAN

The need for prehospital advanced life support (ALS) service appears obvious. This need seems even more obvious the further away from a hospital the emergency happens. A fair but flexible medicare reimbursement mechanism must be established to ensure prehospital ALS for the varying rural populations.

Mr. HOUGHTON. If I could just take a minute and try to spell this out, or ask you to spell it out for me a little more, what you are saying is the rural areas are different from the urban areas, but there is the same level of need. Therefore, it must be attacked differently. It would be nice if service A and service B and service C and service D could all be billed directly, but that is not the way it works, either practically or psychologically. So, you feel that what was taken away in 1985 from Medicare payments is a real detriment to the "fly car" or the life care system in the rural areas.

Do you want to spell that out a little more? I just want to cement it in my own mind.

Mr. WRONSKI. Sure. I would be happy to. You have summed it up well. What the change in policy really did was very simple. It said, we will not pay for a service which we have paid for in the urban areas and the suburban areas which we have identified as needed, which we have promoted in various pieces of literature that we support, and which the country basically has moved toward. That is advanced life support, early response for certain types of care.

But in the rural areas, because of, one, a lack of resources and trained personnel, and because in many States, because of volunteers who provide free services and do not have the administrative capability of handling billing—they literally take a cardboard box home with whatever paperwork they have to do, and often the person who is doing that is also the person who is responding to calls in the middle of the night. So, it is really an unfair burden on the volunteers to ask them to also be a billing agent for Medicare and for another service who is assisting them.

In New York State, as in other areas, this system really has been a cooperative effort by commercial services who have the trained people, who have their ambulances located within the small neighborhood, communities in the rural areas, but can provide a "fly car", and a "fly car" being simply usually a four-wheel-drive vehicle, and they put a paramedic in it with a bag and some drugs and that person can cover a much larger area and serve a variety of volunteer ambulance services.

In one area in New York State, and I believe it is the Corning System, they help provide ALS with a "fly car" system for 27 separate volunteer ambulance-covered communities. So when it is needed, the paramedic care is there and it makes a difference in a small percentage of patients.

Medicare used to pay for it. They will no longer pay for it and it has caused a real burden, and some of these systems are currently financially stressed to the point they may shut down, and that would end ALS service in parts of New York and in other States in this country.

Just as a final, I did, Chairman Thomas, speak to the president, the current president of the EMS State Directors Association and ask before I came here if this is a problem that the other States feel is there and is affecting them, and he very clearly said it is and he wanted copies of our testimony here and asked that we strongly support this.

Mr. HOUGHTON. As you know, Mr. Wronski, I am very partial to the State in which you live and represent, but I would imagine that

this service would be equally as important, not only in Corning, New York, but in Corning, California.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much. I would only say to the gentleman from New York, I think telemedicine also is an exciting area, but my concern is, as we are sometimes want to do in looking for the magic pill or the silver bullet, it makes enormous sense to me in an emergency situation, for diagnostic purposes, where time is critical, but I think one of our biggest problems, frankly, are GPs, prenatal care, gynecologists, simple dental, nutritional information that provides a quality of daily life improvement for a lot of these folk that we are really looking for, as well.

I have found around this place that if we do something like allow you to hook up by computer via satellite relay, we think we have taken care of rural health care problems because you can actually dial this number to determine whether or not the EKG is a concern.

So yes, we have to deal with this 21st century stuff, but we have to try to move what we know from the 20th century into all of America. My concern is we can never afford all of the equipment, but we are not talking about MRIs. I know my colleague from California talked about MRIs in local communities and that does not make sense, but I think we are talking about decent prenatal care and minimal dentistry, as well, and that is not being done.

Is that a fair statement to make?

Mr. WRONSKI. Yes.

Mr. HOUGHTON. Would the gentleman yield?

Chairman THOMAS. Certainly.

Mr. HOUGHTON. I think you are right. Obviously, the meat and potatoes of medicine will always be personal. It is a one on one. That is why you cannot get this tremendous productivity.

Chairman THOMAS. Or, if the gentleman will yield, as the current phrase is, they need "face time."

Mr. HOUGHTON. Face time, OK, but individual rather than TV face time.

Chairman THOMAS. That is correct.

Mr. HOUGHTON. But at the same time, I have seen in a little town called Cuba, New York, the connection between Buffalo Children's Hospital and it has really been breathtaking, because all of a sudden people feel that that hospital is needed because not only does it give it the face time service, but also it has access, which no other area does around there, to the best medical minds and the research going on.

Chairman THOMAS. I thank the gentleman, because these connections are important. As we move forward with antitrust reform and others, these what were initially telemetry links begin to develop into communicative links which develop into relationships which may, in fact, promote long-term structural changes, if we can make sure that the bureaucracy does not stand in the way. So the gentleman has a definite point.

I want to thank the panel very much. The Subcommittee hearing stands adjourned.

[Whereupon, at 12:33 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement for Printed Record of September 12, 1996 Hearing on Rural Health Care Issues

Submitted To: Subcommittee on Health of the Committee on Ways and Means

Submitted by: Representative Maurice D. Hinchey (NY-26)
Designated Representative: Kevin O'Connell

In December 1995 I was contacted by one of my constituents who had recently been rushed to the hospital with chest pains. He had telephoned 911 and a volunteer ambulance corps responded. As it was clear that the patient would require Advanced Life Support, a private ambulance company was also summoned since the volunteers are not qualified to provide this type of assistance. For the simple reason of geographic proximity, the volunteer ambulance was able to reach the patient much more quickly than would have been possible for the private company's Advanced Life Support (ALS) vehicle.

The volunteers placed the patient in their ambulance and began the trip to the nearest hospital. On the way, they were met by the ALS paramedics. Following the standard (and safest) procedure, one paramedic boarded the volunteer ambulance with the necessary equipment and provided Advanced Life Support for the remainder of the trip. Thanks largely to the combined efforts of the volunteers and professionals, my constituent survived the trip to the hospital, eventually recovered and returned home.

Not long after, he received a bill from the paramedic company for $360. Medicare would not pay the bill; nor would my constituent's supplemental insurance carrier. This is why I was contacted. I soon learned a great deal about the circumstances which had led to this unfortunate predicament.

Prior to 1995, the Health Care Financing Administration's (HCFA) Region II office in New York had routinely allowed this type of claim. Then in May 1995, the Corning Ambulance Company in Corning, New York received a letter from HCFA advising of a "change in policy that affects companies... which supply ALS personnel to a volunteer ambulance." The letter went on to say that because ambulance services are defined in Medicare regulations as "transportation by means of an ambulance" and because Medicare does not have a separate "paramedic" benefit, this type of service will no longer be covered.

This letter quickly circulated among the other ambulance companies in the state and soon the practice of submitting ALS intercept claims to Medicare stopped. The paramedic companies were forced to bill the patients directly.

I contacted HCFA to determine whether or not it had any discretion to reverse this change in policy. HCFA responded that, although Medicare provides for an increased amount of reimbursement when a transporting ambulance also provides Advanced Life Support, there is no statutory basis for the issuance of Medicare checks to paramedic intercept providers.

This policy change has resulted in some absurd inconsistencies in Medicare's payment practices. Consider the following three scenarios:

1) As in the case described above, a volunteer, or Basic Life Support (BLS), ambulance reaches the patient first, which is usually the case in rural areas, and administers Basic Life Support. An ALS vehicle meets the BLS vehicle on the way to the hospital and the ALS paramedic boards the BLS vehicle and administers Advanced Life Support. Medicare will not pay its 80% share of the $360 charged by the ALS company.

2) In the same situation, instead of having the paramedic board the BLS vehicle, the patient, on the side of the road or in a parking lot, is transferred to the ALS vehicle and receives Advanced Life Support from the same paramedic with the same equipment as in the first scenario. Medicare pays 80% of the ALS company's $470 bill.

3) Instead of calling 911, the patient calls the ALS company directly, waits longer for it to arrive, and then, if still

alive, receives Advanced Life Support from the same personnel with the same equipment. Medicare pays 80% of the $470 bill.

Several more constituents have contacted me about this problem since that first call in December. Numerous articles and editorials have appeared in local newspapers and magazines. The subject has also been discussed at length at meetings of senior citizens and volunteer ambulance companies. I am deeply concerned by what might happen as more and more of my elderly constituents, living on small, fixed incomes, become familiar with this problem. It would take little imagination to envision a case of a senior citizen having a medical emergency and deciding to avoid the $360 bill by either calling the ALS company directly and waiting for it to arrive, or worse, attempting to transport him or herself to the hospital. In fact, it is not a question of whether or not this will ever happen, but rather how often and at the cost of how many lives.

HCFA has repeatedly suggested that the volunteer companies enter into some sort of arrangement with the professional companies whereby the volunteers would bill Medicare and reimburse the professionals. For several reasons, this is not an acceptable solution. First, as demonstrated by the three scenarios described above, it would be significantly more costly than simply adding a Medicare billing category for ALS Intercept. Second, many of the volunteer companies in New York State are prohibited from billing. Third, those that could make arrangements to bill would probably have to start billing for all services to recover the cost of the additional apparatus that would have to be put in place to manage the billing process. Fourth, it likely that if volunteer companies began billing patients at all, even if just to pass the checks on to ALS companies, misunderstanding on the part of the public would lead to a drastic reduction in donations. Ultimately this could put the volunteer companies out of business. I again refer to the three scenarios described above to make the point that the demise of the volunteer ambulance companies would be quite costly to Medicare. It would be infinitely more costly in loss of human life.

I have cosponsored legislation introduced in the 104th Congress by Rep. Rosa DeLauro (HR 1757) which would correct this foolish policy and provide HCFA with the statutory basis to cover ALS Intercept. I am aware that this legislation has been introduced in previous Congresses, but has never made it out of committee. I urge the Subcommittee to look beyond the short term cost of this measure and see the long term gain, in both monetary and human terms.

Jim Ramstad, M.C.

Committee of Ways and Means
Subcommittee on Health
Rural Health Care Hearing
Thursday, 12 September 1996

Chairman Thomas, I appreciate this opportunity to share some of my thoughts on health care. I commend you for highlighting a challenge to our American health care system -- access to affordable, quality health care in rural communities. However, let's face it, the challenges discussed here today are not uniquely or solely rural concerns.

The western suburbs of Minneapolis do not conjure up pictures of Norman Rockwell's rural America, but there are some commonalities in terms of health care. Many of the issues to be raised at this hearing have a broader impact on the delivery of health care throughout Minnesota and ultimately to the health and well-being of our nation's health care system.

Mr. Chairman, before delving into my statement, I want to salute one of today's witnesses, my good friend and colleague from western Wisconsin, Steve Gunderson. I commend him for his tireless commitment to improving access to and delivery of quality health care in rural communities. During this Congress, as Co-chair of the Rural Health Care Coalition, Steve has literally taken the "bull by the horns" to respond to a variety of health care issues. One of these issues, however, which knows no distinct, definable boundary and is of great importance to Medicare beneficiaries and health care providers in my district is reforming the payment for Medicare risk-based managed care plans.

Currently, Medicare payments to risk-based health care plans are calculated on the basis of Medicare spending in each county's fee-for-service sector -- medical care outside of managed care plans. The variation in adjusted average per capita cost [AAPCC] formula reflects different utilization of health care services.

Dr. John E. Wennberg, Director of the Center for the Evaluative Clinical Studies at the Dartmouth Medical School recently published *The Dartmouth Atlas of Health Care.* The Atlas definitely documents that the rates of hospital beds and physicians per 1,000 residents determines how much care Medicare beneficiaries use. Revising the highly variable AAPCC payment formula will result in greater equity for Medicare beneficiaries regardless of where they live, allowing choices among plans and more equitable distribution of out of pocket costs and additional benefit packages.

Because of the need to correct the inequity in the AAPCC payment formula for millions of Medicare beneficiaries, I strongly supported changes to the formula during Ways and Means Committee consideration of the Medicare Preservation Act. Regrettably, progress made by this Congress to reform our Medicare program, including the geographic disparity and inequities in the AAPCC formula, was vetoed by the President.

Since that time, I have continued to be concerned about this issue and am an original cosponsor of H.R. 3753, the Rural Health Improvement Act, legislation incorporating a number of rural health care reforms including improvements to the AAPCC payment formula.

Title I of this legislation narrows the AAPCC payment gap between rural and urban areas by ending the practice of basing the formula on utilization rates, and it does so in a budget neutral fashion. At a minimum a county would receive 80 percent of the national input-price-adjusted capitation rate. This change helps reflect the true cost of doing business -- uncontrollable factors, such a wage rates or supply costs. The language also implements a three year average for the baseline rather than one year, which was in the *Balanced Budget Act of 1995.* This change gives greater representation of historical health care costs for an area. This provision of H.R. 3753 is based on the Physician Payment Review Commission's *1996 Annual Report to Congress.*

Realizing reforms to the AAPCC formula are not doable in the remaining days of this Congress, it is helpful to know where the debate will begin in the 105th Congress.

About a week before this hearing, the Health Care Financing Administration [HCFA] released the 1997 payment rates for Medicare Managed Care Plans. What HCFA told us was nationally Medicare risk payments will increase an **average** of 5.9 percent as of January 1, 1997 -- lower than the 1996 national **average** increase of 10.1 percent.

In terms of the solvency of the Medicare Trust Fund this is good news -- slowing the growth of Medicare. The bad news is that this average increase reflects wide variation in percentage increases from county to county. Four counties actually will receive **negative** percentage decreases. Because of actual dollar variations are also extreme, many low payment areas get a double whammy -- lower percentage increases off of a lower base.

This situation continues a trend which is inherent in the flawed formula. The table below illustrates the vast variation between counties across the country. I believe it is important to point out that even through the 1996 AAPCC payment increased an **average** of 10.1 percent, not all counties shared in the bounty of that increase. Counties that typically "lost" ground were those in efficient markets and rural counties with historically lower reimbursement rates. Because of these lower rates and lower annual increases these regions will continue to lack the ability to attract managed care options to their area or offer enhanced health care benefits often found in higher payment communities.

Monthly Payments Rates to Medicare Managed Care Plans						
Area/County	1995 Payment	1995 % Increase	1996 Payment	1996 % Increase	1997 Payment	1997 % Increase
National Average	$400.52	5.9	$440.90	10.1	$466.95	5.9
Richmond, NY	668.48	6.2	758.53	13.4	767.35	1.1
Kern, CA	439.15	5.8	478.33	8.9	512.08	7.0
Hennepin, MN	359.33	2.0	386.77	7.6	405.63	4.8
Tulare, CA	333.96	2.9	360.38	7.9	390.78	8.4
Vernon, WI	209.28	6.6	237.09	13.2	250.30	5.5

The payment figures also illustrate the overall instability and unpredictability of AAPCCs -- factors that discourage health plans from entering new markets and remaining in other markets.

If there is a silver lining to HCFA's release of the 1997 risk-based managed care payment rates was in Dr. Vladeck's remarks:

> The formula used to set HMO payment rates is flawed. It shortchanges rural areas and markets where care is delivered more efficiently, and may limit beneficiary choice.

Dr. Vladeck's comments indicate HCFA's understanding of the inequity in the current AAPCC formula and the need for change if we are to offer all Medicare beneficiaries true choices in the type and form of health care they want to receive. I see this as a signal in the future we can work in a bipartisan, pragmatic way to improve the AAPCC payment formula.

Mr. Chairman, correcting the AAPCC payment formula is vital. In this Congress, we have come a long way to improve our understanding the many dimensions of the AAPCC payment issue and the need to make the formula more equitable. I look forward to working with you in the future to make the needed changes to the AAPCC formula. The longer we continue to use our current formula, the longer efficient health care markets will be penalized and rural areas will lag behind leaving Medicare beneficiaries with fewer choices.

STATEMENT BY REP. PAT ROBERTS
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
RURAL HEALTH CARE ISSUES
9/12/96

Mr. Chairman, I thank you for holding this important hearing today to discuss federal programs and demonstrations created to address the special needs of rural communities. We in rural America face unique barriers to receiving high quality health care services. Many rural Americans must overcome vast distances and geographical barriers in order to visit health care providers. In addition, communities have a difficult time attracting and retaining health care providers and hospitals generally face lower reimbursement rates.

I strongly support the Essential Access Community Hospital/Rural Primary Care Hospital program. In Kansas, seven EACHs support ten RPCHs in seven rural health networks. Three additional RPCHs are going through the certification process; four more are actively considering the option. I strongly urge my colleagues to read the testimony submitted by the Hays Medical Center regarding the EACH/RPCH network established in this largely rural area. This testimony is an excellent example of strategies that are working to improve the health care services in rural and underserved areas.

In addition, I thank my colleagues, Rep. Steve Gunderson and Rep. Glenn Poshard, co-chairs of the House Rural Health Care Coalition, for their leadership, hard work and dedication to the improvement of health care services in rural America. I look forward to working together with members of the Rural Health Care Coalition and the Ways and Means Committee to pass legislation to improve rural health care.

Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) Rural Health Network

Northwest Kansas Health Alliance

Prepared by
Hays Medical Center
Hays, Kansas

SAVE THE ESSENTIAL ACCESS COMMUNITY HOSPITAL/
RURAL PRIMARY CARE HOSPITAL (EACH/RPCH)
PROGRAM

PROPOSAL
July 1, 1995

Protecting Medicare requires change for everyone. For Medicare providers, the challenge is to maintain quality patient care while reducing the cost of providing service. In urban areas, this can be accomplished through the institution of appropriate managed care practices already successful in the private sector. In rural areas, healthcare networks must be formed to provide an organized, cost effective system of service throughout an entire region. In this manner, primary care is provided in rural communities and supported by a secondary hospital through telecommunications and a predetermined system of care.

Many rural hospitals are heavily dependent on the Medicare program, which does not cover the full cost of providing service. Medicare losses in these rural communities are currently subsidized through local taxes. At the same time, it is generally more expensive to provide essential medical services in a rural area than an urban. For example, recruitment and retention of the necessary professionals such as physicians, physical therapists and registered nurses is significantly more difficult without an available labor pool. Rural hospitals lack the economies of scale necessary to purchase supplies and equipment, and to maintain the technology necessary to meet medical standards.

When essential health services are not available or adequately coordinated, Medicare beneficiaries are denied early diagnosis and treatment, and ultimately Medicare program costs are increased as more extensive and expensive intervention is required elsewhere. Without a transition to a more efficient regional health system, the proposed cuts will close many rural hospitals, jeopardizing the very existence of small towns. A hospital is often times a rural community's largest employer, and critical in maintaining both population and local business.

Due to this rural dependency on Medicare, a program providing funds to develop and operate regional rural networks is critical. The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) initiative is a strong example of such a program. Care coordination between a primary and secondary hospital, utilizing advances in tele-communication, will ensure quality and be cost justifiable in the long term. If cuts are made without providing for this system, Medicare program costs may in fact rise. Careful planning is needed to prevent a future rural health care crisis.

Rural Medicare beneficiaries in the seven EACH/RPCH states are now beginning to receive the benefit of a regional rural medical care delivery system through the program's two components. The grant program has met its objectives, providing seed money for the development of network structure. The operating component should be maintained, throughout any changes in Medicare, to keep progress moving forward.

One of the best examples of a regional rural healthcare network, sponsored by the EACH/RPCH program, is saving costs and improving quality patient care in Northwest Kansas. In an unprecidented move, the National Rural Health Association recently recognized the Kansas EACH/RPCH program as the 1995 recipient of the Outstanding Rural Health Program Award for coordination, networking, innovation and lasting impact. Within Kansas, the most developed EACH/RPCH network is the Northwest Kansas Health Alliance. Hays Medical Center is the designated EACH facility for this region. Grisell Memorial, Ransom, is designated the Rural Primary Care Hospital and Rawlins County Hospital, Atwood, has completed the application process. There are 40 other hospitals that are collaborating with Hays Medical Center across the region.

As an EACH facility, Hays Medical Center began to receive additional Medicare funding under the sole community provider formula in October, 1993. Prior to that designation, Hays Medical Center experienced significant difficulties and was forced to layoff 15% of its workforce following the sunset of Medicare Dependent legislation. During this era, the Medical Center also lost nearly 50% of the active Medical Staff. By the spring of 1993, only one family practitioner was providing service in a community of nearly 20,000 people. At that time, a local poll identified the number one social problem as access to medical care.

The EACH/RPCH grant funds provided Hays Medical Center the opportunity to conduct a long range strategic planning process, creating a vision of rural health networking for Northwest Kansas. In this network, primary care would be provided by not-for-profit community providers in rural communities. Secondary care, including specialized surgery, emergency care and diagnostic imaging services, would be provided by Hays Medical Center. Tertiary care services involving subspecialists would be provided through KU Medical Center in Kansas City and through agreements with not-for-profit community hospitals in Wichita.

This rural health system would be supported by telecommunications, information systems linkage and a patient transportation system. In addition, the plan would be supported by speciality clinic visits to rural areas, transfer agreements and mobile technology services.

The strategic planning process underscored serious problems in recruitment and retention of physicians and healthcare specialists. Several rural hospitals in the service area were operating at a deficit, some relying on no fund warrants to keep the doors open. There was poor coordination of service, with little communication

between providers. Transportation of patients was available mainly through volunteer ambulance services, and the urban provider planned to remove air ambulance service.

With the approval of EACH status, Hays Medical Center officials went to work implementing a regional medical network. In the last two years, the following has been accomplished:

- A 24-hour regional emergency center staffed by physicians, providing rapid emergency support region wide.

- A center for telemedicine, providing specialty consults for patients, vacation relief to rural physicians, continuing medical education, and service coordination between providers.

- Recruitment of 30 primary care and specialty physicians, resulting in national recognition as turnaround of the year by the National Association of Medical Care Recruiters. Specialists recruited to meet documented regional health needs included: orthopedic surgery, radiation oncology, medical oncology/hematology, family practice, physical medicine and rehabilitation, neurology, geriatric and adolescent psychiatry, internal medicine, pediatrics, and emergency medicine. One fourth of the active Medical Staff has been recruited due to the EACH/RPCH program.

- Teleradiology equipment installation in eight hospitals, providing the timely interpretation of results and a significant improvement in rural patient care.

- Mobile technology expansion including mobile CT scanner, mobile mammography and mobile sonogram units.

- An air ambulance, provided through unique partnership, now services the region. Flight nurses and paramedic staff work in emergency and intensive care units while not in the air, thereby reducing service costs.

- Major capital equipment expenditures were made in critical areas including surgery, intensive care, and radiology. A cardiac cath lab plan is now underway as several Northwest Kansas counties exhibit three to four times the national average of cardiac related mortality and morbidity.

- A 37 hospital rural medical information network entitled the High Plains Medical Information System now exists, and with upgrading will soon provide state-of-the-art programming to rural hospitals and physician clinics. Plans include development of a virtual medical center linking remote professionals with clinical support resources.

- Assistance in integrated community planning with administrators, public health officials, and county commissioners is further coordinating rural health services.

- Four rural health clinics have been established in the service area and shared staffing programs, providing professional education and vacation relief to rural hospitals, have been successful.

- Biomedical engineers in Hays service x-ray and other clinical equipment at 41 regional healthcare facilities.

- Expansion of a network of visiting physician clinics, both from Hays and KU Medical Center, bring needed subspecialists to service the region.

- Ongoing development of a primary care physician network, with physician practices receiving EACH facility financial and clinical support. HMC's Office of Rural Health was created through EACH/RPCH to identify and meet the needs of rural hospitals and physicians. This office is currently providing emergency assistance to a community which recently lost its hospital in a hailstorm.

- Expansion of home health services including rural satellite offices, and one of the nation's first home health telemedicine programs, providing care at less than 1/6 standard costs.

- Network participants have been afforded introduction to the latest in healthcare systems development including collaborative pathways and continuous quality improvement workshops, professional staff and department manager exchanges, and shared staffing arrangements. Provision of traditionally expensive professional consultation services, such as dietary and physical therapy, are also improving both healthcare efficiency and patient care.

- Plans are underway to develop a managed care system for Medicare beneficiaries encouraging wellness, prevention and early diagnosis of disease.

The EACH/RPCH network is successfully collaborating with other rural health entities including the Great Plains Health Alliance, a rural healthcare management organization, and Med-Op, a rural hospital cooperative. Our vision is to include the physicians as leaders in a healthcare network for the Northwest Kansas region.

There are many anecdotal stories regarding lives saved, cancers detected in time, and babies born early but treated at less expensive, local facilities. Our rural doctors are no longer alone and are receiving specialty support, continued medical education and vacation relief. We believe the EACH/RPCH network will continue to encourage physicians to locate to our area and spend their years serving an appreciative community.

Like most rural communities, as we look to the future we see a significant increase in the portion of elderly residing in our counties. We believe through proper healthcare planning and the applicable use of technology, these elderly citizens can enjoy a secure and healthy retirement in the communities that they help to build and maintain.

The EACH/RPCH program is working very well in Northwest Kansas, offering a responsible vision for the future. The alternative is closed hospitals, disorganized care and an alienated population. The rural hospital of the future will no longer be a full service acute care facility. It will be a primary care facility, linked in partnership with a full service secondary care hospital and networked through shared planning services and technology. The incentive to become a rural primary care hospital should be cost reimbursement from Medicare. The incentive to develop appropriate services to support a regional health network should remain EACH Medicare funding. Without it, secondary hospitals will be forced to focus solely on the needs of their immediate communities, jeopardizing the future of rural healthcare networks.

We are urging the following legislative action:

1) Support legislation which will grandfather in existing EACH/RPCH Medicare reimbursement status for existing networks.

2) Protect Rural Essential Access Community Hospitals which are utilizing reimbursements to improve the efficiency of the rural health care delivery system itself.

3) Support action on the Senate spending bill which would restore funding to the Federal Office of Rural Health Policy and the State Offices of Rural Health.

It is only together that rural healthcare facilities can remain viable. The EACH/RPCH program, appropriately funded, provides the infrastructure to create networks that will assure rural healthcare for generations to come.
If you have questions regarding the Northwest Kansas EACH/RPCH program, please contact:

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Hays Medical Center
2220 Canterbury
Hays, KS 67601
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MEDICARE SUBVENTION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

SEPTEMBER 17, 1996

Serial 104–81

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MEDICARE SUBVENTION

TUESDAY, SEPTEMBER 17, 1996

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

The Subcommittee met, pursuant to notice, at 2:13 p.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
September 13, 1996
No. HL-24

CONTACT: (202) 225-3943

Thomas Announces Hearing On Medicare Subvention

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 Medicare subvention. **The hearing will take place on Tuesday, September 17, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.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 and for inclusion in the printed record of the hearing.

BACKGROUND:

The Health Care Financing Administration and the Department of Defense (DoD) have developed an agreement to coordinate the Medicare program and the military health care services system in a three-year demonstration of Medicare subvention. The demonstration would involve dual-eligible beneficiaries (military retired personnel and their family members and survivors who are also eligible for the Medicare program). Under this arrangement, the Medicare program would treat the DoD and its Military Health Services System as a risk-type health maintenance organization for the dual-eligible Medicare\DoD beneficiaries. The DoD would continue to maintain its current level of effort in terms of financial commitment to caring for the dual eligible population. Medicare would pay for dual-eligibles receiving care from the DoD managed care program above the DoD's current level of effort. The demonstration would take place over three years in selected geographic sites in Washington State and Texas (including the Tacoma-Seattle and San Antonio areas). Approximately 60,000 dual-eligible beneficiaries live in these sites.

In addition, H.R. 3142, the "Uniformed Services Medicare Subvention Demonstration Project Act" would establish a demonstration project to allow the DoD to receive Medicare capitated payments for health care coverage provided to Medicare-eligible military beneficiaries under the TRICARE program. The bill, as introduced, was referred to the Committee on Ways and Means, and in addition, to the Committees on Commerce and National Security. The National Security Committee recently considered the legislation.

FOCUS OF THE HEARING:

The hearing will focus on issues surrounding the establishment of a Medicare demonstration program on subvention, and the implications of such a demonstration.

(MORE)

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, October 1, 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 on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/' or over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. Good afternoon. Today's hearing will focus on the proposed demonstration for Medicare for military retirees. We are also going to examine the question of expansion to veterans.

The Medicare subvention proposal would authorize the Department of Defense and the Department of Health and Human Services to conduct a 3-year demonstration project that will provide certain military retirees the option to use their Medicare benefits to join a Defense Department-sponsored health maintenance organization, I believe, called TRICARE.

In other words, Medicare would begin to pay premiums to the Department of Defense for the medical coverage of military retirees.

The legislative goal of both departments is to provide better care for military retirees and their eligible dependents without increasing Medicare's costs.

Some believe the proposal will actually reduce Medicare expenditures. However, the CBO has estimated the program will cost $200 million a year.

The Medicare Board of Trustees tells us that the Part A Trust Fund will be exhausted in 2001. Based upon all of the data that we have seen on snapshots on year to date and the July funding, that date may in fact move to the year 2000 or earlier.

It concerns me that we may be placing additional costs and burdens on the part of the Medicare Part A Trust Fund. If it can be shown that CBO is wrong, I am all for giving beneficiaries more choices. After all, that was one of the main thrusts of our proposal in restructuring Medicare to provide options to beneficiaries. My concern is that we were dealing primarily with the private sector where cost factors are on the surface and broken down, especially in the private sector in the business arrangement. We may not be able to get complete cost center data for the Department of Defense that would create a comfort level.

The last thing we want to do—at least the last thing I want to do—is to simply use Medicare to prop up military treatment facilities that are already funded through appropriations, or to provide funds as the CBO indicated where the Department of Defense through this demonstration project would be supplied money that may or may not be used for health care.

I look forward to hearing from Dr. Vladeck, Administrator of HFCA, and Dr. Stephen Joseph, the Assistant Secretary of Defense for Health Affairs on these important issues.

In front of me is the Chairman of the Veterans' Affairs Committee, Bob Stump of Arizona, and Ranking Member, Sonny Montgomery. They have a proposal to establish the same type of demonstration project that would require Medicare reimbursement for health care services to certain Medicare eligible veterans.

This proposal opens up a whole host of issues because of the very nature of how health care is delivered to veterans. I look forward to their testimony, and frankly, I am very pleased, although it is at a time late in this session, that we are finally beginning to look at these government health programs and at the concern that every World War II veteran is now Medicare eligible. All of us agree that bricks and mortar is not something that the Veterans Administration is going to be heavily into, and as the Department

of Defense carries out a significant medical program for not just military retirees but their dependents as well, the integration in some way of all of these programs needs to be in our thinking as we examine Medicare for the larger population as well.

So I would turn to my Ranking Member, the gentleman from California, for any opening statement he might make.

Mr. STARK. Thank you, Mr. Chairman. Thank you, for holding this hearing. My questions, or my concerns, deal with how this demonstration can ensure quality for our retired servicepersons, and I want to make sure that the military and veterans hospitals stay current with the latest quality standards, and that they allow access to a full range of centers of excellence. I also worry that in this expansion, for example, what would happen to the beneficiaries that I know my distinguished colleagues Mr. Stump and Mr. Montgomery will suggest, who could use their Medicare go to veterans hospitals, what if they gave up Medigap policies, and then wanted to return, or moved? How would they get back into a Medigap policy at a reasonable price without waiving preexisting conditions? It is one thing to move people into a program, but people do change their mind, or move, or veterans hospitals have been known to close. What do you do then if the person has relied on the veterans hospital treatment and cannot get back into the AARP Medigap policy, and really then is at risk for the 20-percent copays. This could really shove them over into a Medicaid problem.

I am somewhat reluctant to get started into something like that until we make sure that we have covered all the bases for the people who are coming into it.

Just for example, it is my understanding that we now pay about $150 million a year for 60,000 retirees. That is $2,500 a head. You can buy the best Medigap policy in the country for $1,500 a year, which gives you pharmaceuticals, and care in Europe if you happen to be traveling, and everything you could want. We would save $60 million a year if we just went out and bought them a Medigap policy.

Now, you have to tell me that they are getting $1,000 a year worth of something that we should not give to private insurers for the same thing.

I think there are a lot of unanswered questions that could work to the disadvantage of the broad population of military retirees, if we do not make sure that this all fits together smoothly. Each group does what they do best. And I look forward to hearing the testimony of our distinguished colleagues in HCFA and in the Department of Defense as we wind through all this.

Thank you.

Chairman THOMAS. Thank you.

Mr. Chairman, Ranking Member, we have your written testimony. It will be made a part of the record, and you may inform us in any way you see fit about your idea and where you think the veterans and Medicare ought to go.

STATEMENT OF HON. BOB STUMP, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. STUMP. Thank you, Mr. Chairman.

With your permission, I will summarize my statement.

Mr. Chairman, let me first thank you for holding this hearing on Medicare subvention. It is something that a lot of us have been working toward for a long time.

Last week as you stated, the National Security Committee did mark up H.R. 3142. Mr. Montgomery and I had an amendment that we were prepared to try to attach to that bill which eventually passed the Committee by unanimous vote. But after some persuasive arguments from Mr. Hefley, we decided perhaps it was best for us to go our own route. We in turn, introduced a freestanding bill which is H.R. 4068, which we will mark up tomorrow in the VA Committee.

Since your Committee has primary jurisdiction over these matters, we wanted to call our bill to your attention. We appear today, on behalf of H.R. 4068, and on the DOD subvention bill, H.R. 3142.

Ours is quite similar, Mr. Chairman. It would establish a 3-year demonstration project for Medicare subvention for the Department of Veterans Affairs. It is very similar in policy and scope to H.R. 3142 and contains the same cost containment provisions that are part of H.R. 3142.

It calls for the Department of Veterans Affairs and the Department of Health and Human Services to establish a demonstration project under which the VA would collect and retain Medicare payments for Medicare eligible veterans. This project would operate over a 3-year period for approximately 30 VA medical centers selected by the Secretary of Veterans Affairs. To ensure cost neutrality, the Health Care Finance Administration would reimburse the VA at only 93 percent of the adjusted per capita cost.

VA would receive reimbursement only for new users, those Medicare eligible veterans not currently being treated by the VA. These are veterans who most likely fall below the disability level of 50 percent, and above the poverty level which is roughly $21,000. We are talking about new users.

We have been moving aggressively in this direction on the VA Committee. We have already passed H.R. 3118, which mandates that the VA offer more outpatient care, trying to get away from costly inpatient care.

CBO stated that this bill would cost a fantastic sum of money, and to answer that, we agreed to cap our cost on H.R. 3118. We have also agreed to do this, as I believe I am correct in saying that the DOD bill has already been capped at $65 million. Mr. Stark mentioned the cost of CBO was in the neighborhood of $200 million. And I believe the bill that covers DOD has already agreed to a cap at a cost of $65 million.

We are sure that eligibility reform will work. We have argued for a long time that we can treat many people for less money if we can get away from this archaic business of having to hospitalize everyone to treat them. It is my opinion that we should never build another VA hospital bed in this country. We have ample, though there may be exceptions in the Sun Belt.

With regard to outpatient care, we are in a sense an HMO; we operate on a capitated budget. I know that it may not answer your question, Mr. Stark. It may be a little too technical for me to answer without information from the VA. I can tell you that we are working in that direction, because we want to offer these services

to veterans. Veterans have trouble understanding why they cannot go to a VA facility now, and have VA pick up the cost.

Mr. Chairman, this concludes my remarks. I will now let my colleague, Sonny Montgomery testify. Between the two of us, we hope we can answer your questions, and thank you very much for holding this meeting today.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Honorable Bob Stump
on
H.R. 4068, Veterans Medicare Subvention Demonstration Project Act
before the
Ways and Means Subcommittee on Health
September 17, 1996

Mr. Chairman, I appreciate the opportunity to appear before the Subcommittee today with my good friend, Sonny Montgomery, -- and I want to compliment you, Mr. Chairman, for holding this hearing on the topic of Medicare-subvention.

Last week the Committee on National Security, which Sonny and I also serve on, marked up H.R. 3142, to establish a demonstration project for DoD Medicare-subvention.

I had prepared an amendment to that bill, which we were prepared to offer at the National Security mark-up. However, instead of offering the proposal as an amendment to H.R. 3142, we introduced it as a free standing bill, H.R. 4068.

The Ways and Means Committee has primary jurisdiction over H.R. 4068, with the bill also being referred to the VA Committee and the Commerce Committee.

Mr. Chairman, H.R. 4068 would establish a 3-year demonstration project for Medicare-subvention for the Department of Veterans Affairs.

This bill is very similar in policy and scope to H.R. 3142, and contains the same cost containment type provisions.

It calls for the Department of Veterans Affairs and the Department of Health and Human Services to establish a demonstration project under which the VA would collect and retain Medicare payments for Medicare-eligible veterans.

The project would operate for a three-year period in approximately 30 VA medical centers selected by the Secretary of Veterans Affairs.

The bill requires the VA to establish managed care plans and enroll veterans who desire to participate under this demonstration.

To ensure cost neutrality, the Health Care Financing Administration would reimburse the VA at only 93 percent of the adjusted per capita cost.

VA would only receive reimbursement for "new users", those Medicare-eligible veterans not currently being treated by the VA.

To avoid double billing, the cost of Medicare- eligible veterans currently receiving care at the VA would still be covered by VA's annual appropriation.

Finally, the bill subjects the VA to a thorough reporting and evaluation system on which to judge the merits of the demonstration project and whether it should be modified or continued in the future.

Mr. Chairman, the VA is moving aggressively to transform its health care delivery system from one that has traditionally been hospital and inpatient-based, to a modern system based upon the principles of primary and outpatient care.

Additionally, the House has passed H.R. 3118, which reforms VA's eligibility criteria, further accelerating this shift to more cost effective care.
However, like Medicare-eligible military retirees, many Medicare-eligible veterans cannot gain access to the treatment facilities established to serve them.

Veterans have trouble understanding why they can't get their care from the VA and have Medicare reimburse VA, just like it would any other provider of health care.

I strongly believe Congress should establish Medicare-subvention demonstration projects for both DoD and the Department of Veterans Affairs.

H.R. 4068 does exactly that for the VA.

I urge you to act on both proposals before this Congress adjourns.

Thank you Mr. Chairman.

STATEMENT OF HON. G.V. (SONNY) MONTGOMERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. MONTGOMERY. Thank you, Mr. Chairman. This is kind of a first for Mr. Stump and I. We have never testified in the big room before, so thank you for giving us this opportunity. We have been in Pete Stark's little room in years past talking about this same subject.

Chairman THOMAS. I am sure you sit on your wallets in this room.

Mr. MONTGOMERY. I will follow my chairman. I will be brief and cover some points.

This veterans bill, as he said, closely parallels H.R. 3142, and the Veterans' Committee, as Mr. Stump said, will take up H.R. 4068 tomorrow, and I assume we will pass a bill.

The VA health care system, Mr. Chairman, has transformed itself into a modern primary care delivery system. The demonstration project authorized by the bill we have introduced should make VA health care available to some of the veterans who are turned away for such care today. And I think that is really the bottom line for us, to get more veterans to be treated at our VA hospitals.

At the same time, there should not be any increase in Medicare costs.

Now, I think this is what the—we need the demonstration for. The bill would ensure that there would be no increase in two ways. First it guarantees that Medicare will only pay 93 percent of what it normally pays for health care for veterans carried under the demonstration project.

Second, it requires the VA to continue to pay for the care of the veterans it currently serves. In other words, Medicare will not pay a cent for a veteran now under VA care. Medicare will only pay for new patients that the VA serves above the VA current level.

Now, this is only a demonstration project. We would like to be included with the military if this Subcommittee sees fit to move ahead with that other bill.

And let me emphasize this, I kind of believe that we can do this work for less than Medicare is costing now in private hospitals. And I have said this over and over again, we have our own brick and mortar; we have our hospitals; they are paid for. Yes, the taxpayers paid for them. We have the largest volunteer system in world. People, these Legionnaires behind us, they work every day in these VA hospitals. And one of the best things we have is the university medical school support.

You get a knee operation, which I have had, it is about $6,000 in a private hospital. In a VA hospital, it will cost from $2,000 to $3,000. So I just cannot believe that we cannot service Medicare veterans at a lower cost in our VA hospitals than in the private hospitals. We have the system, we are ready to go, and we think we can save money. That is why we want to have this demonstration project.

Thank you.

[The prepared statement follows:]

REMARKS OF HON. G.V. (SONNY) MONTGOMERY

BEFORE THE COMMITTEE ON WAYS & MEANS

SUBCOMMITTEE ON HEALTH

SEPTEMBER 17, 1996

MR. CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY. I WILL BE BRIEF. FOR THE LAST SEVERAL YEARS, VETERANS GROUPS AND MILITARY RETIREES HAVE SEEN THEIR HEALTH CARE OPTIONS SHRINK. ALTHOUGH THEY MAY BE ELIGIBLE FOR MEDICARE, DOD-SPONSORED HEALTH CARE, AND VA CARE, RESOURCES TO SUPPORT THEIR CARE THROUGH VA OR DOD TREATMENT FACILITIES HAVE NOT KEPT PACE WITH THE DEMAND FOR SERVICES.

I SUPPORT FAVORABLE CONSIDERATION OF H.R. 3142. THIS LEGISLATION, WHICH WAS FAVORABLY REPORTED BY THE NATIONAL SECURITY COMMITTEE LAST WEEK ESTABLISHES A WORTHWHILE DEMONSTRATION PROJECT FOR MEDICARE ELIGIBLE MILITARY RETIREES. I ALSO ASK THAT YOU CONSIDER H.R. 4068, A VETERANS' BILL THAT CLOSELY PARALLELS H.R. 3142. THE VETERANS' COMMITTEE IS EXPECTED TO FAVORABLY CONSIDER H.R. 4068 ON WEDNESDAY, SEPTEMBER 18.

AS MR. STUMP HAS SAID, THE VA HEALTH CARE SYSTEM IS TRANSFORMING ITSELF INTO A MODERN PRIMARY CARE DELIVERY SYSTEM. THE DEMONSTRATION PROJECT AUTHORIZED BY THE BILL WE HAVE INTRODUCED SHOULD MAKE VA CARE AVAILABLE TO SOME OF THE VETERANS WHO ARE TURNED AWAY FROM SUCH CARE TODAY. AT THE SAME TIME, THERE SHOULD NOT BE ANY INCREASE IN MEDICARE COSTS. THE BILL WOULD ASSURE THIS IN TWO WAYS. FIRST, IT GUARANTEES THAT MEDICARE WILL ONLY PAY 93% OF WHAT IT NORMALLY PAYS FOR HEALTH CARE FOR VETERANS CARED FOR UNDER THE DEMONSTRATION PROJECT.

SECOND, IT REQUIRES VA TO CONTINUE TO PAY FOR THE CARE OF THE VETERANS IT CURRENTLY SERVES. IN OTHER WORDS, MEDICARE WON'T PAY A CENT FOR THE VETERANS NOW UNDER VA CARE. MEDICARE WILL ONLY PAY FOR NEW PATIENTS VA SERVES ABOVE THE LEVEL CURRENTLY RECEIVING VA CARE.

THIS IS ONLY A DEMONSTRATION PROJECT, MR. CHAIRMAN. I THINK IT IS WORTH TRYING. IF IT DOESN'T LIVE UP TO OUR EXPECTATIONS, IT WILL EXPIRE. BUT THE ADMINISTRATION AND ALL OF THE VETERANS' GROUPS THINK IT'S WORTH TRYING, AND SO DO I. PLEASE GIVE IT YOUR FAVORABLE CONSIDERATION.

Chairman THOMAS. Thank you both very much.

Sonny, you say you have got the system, you are ready to go. One of the things that has occurred is that the Department of Defense has set up its so-called TRICARE, and they are ready to go. Whether they make sense or not is the question that we are dealing with, but they are in fact ready to go.

Where are we with the managed care concept with the VA, I believe it is called VISN, V-I-S-N. Could they take on a demonstration project such as this within the next 6 months or early next year? Are they comparable in terms of up and running?

Mr. MONTGOMERY. I have this comment I would like to make that, in fact the VA has done a great deal of planning to prepare to establish managed care plans. It is in the workings. We have a new system working downtown at the VA health care center, and I think they can do it. And they are prepared to do it. I was told that. You probably could ask the VA Administrator if he thinks they could do it. But our studies show, and we anticipated your question, we can do it.

Chairman THOMAS. And anyone, Mr. Chairman, or any of your resources, how many veterans currently use the VA health care system?

Mr. STUMP. I believe the figure is 2.2 million veterans.

Mr. MONTGOMERY. Is 2.2 million; that is a year.

Chairman THOMAS. So 2.2 million use it. And what is the universe of eligible veterans to use the system?

Mr. STUMP. About 9 to 10 million veterans are eligible for VA care. There are 26 million veterans. I believe approximately 11 million veterans are qualified to use the VA. These are veterans with disability and indigent status.

Chairman THOMAS. So if we have 26 million veterans, approximately 11 million of the 26 million currently meet the disability and/or income threshold, which makes them eligible. My understanding is your legislation would remove the disability and income requirement?

Mr. STUMP. Do you mean this bill, Mr. Chairman?

Chairman THOMAS. Yes.

Mr. STUMP. No, it would not.

Chairman THOMAS. It would still be limited to that group that is eligible to use the VA——

Mr. STUMP. It would be limited to that group between the indigent status and the 50-percent disabled group, the new users that are not using it now.

Chairman THOMAS. How many would that be?

Mr. STUMP. Mr. Chairman, I cannot answer that. I do not know whether Mr. Montgomery has an answer or not. I do not know.

Mr. MONTGOMERY. I know the problem you are aiming at. We have the service-connected——

Chairman THOMAS. I do not know what problem I am aiming at, Sonny, I am just trying to get numbers.

Mr. MONTGOMERY. OK. Say the service-connected veteran, and the low-income non-service-connected veteran, we should continue to take care of them and not put them under Medicare. But I do not think the bill spells that out, but that should be done.

Mr. STARK. If the Chair would yield?

Chairman THOMAS. Sure.

Mr. STARK. I only have 2 years of active duty and 8 years or something of reserve, so I am a veteran, but I am not retired. Now, when I get Medicare in a couple of weeks, could I then go to a veterans hospital? Would I be one of the new eligibles?

Mr. MONTGOMERY. You can go to the veterans hospital as long as you have an honorable discharge, and you have one. The problem is how the Veterans Department would classify you. If the beds are available, you can get in there. But it is the classification——

Mr. STARK. Under your bill, would I then be able to use my Medicare at a veterans hospital?

Mr. MONTGOMERY. Yes, you would be. You would be eligible. And you would have a better chance if we could have Medicare eligible. That is one of the purposes, to open it up some more.

Mr. STARK. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. And obviously, what we would need to do is to get a handle on the number of folks we are dealing with here, at least in terms of the DOD HCFA one. We have some figures that we have been able to look at in the three project areas in the potential universe.

Now, as CBO will indicate, there is a potential problem with that universe by virtue of how many would have used fee-for-service who now move into managed care, and it begins to create the same problem that our friends on the other side of the aisle discussed in terms of medical savings accounts; that is, if you are sending fixed amounts of money that otherwise would not have been spent under managed care because healthy people are going to be able to be counted in these groups as well, we need to figure out the magnetism of a Medicare Program tied to veterans; and the same problem with the DOD Medicare Program tied to military retirees that may attract people who actually require us to spend more money than we otherwise would have spent if they stayed in the traditional Medicare fee-for-service.

So the numbers become fairly significant if you are going to look at multipliers as you carry out the program. So we are going to have to sit down and work out numbers.

Mr. STUMP. Mr. Chairman, I think that the VA could supply those figures to us almost immediately.

Chairman THOMAS. And obviously—my assumption is, not obviously, my assumption is that because the bill is so recent, we do not have a cost estimate from CBO. I know we just got the——

Mr. STUMP. We requested a CBO cost estimate, but we do not have it.

Chairman THOMAS. Right, it is going to take some time.

Mr. MONTGOMERY. Mr. Chairman, we are really making major changes in our VA health care system, and they are all for the better. And 95 percent of all the VA applicants or persons who go into a VA hospital, mainly go into outpatient clinic care. And Mr. Stump and I have introduced a bill where more could use it.

So we are really trying to open it up, and this is just another step forward that we presented to you today.

Chairman THOMAS. The reason I said it was very appropriate that you folks did introduce your bill is that we have a situation where we have had separate medical structures of the military for

a long time, and we are beginning to move in a direction of merging, or at least contracting from the general to the specific. And in the back of my mind, I am wondering why we do not just go completely general for everybody. Somebody has got to tell me why it makes more sense funneling money from the larger societal structure into the specific structures.

The primary reason to do it would obviously be cost savings, and we are going to have to begin working on just how much it does cost. The assumption is it is cheaper. But I think as we begin to analyze it, we will find that perhaps the ability to determine cost centers is not as easy as we might think based upon the way in which traditionally these programs have determined their cost. And these are just concerns. We need to get at it. The timing is good. It is appropriate, because as we begin to look at plans for all of the society, you folks need to make sure that you are at the table, because some of the restructurings that you are suggesting may in fact make a lot of sense. And then again, based upon the numbers, they may not.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. I think you let me interrupt to get my inquiry in, and I appreciate the witnesses bringing this to us. I am not quite sure where we are procedurally with this, or when the other bill, which—you want this amended to the bill that is going to bring up the Defense Department demonstration, or do you want a separate bill?

Mr. STUMP. Mr. Stark, we have introduced a separate VA subvention bill. Mr. Montgomery and I will mark up H.R. 4068 in Committee tomorrow. We had originally wanted to include it with the DOD bill, but we did not do this. We have a clean bill.

Let me say one more thing. We would be perfectly willing to work to put additional caps on this legislation. We are that sure this bill will not cost additional money. We want to get a demonstration product project off the ground and prove that we can do it at less cost than Medicare is now doing.

Mr. STARK. Thank you.

Chairman THOMAS. Does the gentleman from New York wish to inquire?

Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Just let me understand this. I am a veteran, and I have diabetes. How am I treated differently now than I would be under the demonstration project, and also who pays for it?

Mr. MONTGOMERY. Well, you are certainly not eligible for free care right now, I can answer that because of your other means. I will put it like that. But if the beds were available, you would be eligible, if you paid the required copayments and you have an honorable discharge.

On a diabetic condition, if you are not service connected, and you do not qualify as low income, the criteria that has been set up by the Veterans Department, they could not take you in unless they had extra treatment capacity and you paid a copayment. So your diabetic condition would not be treated. Does that answer it?

Mr. HOUGHTON. Under either condition?

Mr. MONTGOMERY. The only way you can get in is if everybody moves out of Minnesota, there are only a few veterans left up there, and we have a big hospital with a lot of beds open, then you could go into that hospital.

Mr. HOUGHTON. I guess that answers it. Fine, thank you.

Chairman THOMAS. Perhaps we need to, just before we go to the gentleman from Connecticut, understand prior to the other testimony what we are dealing with.

What we currently have in the bill that was moving earlier is a demonstration program between the Department of Defense and HCFA dealing with military retirees and their dependents.

Mr. STUMP. That is correct.

Chairman THOMAS. Now, all military retirees are veterans. But not all veterans are military retirees, because they have got to spend what, a minimum of 20 years, to reach the military retiree status.

So by definition, the military retiree universe is a smaller one than the veterans.

By the structure that the Veterans Administration has established, not all veterans as per the discussion with the gentleman from New York, being a veteran is not sufficient to be eligible for care at a VA hospital, you have to meet additional criteria.

What are you planning in this bill to expand the criteria for veterans to be eligible in the veterans structure? Anything at all?

Mr. STUMP. None, Mr. Chairman.

Chairman THOMAS. Let me wait until all the visitations have occurred.

Do you agree, Sonny?

No additional expansion of veterans for treatment at veterans facilities with your bill?

Mr. MONTGOMERY. I would think under the demonstration that that would bring—I am not sure of this—but I think that would bring in more dollars, and then we could treat other veterans. That is kind of the idea of——

Chairman THOMAS. I understand that. I am not concerned about how you manage the money, I am concerned right now about the universe of eligibility for people who may use it.

Now, what would occur is you might—I believe the current universe is 11 million of the 26 million—you maybe go beyond the current 2.9 million who use the service closer to 11 million if you added this additional service which would attract people who were otherwise eligible into the system. But that does not increase the universe of eligibles. It merely offers another program which those who are in that universe might feel that it would be more attractive for them to go to the veterans facility. That is what we are talking about.

Mr. STUMP. Mr. Chairman, if I may, we are only talking about veterans.

Chairman THOMAS. Veterans.

Mr. STUMP. Category C veterans who are Medicare eligible. These are veterans who are 65 and not currently covered under the indigent status or under the disability status.

To answer your question, the expansion is only to those that are 65 who have not previously used the VA.

Chairman THOMAS. OK. Then it is not the 11 million that are currently, it is the 11 million who are 65 or older, is that correct?

Well, we will sit down and work out the numbers. I am trying to understand the potential universe if this benefit were added to the VA structure of those who would otherwise be eligible but now do not currently use the VA system. Am I making sense?

Mr. STUMP. Yes, Mr. Chairman, you are to me. I would say that there is no reason to ever expect we would attract that number of people.

Chairman THOMAS. I understand. You and I make sense a lot of times with each other, it is just that the rest of the world listening to us sometimes——

Mr. STUMP. We do not know that number.

Chairman THOMAS. Well, and that, of course, is a concern, and we will just have to sit down and work these numbers through, because what happens is the whole question—and I do not want to get into the details of what we do here, but we have been wrapped up for the better part of several years now dealing with adverse risk selection, and the question of if you set up a program which attracts someone who would be cheaper if they stayed in the old program, and because of the managed care comprehensive costing structure, they come into this program, it actually costs us more than it would if we left them alone. And this is a magnet to military and veterans that may attract some people who would otherwise stay out of the system and to the society be cheaper in their treatment.

And so that is why we have got to be concerned about the way in which we open up programs, especially under managed care structures.

Mr. STUMP. Mr. Chairman, it is hard for me to imagine that we would attract those people. Certainly there are many, many, instances where we cannot compete with the modern up-to-date private-sector hospitals. We are only looking for those veterans that for convenience or other reasons may prefer to go to the VA hospital. These are veterans who are Medicare eligible, and do not qualify because of their disability, or do not qualify because of their income.

Chairman THOMAS. I understand that, and Mr. Chairman, I am only concerned that if we OK the program, then 1½, 2, 5 years down the road, there is not a vote on the floor of the House to upgrade the facilities because after all, we do treat Medicare eligible, and they deserve the same treatment facilities that the private sector gets. And so I just want to know what I am buying when I——

Mr. MONTGOMERY. Mr. Chairman, there is a provision in the bill——

Chairman THOMAS. I understand the demonstration project, but I am talking about the—I am talking about the other side of the demonstration project.

Mr. MONTGOMERY. Well, there are two secretaries, the Secretary of Health and Human Services, and the Secretary of the Veterans Department have to establish a maximum number of Medicare eligible veterans for which payment may be made. That is in the bill——

Chairman THOMAS. That is for the demonstration project.

Mr. MONTGOMERY. That does put some control on the demonstration project.

Chairman THOMAS. Right. That is for the demonstration project. I understand that.

Mr. MONTGOMERY. That is correct.

Chairman THOMAS. All right.

Mr. Lewis, do you wish to inquire?

Mr. LEWIS. Thank you, Mr. Chairman. I do not think I want to inquire, but I want to take this opportunity to commend Mr. Stump and Mr. Montgomery for their long commitment and dedication to the need and welfare of veterans. And with Mr. Montgomery's decision to retire, I want to take that opportunity to also say that I first met Chairman Montgomery in May 1961 when he was the General of the Mississippi National Guard.

And over the years, since I have been here, I have seen him as a friend, as a person who has kept his eyes focused with a vision, with a dream, to do what he considered was best for veterans, and for the people of this country, and I just want to say to you, Chairman Montgomery, we are going to miss you, and thank you for being here, and Mr. Stump, thank you also for being here to testify today.

Mr. MONTGOMERY. I thank the gentleman for the comments on Mr. Stump and myself. We were on the same bus, the Freedom Riders bus, we are very close friends, and it shows you what a great country we have got that you are here to help us, and we were there, back in those days. So thank you for our long friendship.

Chairman THOMAS. Thank you very much. The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you. As I followed this discussion about numbers, the conclusion that I am coming to is that there are 9.2 million veterans over 65, veterans including military retirees, is that correct?

Mr. MONTGOMERY. We will have to get that number.

Mrs. JOHNSON. You have to get back to that, because I am drawing the conclusion there are 9.2 million veterans. I do not know if that includes retirees.

Mr. MONTGOMERY. All retirees are veterans.

Chairman THOMAS. Yes, 1.3 military retirees using military hospitals, and 2.9 military—I mean, just veterans, using VA hospitals. So that would give me 3.1 million veterans who are using either military hospitals or VA hospitals already out of the 9.2 eligible.

So, I mean, those are the kind—you can get back to us on this. I mean, this is I think not a good thing to try to clear up here, but we need a clear understanding of who the universe is, and whether there would be any new choices for current veterans who are part of that 2.9 million who use our VA hospitals, would they now have access to the military hospitals? Would the 1.3 million retirees now have the choice of military hospitals or VA hospitals? Are we creating a larger universe of choice for all veterans, whether they are retirees, or just veterans? No? So, I think that if we are doing that, then we are actually eliminating the old definition of "low income," or "service connected," something that we all anguished at the time that we did it, and would really like to find a way to be more flexi-

ble in including both VA and military hospitals into the larger system. We hope to do this through Medicare.

I mean, we worked—I have been an advocate of that approach for a long time, so I am very sympathetic to what you are trying to do here.

Does your bill look at guaranteeing military retirees in areas where a military hospital has closed? This is a big problem I am running into, military retirees in an area where military hospitals have closed, having penalty-free access to part B of Medicare. I mean, now they can get back into Medicare, but they have to pay a penalty. Well, they should not have to pay a penalty to get back into part B Medicare because they did not choose it because they were military retirees.

So we might want to get a cost of that, too, because that should be a fairly inexpensive matter to fix. And just as retirees in America, anyone over 65 in America, they ought to have access, and it is not their fault that we told them they were going to get military coverage, and then we withdrew it.

So that, I gather, is not part of your demonstration, but I would ask your staff to look at that as we move forward.

Then, I just need to understand a little more clearly, in the bill, apparently Medicare will give DOD capitated payments for beneficiaries who enroll in these TRICARE options but only after DOD has surpassed its level of effort. In other words, Medicare would not put new money in until DOD spends all the money it is given by us for retiree health care. And I find that a little confusing.

How are we going to know when they hit that? Aren't they already there? I mean, we only appropriate as much as it requires to keep them open and care for a certain number of patients. Would we do that on census, that if their census exceeds a certain amount, and they're Medicare eligible, then we would compensate them for those Medicare patients?

You see, we need to sit down in a little different forum than this and understand these, sort of, you know, technical aspects of how this would work.

Mr. STUMP. Mr. Chairman, if I may attempt to answer that; in a sense, Mrs. Johnson, we do not—I do not—I cannot concur in the figures you are using. I want to get those figures. But most military retirees are above the income level. They would not qualify. They would use the DOD. Now, we are mixing DOD and VA here.

Mrs. JOHNSON. Does this bill only apply to VA?

Mr. STUMP. There are two bills, the one that armed services put out last week and our bill. We have introduced a new bill that we are going to mark up tomorrow, H.R. 4068, that applies only to VA.

What we are asking for, and have been working for for a long time, is Medicare subvention. DOD has a bill. We have a bill. We are trying to get part of that, nothing more, hopefully nothing less. We just want to be included in this whole movement if we are going to go to Medicare subvention.

Chairman THOMAS. If the gentlewoman would yield, we partly have the cart before the horse here, because the horse is the TRICARE, the DOD Medicare agreement which is in legislative form, and has been moving.

The veterans are saying if in fact this is moving, we would like to have the same treatment. That bill will be marked up in Veterans' Committee as the Chairman said——

Mr. STUMP. That is correct.

Chairman THOMAS [continuing]. Tomorrow. It is just that this hearing occurred today, and out of courtesy, the Members get to go first, so in essence, they are talking about the cart; the horse will come up when we are finished with the Members. I do not mean that——

Mr. MONTGOMERY. Mr. Chairman, I am sure these witnesses behind us who come up next learned a lot here.

Chairman THOMAS. They are chomping at the bit.

Mr. MONTGOMERY. Yes, I am sure they are with the tough questions you have given us——

Mrs. JOHNSON. Another bullet here is that enrollment will be limited to dual eligibles who previously used military treatment facilities and who agree to participate in part B of Medicare. I guess this refers to the other bill.

I am looking forward to working with you. I think these are very important issues, and I think we have to be much more aggressive in dealing with the relationship between our system of health care for veterans, and our system of health care for retired Americans. And as we get at the end of the hearing, I am sure my questions will be refined and we will be able to move forward.

Thank you.

Mr. STUMP. Those military retirees that we see are those with service-connected disabilities, using the VA system over the DOD system.

Mr. MONTGOMERY. And we tried, when we were closing these military hospitals, and I am sure one of the Assistant Secretaries can talk about that with Defense, probably when they close a military base, if the VA could, and we might have done it in one or two places, but have come in and set up some type of outpatient clinic, I think that would solve a lot of problems of the military not having a place to go.

Mrs. JOHNSON. But at the very least, they ought to——

Mr. MONTGOMERY. It was another money matter.

Mrs. JOHNSON. Right, and the very least, they ought to be able to provide a list to Medicare of the retirees that are affected, so that they do not have to pay the penalty for part B to get back into part B, which would then give them access to the health care resources of the region.

Anyway, thank you very much for your leadership on this, a really difficult issue, and I look forward to working with you.

Chairman THOMAS. Any additional questions?

I want to thank both of you. This is an example of the timeliness and the concern that both of you have shown in making sure that veterans are adequately taken care of, and I commend you for your continued vigilance.

Mr. STUMP. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

Now, I would ask Bruce Vladeck, Administrator of the Health Care Financing Administration, and Dr. Stephen Joseph, Assistant Secretary of Defense, Health Affairs, to come forward and perhaps

provide us with an understanding of the current legislation that has been marked up between the Department of Defense and HCFA in this 3-year Medicare subvention demonstration project.

Mr. Vladeck, you are on my left, your right, so you might as well begin. The written testimony will be made a part of the record, and you may inform us in any way you see fit.

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

Mr. VLADECK. Thank you very much, Mr. Chairman.

Chairman THOMAS. Welcome back to the big room.

Mr. VLADECK. Thank you, sir. I am pleased to be here today, as always. I am especially pleased to appear with my colleague of many years, Stephen Joseph. He and I worked together in New York a decade ago, and I have been pleased that we have had the opportunity to work together again in Washington. We did have some discussion on our way up to this table as to which of us was representing which end of the horse, and we will defer that until a later time. We have worked very closely with the Department of Defense, Dr. Joseph's office, for the past year to come to an agreement for a demonstration project on Medicare subvention under which Medicare would pay for dually eligible Medicare military retirees in the Department of Defense managed care program.

In forging this program, we believe that we have set the stage for a project that will provide quality service for dual eligible beneficiaries, while at the same time addressing the concerns about the well-being of the Medicare Trust Funds, and the trust funds' availability for all current and future Medicare beneficiaries.

More than 1 million of our current 38 million Medicare beneficiaries are also eligible to receive health care through the Department of Defense. Over the years, we have had these two parallel systems. The demonstration which we have proposed in the legislation will provide us the opportunity to very carefully and systematically assess the effects of working more closely together on improving the efficiency of care. The demonstration will also ensure access to services and the quality of care for that portion of the 1 million beneficiaries, who live around a number of military facilities in Texas, the State of Washington, Oklahoma, Louisiana, and Arkansas.

In working together on this demonstration, we had two major concerns. The first is that we wanted to make sure that Medicare beneficiaries who were also military retirees could be assured of receiving high quality care, no matter which system they received it in.

Second, we are of course concerned about the fiscal impacts of the demonstration and the potential longer term policy decisions on the Medicare Program. We are aware of the CBO scoring of an earlier version of subvention legislation to which the Chairman referred earlier.

A large part of our discussion with the Department of Defense over the last number of months has revolved around mechanisms to protect the Medicare Trust Funds, to limit Medicare's liability under this program, and to be sure that we could get the informa-

tion that would permit us to fairly evaluate the fiscal impacts of this project without any substantial risk to the trust funds.

Our agreement provides that the Department of Defense will maintain its existing level of effort on behalf of beneficiaries who participate in the demonstration project. We have very elaborate procedures for measuring, updating, and applying the existing level of effort. Through contract of services, the Department of Defense will make available to demonstration participants the same services which Medicare beneficiaries are entitled. Currently, the Department of Defense does not provide these services, such as skilled nursing facilities and home health care.

We have also capped Medicare's total payments under this demonstration at a total of $65 million a year. Perhaps most importantly, in terms of the financial impacts of this demonstration program, we have provided for an annual reconciliation process. This process would involve the two departments jointly and possibly include the participation of the General Accounting Office to review in detail the outlays, both on our part, and on DOD's part, for beneficiaries served in the demonstration's DOD facilities. In addition, this reconciliation process would ensure that the effects on the Medicare Trust Funds are limited

At the same time, and this is the bottom line for us in a most fundamental way, the agreement as it is incorporated into the proposed legislation not only protects, but expands the freedom of choice of Medicare beneficiaries. As is now the case, they can continue to receive Medicare services in the fee-for-service system, or enroll in any of a number of different managed care plans that are available to them in the communities in which they live. However, beneficiaries who are already using the military system, and choose to do so, could under this demonstration have the additional choice of receiving all of their services through the DOD system without having to worry about issues of availability of services, or of space available kinds of care.

We believe that we have taken all the necessary and prudent steps to protect the trust funds. We believe that we have taken all the necessary steps to improve the choices and the quality for our beneficiaries, without putting them at risk.

The question is whether this will succeed at demonstrating that indeed we can adopt these new policies without additional cost to the Medicare Program, or to the Federal Treasury in general. The answer is that we do not know.

That is why we have called for a demonstration project under very carefully defined terms. That is why the legislation calls for an independent evaluation and for an evaluator who will monitor performance as we go. The demonstration will give us hard answers to such questions, not only about cost impact, but on the changes in access to care and the quality of care for our beneficiaries. In addition, the demonstration will determine quite importantly the impacts on other local providers of health services and any shift in utilization toward military treatment facilities.

After 3 years, we should see the effects of coordination between our two programs, including overall spending on beneficiary satisfaction, access to care, and quality of care.

We are confident that after a very lengthy and complicated process, with thanks to the persistence and good efforts and cooperation of the Department of Defense and our own staff, we have put together a project that holds considerable promise for improving the availability of health care to 1 million of our beneficiaries who certainly deserve all the help and support which we can give them. This project also limits all the risks which have been considered in previous projects.

We are hopeful that the demonstration will succeed. We are certain the project has been established in a way that will let us know whether it has succeeded or not. This idea has been considered for a long time. It is something that the President feels very strongly about, and we are pleased to be in a position to go forward with a test that will give us information about the project's real implications.

In conclusion, I am pleased to appear before you again today. I know Dr. Joseph has some comments, and then obviously, we are happy to respond to any questions.

[The prepared statement follows:]

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

"MEDICARE SUBVENTION"

I am pleased to be here today to discuss Medicare subvention, a demonstration project that will be conducted by the Health Care Financing Administration (HCFA) and the Department of Defense (DOD) whereby Medicare will pay for dual-eligible Medicare/DOD beneficiaries in the DoD managed care program. In forging this agreement, we believe the stage has been set for a project that will provide quality service to these dual-eligible beneficiaries and, at the same time preserve and protect the Medicare Trust Fund for all Americans.

We are happy to be joining with our colleagues in the Department of Defense (DoD) in moving forward with this test. Of the 38 million Medicare beneficiaries, more than one million are dually-eligible to receive health care through the Department of Defense's military health services system and through the Medicare program. Over the years, DoD and Medicare have separately provided access to quality care for these dual-eligible beneficiaries. This demonstration will give us the opportunity to assess the effects of coordination on improving efficiency, access, and quality of care for this population in a selected number of sites in Texas, Washington State, Oklahoma, Louisiana and Arkansas.

As HCFA and DoD collaborated to design this demonstration, we at HCFA kept our eyes on two imperatives: We must protect beneficiaries and we must protect the Medicare Trust Funds. As you know, this Administration has expressed its concern about the solvency of the Trust Funds, and has proposed measures to strengthen them each year since coming into office. We must ensure that Medicare benefits are available for all beneficiaries. As we worked on the design of this program, strategies to prevent further depletion of the Trust Funds were utmost in our thinking.

I'd like to detail for you some of the provisions of our agreement with DOD and the safeguards that we have created.

Our agreement protects the Medicare Trust Funds against the risks of cost-shifting. First and foremost, DoD will receive Medicare payments only after it surpasses its current "level of effort", i.e., the dollar amount DoD now spends rendering health care services to dual-eligible beneficiaries in military treatment facilities in the demonstration sites. This level of effort will be updated for each year of the demonstration.

Some services that are covered under Medicare are not covered by DoD, such as skilled nursing facility and home health care. Enrollees in the demonstration will be provided with the full Medicare benefit package.

After DoD meets its level of effort in the area covered by the demonstration, Medicare will reimburse DoD on a capitated basis equal to a percentage of the Adjusted Average Per Capita Cost (AAPCC) applicable to the beneficiaries enrolled in the demonstration. We have agreed to adjust the applicable AAPCC to exclude some of the costs associated with capital, indirect and graduate medical education and disproportionate share hospitals. These exclusions are believed to be outside the purview of the Medicare payments under the demonstration. The reimbursement rate will be set at 93 percent of the applicable AAPCC in the first year. This is two percentage points less than the 95 percent that Medicare currently pays to risk HMOs. It reflects the increased efficiency of the DoD in providing care to Medicare beneficiaries. In years two and three, this rate will be set at 90.25 percent. At the end of each year, DHHS and DoD will reconcile any payment discrepancies and correct for any mistaken

overpayments.

The maximum total Medicare reimbursement to DoD for any demonstration year will not exceed $65 million. Further, DoD has agreed to open its facilities to audits by HCFA, and the Department of Health and Human Services Inspector General. We have designed this demonstration so that there will not be an increase in the total costs of Medicare. If it is found that Medicare costs are more than they would have been without the demonstration, the two departments have agreed to take any necessary corrective action. For example, DoD may reimburse HCFA; we may suspend or terminate the demonstration; or, we may adjust reimbursement rates or levels of effort. These are some of the most significant steps that we have taken to limit the total risk to the Medicare Trust Fund.

Our agreement protects, indeed expands, beneficiaries' freedom of choice--they can use their Medicare benefits to enroll in and easily disenroll from TRICARE, or they can obtain care from civilian providers and continue to seek care from DoD on a space-available basis. Our agreement protects beneficiaries' quality of care because DoD will provide the complete range of Medicare benefits (including skilled nursing facility and home health care services not normally provided by DoD), and in so doing will adhere to Medicare's conditions of participation and quality standards.

Thus, we strongly believe that we have taken all possible steps to protect both beneficiaries and the Trust Funds from harm. Will we succeed? The answer will lie in a rigorous evaluation of this demonstration by an independent evaluator. Over the demonstration's three years, the independent evaluator will monitor performance and collect data to answer these crucial questions:

- Is there an impact on the costs to either the Medicare Trust Funds or DoD?
- Do beneficiaries experience improved access to health care?
- Is there any change in quality of care provided to the enrolled population?
- Is there any effect on local health care providers and other Medicare beneficiaries in the surrounding community?

At the end of three years, we will see how coordination between our two programs improves efficiency, access, and quality of care for dual-eligible beneficiaries. If Congress should decide on a GAO study of the demonstration, both DoD and DHHS have agreed to jointly assist GAO with that review and report. In the meantime, we have put the necessary safeguards in place to protect beneficiaries and protect the Medicare Trust Funds

The President strongly supports this demonstration. Secretary Shalala enthusiastically approved the agreement between the Health Care Financing Administration (HCFA) and DoD to coordinate our two programs in this three-year demonstration of Medicare "subvention."

We are hopeful that this demonstration will succeed, and that through it the beneficiaries we share in common with DoD will receive enhanced choices and improved services -- the real "bottom line" in this effort.

Chairman THOMAS. Thank you very much, Mr. Assistant Secretary, any written testimony will be made a part of the record. You may inform us in any way you see fit.

STATEMENT OF HON. STEPHEN C. JOSEPH, M.D., M.P.H., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE

Dr. JOSEPH. Thank you, very much, Mr. Chairman. With your permission, I would submit my entire testimony, and summarize verbally, focusing my remarks on some of the issues and questions that have been raised in the prior panel, and now here.

Bruce Vladeck, just as he used to try to do in New York, has stolen my best line about who is which end of the horse, but since I get to go last, I guess I know.

But it is a pleasure to be here before this Subcommittee today and talk about this agreement which has been worked out, hammered out is probably a better word, between the Departments of Defense and Health and Human Services for a Medicare subvention demonstration.

This is an idea that has been in discussion and debate for over a decade. It is not easy to implement, because of many of the factors that you have already mentioned, and many others, and will require the enactment of legislation.

One thing that I think is important to keep in mind, Mr. Chairman, is that military medicine has a mission to provide health care wherever and whenever our men and women in uniform need it. And that mission thus has two interlinked responsibilities.

The first which we must never forget, and which is really different from any of the other Federal health systems, is to operationally deploy medical capability, people, equipment, and supplies, with the troops when they deploy, in order to provide that care on the battlefield.

The second part of that mission is to operate a vibrant health care delivery system to provide health care, what we call peacetime health care, as opposed to the wartime health care, the first part of the mission; to provide health care to our 8.3 million beneficiaries; and to ensure that our medical personnel who must be prepared for wartime deployment, physicians, nurses, technicians, corpsmen, medics, are trained, and sharp, and ready to deploy.

In meeting the requirements of that second so-called peacetime health care responsibility, the military health services system must have a large and varied patient population.

For that reason, the Congress years ago authorized the MHSS to provide care to the families of our active duty personnel, and then to our retirees and their families. This care, however, and this is the central fact, was put on a space available basis so that nothing interferes with care for the active duty force.

Military medicine today is rapidly moving toward a managed health care delivery framework, known as TRICARE which you have mentioned. By next year, we will have fully implemented TRICARE in our 12 regions across the Nation, and in our overseas commands, and we believe that we already have strong evidence of success.

But unfortunately with our move to managed care in TRICARE, the one group of beneficiaries who are not fully participating in this success is the growing number of our Medicare eligible beneficiaries, some 1 million in all.

Medicare subvention, or the reimbursement from Medicare for care that the military health services system provides to dual eligible personnel, would allow our Medicare eligible beneficiaries to enroll in our managed care system, TRICARE Prime.

After significant negotiation and examination of how the Medicare system works, and how our system would satisfy the Medicare risk HMO requirements, we have worked out an arrangement that will allow a demonstration of the Medicare subvention concept.

Permit me to say here in response to Mr. Stark's earlier comments, CBO has not scored this demonstration. The CBO figures which you mentioned earlier, Mr. Stark, were a scoring of an earlier proposal on actually a theoretical rather than a real proposal.

Furthermore, as Bruce Vladeck has already mentioned, the demonstration that is on the table now has a $65 million cap on transfer expenditures after current level of effort is met, and also there is a rather elaborate process for reconciliation at the end of each year's period, which would keep this from being a cost increase to Medicare, or to Federal outlays total for that matter.

Chairman THOMAS. Dr. Joseph, just to make sure the record is straight now rather than wait in until the conclusion of your testimony, we have in our possession dated today, and I know it only came this afternoon, you may not be in possession of a CBO analysis, which I believe is on the actual bill, not a theoretical.

Dr. JOSEPH. Sir, you may be correct, but the best of any information was that the Hefley bill has not been scored, the President's legislative submission has not been scored, and the $200 million figure, which is a figure very familiar to Mr. Vladeck and I——

Chairman THOMAS. I apologize for interrupting. Go ahead with your testimony, and then we will have CBO come up, so we can begin to clear some of this up.

Dr. JOSEPH. Fine.

Chairman THOMAS. I apologize, and would you please continue.

Dr. JOSEPH. The demonstration as proposed would cover the area of San Antonio, plus three other sites in our region 6, which is that region of the country; and the Madigan-Bremerton area in TRICARE region 11, which are the States of Washington and Oregon.

We will also identify three sites in region 6 to serve as comparison sites.

The demonstration will last for 3 years, and both agencies have the option of extending it for 18 months for enrolled beneficiaries. The agreement stipulates that we would begin the demonstration 60 days following enactment of legislation, or on January 1, 1997, whichever is later. And there is a provision for each agency, or either agency, to withdraw from the demonstration with 12 months written notice.

People who would be eligible for participation in the demonstration will include those who are eligible both for care from DOD and through Medicare's agent program; enroll in TRICARE Prime, our HMO option, or covered by Medicare part B; agree to receive cov-

ered services only through TRICARE; are residents of the geographic areas covered by the demonstration, and where enrollment in the demonstration is offered; and who as dual eligibles, used the military treatment facility before July 1, 1996, or became dual eligible starting after June 30, 1996.

The services to be covered under this demonstration include the standard Medicare benefit in addition to specific TRICARE Prime benefits. One of the major considerations in developing this arrangement is the agreement that DOD will continue to maintain its level of effort in providing care for the dual eligible population, in order to avoid imposing these costs on the Medicare Trust Fund.

This commitment to continuing our current level of effort has generated a series of very detailed conditions, reimbursement criteria, and evaluations by both agencies.

DOD will meet or be deemed to meet the applicable and agreed upon requirements similar to a Medicare risk HMO. With respect to reimbursement, it is based on capitation, the same as for Medicare health maintenance organizations. The reimbursement rate is at a level at least 2 percentage points less than for Medicare HMOs, and with rate adjustments that would avoid double payment for MHSS costs already funded by appropriations.

Enabling legislation for this demonstration has been submitted to the Congress, and we look forward to working with a bipartisan coalition of Members to quickly enact it this year.

The cornerstone of this historic agreement is that there be mutual benefit for our dual eligible beneficiaries, for the Medicare Trust Fund, for DOD, and for the American taxpayer. The agreement is specifically designed such that it will not increase the total cost of Medicare. In partnership with the Department of HHS, our goal is to implement a cost effective alternative for delivering accessible and quality care to dual eligible beneficiaries.

In closing, Mr. Chairman, I want to recognize the powerful support from those here in Congress who have championed this effort. Without the very essential bipartisan drive, and the support of many Members in both Houses, and on both sides of the aisle, we would not be at this threshold of opportunity. We need your support, that of your Subcommittee, as we move to see the enactment of enabling legislation.

I will be happy to respond to your questions, or your comments on the specifics, or on the concepts. Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF STEPHEN C. JOSEPH, M.D., M.P.H.
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS
U.S. DEPARTMENT OF DEFENSE

Mr. Chairman, Distinguished Members of the Committee, it is with great pleasure that I am here today to speak with you about the just-concluded agreement between the Departments of Health and Human Services and Defense for a demonstration of Medicare Subvention.

This demonstration embodies a concept offered by the President in his health care reform package, it is a concept that President Clinton strongly supports today. In his round-table discussions with veterans and military retiree representatives, the President has sought to learn of the key issues these groups face. Each session has included a strong plea by beneficiaries that the health care benefits of older veterans and military retirees not be forgotten, that they be allowed to continue using the system, the hospitals, the physicians they have come to trust...and that their entitlements to Medicare be available for use in the Military Health Services System. Very recently, at one such round-table discussion, Major General Jim Pennington, President of the National Association of Uniformed Services, sought the President's commitment to move more expeditiously on plans to test Medicare subvention. The President gave his commitment, directed his staff to move expeditiously, and I am here today to present to you the significant progress we have made in meeting the President's commitment.

Medicare subvention is an idea that has been discussed for over a decade. It is not an easy-to-implement idea and will require the enactment of legislation. It involves tremendous cooperation and synchronization of very different federal health care programs. For the past two years, members of the military medical departments and my Health Affairs staff have incrementally and painstakingly built the conceptual design that has led to the agreement just signed. In building that demonstration design, we sought and gained strong support from the Secretary and Deputy Secretary of Defense, the Chairman and the Joint Chiefs of Staff as well as other senior leaders within the Department. This is a moment of realization for all who have worked with such dedication to achieve this agreement with the Department of Health and Human Services.

As you well know, Medicare subvention is not solely an Administration commitment. This issue has reached the offices of many Members of Congress. There have been bills sponsored in the Senate and here in the House, last year and this year, with over 200 Members co-sponsoring the bills introduced by Mr. Hefley.

This is a measure that transcends politics, it has the backing from Members on both sides of the aisle, on both sides of the Capitol. It is a measure that responds to the concerns of tens of thousands of our older military retirees who have served this nation well.

This widespread support recognizes the fact that military Medicare-eligible people are living across this nation, in every state, and they take an active role in voicing their concern that commitments made must be kept. It also recognizes the determined advocacy and tireless efforts of The Military Coalition and the National Military and

Veterans Alliance. These representatives of military beneficiaries have sought Medicare subvention for many years, so this demonstration should be a welcomed one, and a proposal that they should feel proud to have played a major part in achieving.

Mr. Chairman, military medicine has a mission to provide health care wherever and whenever our men and women in uniform need it. That mission has two interlinked responsibilities. First, to operationally deploy medical capability -- people, equipment and supplies -- with the troops in order to provide that care. Second, to operate a vibrant health care delivery system to ensure our medical personnel -- physicians, nurses, technicians, corpsmen and medics -- are trained and ready to deploy. In meeting the requirements of that second responsibility, the Military Health Services System must have a large and varied patient population. For that reason the Congress, years ago, authorized the MHSS to provide care to the families of our active duty personnel, and then to our retirees and their families. This care, however, is on a space available basis so that nothing interferes with care for the active duty force.

In the last thirty to forty years much has changed. The Armed Forces have grown smaller, the military infrastructure has shrunk, the budget grows tighter, and the national security strategy has dramatically changed. In each of these evolutions, the Military Health Services System has participated. We have fewer health care facilities, fewer medical personnel, more -- and more-intense -- missions to support, and we must find ways to be more accountable to the American public for the dollars we spend.

In keeping with these changes, and with definitive guidance from our Congressional oversight Committees, military medicine began its shift to managed health care delivery. By next year, we will have fully implemented TRICARE across the nation and in our overseas commands. This is a total transformation, a revitalization of the Defense medical system. It involves our beneficiaries making a choice for how they will receive their health care...and many are choosing our Health Maintenance Organization option: TRICARE Prime. The reasons are many, but among them are the improved access to high quality care and the assurance that they can receive care in military medical facilities. TRICARE is proving to be a great success.

Unfortunately, the one group of our beneficiaries **not** fully participating in this success is the growing number of our Medicare-eligible beneficiaries. These men and women have served their country and they have paid faithfully into the Medicare Trust Fund. They are covered by Medicare if they choose to seek care from physicians outside the Military Health Services System, and they are able to seek care in military medical facilities on a space-available basis. But, that space availability is at risk as more beneficiaries sign up for TRICARE Prime. The Prime enrollees are filling the appointment schedules of our military providers.

Medicare subvention, or the reimbursement from Medicare for care the Military Health Services System provides to military Medicare-eligible personnel, would allow our Medicare-eligible beneficiaries to enroll in TRICARE Prime. Rather than splitting their

health care needs between providers outside the Military Health Services System and the space-available military facilities, these beneficiaries would be able to access the military medical treatment facilities the same as our other enrolled retirees. It is the ability to receive care from the military system that these beneficiaries want.

As the individual responsible for the military health care delivery system, I want them to have access to this system, the Surgeons General of the military services want to care for them, and the military's senior leadership want them to be able to come to military treatment facilities. Many ask why?, why not just have these beneficiaries go downtown using their Medicare eligibility, it would be less expensive for the military services. Our response is threefold. First, because we want to honor the commitments made to them; second because they are our patients, and it is the military system where they are most comfortable especially when they are in need of health care; and third, because we need them for the variety of health problems they present, which contributes to our medical readiness training.

After significant negotiation and examination of how the Medicare system works and how our system would satisfy the Medicare risk HMO requirements, we have worked out an arrangement that will allow a demonstration of the Medicare subvention concept. (See Attachment)

The demonstration will cover San Antonio plus three other sites in our TRICARE Region 6, and the Madigan-Bremerton area in TRICARE Region 11. We will also identify three sites in Region 6 to serve as comparison sites. The demonstration will last three years, and both agencies have the option of extending it for 18 months for enrolled beneficiaries. We plan to begin the demonstration 60 days following enactment of legislation or on January 1, 1997, whichever is later. Either agency may withdraw from the demonstration with 12 months written notice.

People eligible for participation in the demonstration will include those who:

- Are eligible both for care from DoD and through Medicare's aged program,
- Enroll in TRICARE Prime,
- Are covered by Medicare Part B,
- Agree to receive covered services only through TRICARE,
- Are residents of the geographic areas covered by the demonstration and where enrollment in the demonstration is offered,
- As dual-eligibles, used a military treatment facility before July 1, 1996, or became dual-eligible starting after June 30, 1996.

The services covered under this demonstration include the standard Medicare benefit in addition to specific TRICARE Prime benefits. One of the major considerations in developing this arrangement is the agreement that DoD will continue to maintain its level of effort in providing care for the dual-eligible population in order to avoid imposing these costs on the Medicare Trust Funds. This commitment to continuing our current

level of effort has generated a series of very detailed conditions, reimbursement criteria, and evaluations by both agencies. DoD will meet, or be deemed to meet, the applicable and agreed upon requirements similar to a Medicare risk HMO. With respect to reimbursement, it is based on capitation, the same as for Medicare health maintenance organizations. The reimbursement rate is at a level at least two percentage points less than for Medicare HMOs and with rate adjustments to avoid double payment for MHSS costs funded by appropriations.

Enabling legislation for this demonstration has been submitted to the Congress and we look forward to working with a bipartisan coalition of Members to quickly enact legislation this year.

The cornerstone of this historic agreement is that there be mutual benefit...for our dual-eligible beneficiaries, for the Medicare Trust Fund, for DoD, and for the American taxpayer. This agreement is designed such that it will not increase the total cost of Medicare. In partnership with the Department of Health and Human Services, our goal is to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries.

In closing, Mr. Chairman, I want to specially thank the many advocates in the military beneficiary associations who have worked relentlessly to pave the way for this agreement. I want also to thank Dr. Vladeck and the members of his staff who have joined us in negotiating the details of the agreement, and who will continue our new partnership through the course of the demonstration.

I want to recognize the powerful support from those here in Congress who have championed this effort. Without the very essential bipartisan drive and the support of many Members in both Houses and on both sides of the aisle, we would not be at this threshold of implementation. Mr. Chairman, we need your support, and that of your Committee, as we move to enact the enabling legislation.

I would be happy to respond to your questions at your convenience. Thank you.

THE DOD-MEDICARE SUBVENTION DEMONSTRATION

The Departments of Health and Human Service and Defense have forged an agreement to coordinate the Medicare program and the military health care services system in a three-year demonstration of Medicare "subvention."

The demonstration will involve dual-eligible beneficiaries (military retired personnel and their family members and survivors who are also eligible for the Medicare program).

It will take place over three years in five geographic areas in Washington state and DoD Region 6 (Texas, Oklahoma, Louisiana, and Arkansas), including (1) Tacoma-Seattle, and (2) San Antonio. Approximately 60,000 dual-eligible beneficiaries live in these sites (the exact number will depend on the location of the other three areas).

Medicare will give DoD capitated payments for beneficiaries who enroll in TRICARE--DoD's regional managed care program modeled on health maintenance organization (HMO) plans offered in the private sector--but only after DoD surpasses its "level of effort" (i.e., the dollar amount DoD now spends delivering health care services to dual-eligible beneficiaries in military treatment facilities in the demonstration sites).

Enrollment will be limited to dual-eligibles who previously used military treatment facilities and who agree to participate in Part B of Medicare.

DoD will provide the complete Medicare benefit, including skilled nursing facilities and home health care, and will meet Medicare's quality standards and conditions of participation as a Medicare HMO.

For every enrollee above the level of effort, DoD will receive 93 percent of the adjusted average per capita cost (AAPCC) in the first year. (Medicare risk HMOs receive 95 percent of the AAPCC.) In later years, DoD will receive 90.25 percent of the AAPCC, adjusted to exclude some or all of the costs associated with direct and indirect graduate medical education, disproportionate share hospital payments, and capital expenditures.

An independent evaluator will assess the costs to DoD and Medicare, the quality and accessibility of care for dual-eligible beneficiaries, and any effects on local health care providers and other beneficiaries.

Because of the Administration's concern about the solvency of the Trust Funds, the demonstration will include these key protections: (1) a $65 million annual cap on Medicare payments; (2) an end-of-year reconciliation process to correct for any mistaken overpayments; and (3) audits of DoD facilities by the DHHS Inspector General and HCFA.

Beneficiaries will have enhanced choice. They will be able to use their Medicare benefits to enroll in and easily disenroll from TRICARE, obtain care from civilian providers, or continue to seek care from DoD on a space-available basis.

Chairman THOMAS. Thank you very much.

Since we are going to be discussing some numbers that have been generated, I think it would facilitate the discussion if, Mr. Van de Water, you would come up and then we can either clear up, or establish some degree of certainty.

Mr. Vladeck, and Dr. Joseph, receive, both of you indicated—excuse me, I know Dr. Joseph indicated—Bruce you may not have—I think in your written testimony that there was need for legislation, that we have to pass legislation.

What is it that requires us to pass legislation—well, let me ask Bruce a different way.

You cannot do this under your demonstration authority, right?

Mr. VLADECK. Yes, sir.

Chairman THOMAS. Why?

Mr. VLADECK. I believe it is section 1814 of the Social Security Act—please do not hold me to that the exact citation—but there is a specific provision in the act that forbids Medicare payments to the Department of Defense's facilities, Veterans Affairs' hospitals, facilities operated by the Indian Health Service, and other Federal Government-operated facilities.

HCFA's demonstration authorities, as you know, are in several other places in the law, and involve relatively specific sorts of demonstrations that we may undertake. HCFA's demonstration authorities have to do largely with payment or covered services, and in some instances, types of providers.

HCFA's General Counsel's reading of the statute indicates that the demonstration authorities elsewhere in the law are not broad enough to waive the section of the bill that specifically forbids payment to a military facility.

Chairman THOMAS. So legislation is necessary to broaden the scope for entering into demonstrations?

Mr. VLADECK. We have written this legislation to specifically authorize this demonstration. The legislation is not designed to repeal or to undermine the broader restrictions that currently exist in the law, nor to broaden our general demonstration's authorities.

Chairman THOMAS. Was it or was it not necessary in this specific legislation to also specifically spell out, if that is not redundant, the payment structure, 93 percent of the adjusted average per capita cost, and what you do with graduate medical expenses attached to ordinary Medicare payments. Was that necessary to be done in this legislation?

Mr. VLADECK. No, sir.

Chairman THOMAS. Why didn't you just get a general agreement and then work out the pricing without locking in a specific structure that is different than current risk contracts?

Mr. VLADECK. Frankly, I think it is fair to say that the administration wished to avoid problematic relationships with the Congress. Therefore, we decided not to propose legislation of this sort until there was an agreement within the executive branch on exactly what the demonstration would constitute. In addition, we did not want to put ourselves in the position of having the Congress authorize or mandate a demonstration project. We might have had difficulty reaching an agreement. It was decided that we would introduce legislation once we had agreement among the various parts

of the executive branch. We would then be able to tell the Congress that based on our agreement, we were knowledgable of what the proposed project would accomplish. Congress would know what they were buying by the authorization. We could promise Congress that implementation of any legislation would not be slowed up, or impeded by issues of interagency relations.

Chairman THOMAS. And that could not have been fulfilled with a general statement of budget neutrality, or that current level of effort would be exhausted by the DOD prior to payment for Medicare.

I guess my concern is that what you are doing also on this legislation is to a degree setting a precedent, so you are very comfortable in indicating to this Subcommittee that the specific payment arrangement on this contract is in no way an indication that this is a structure that HCFA would like to expand beyond this demonstration project, whether or not it proves successful.

Mr. VLADECK. Clearly, Mr. Chairman, the establishment of a payment level below 95 percent of the AAPCC in the second and third years—in all 3 years of this demonstration, and the separate treatment in the second and third year of the AAPCC that can be attributed to graduate medical education, or disproportionate share, or capital expenses, parallels our thinking about changes in Medicare payment policy involving managed care plans. This position is reflected in the President's balanced budget proposal which we have previously discussed in hearings before this Subcommittee.

We wanted the demonstration to be consistent with our thinking on broader policy issues. At the same time, we didn't want to have any uncertainty or confusion about what we were requesting from the Congress in this legislation. The legislation specifically authorizes this project, and does not broaden the authorities of the Secretary, or of HCFA, relative to the Medicare Program. We wanted to provide you with a relatively well defined package so that we could say in good faith, "This legislation permits us to do exactly this."

Chairman THOMAS. I guess you might understand the sensitivity of this Subcommittee which believes it has jurisdiction over the subject matter when in fact changing the AAPCC risk contract structure is now being done in a bill that has another Committee as its primary jurisdiction. That concerns us very much.

Mr. VLADECK. Yes, sir.

Chairman THOMAS. On the memorandum of agreement, I understand you are going to be doing it in two regions, so perhaps for the record, we need to supply some rationale for the selection of regions 6 and 7 of largely Texas and the Southwest area, and the Washington-Oregon area. What was the thinking in terms of going with these particular areas?

Dr. JOSEPH. The rationale basically comes in two parts. The first, we wanted regions that were as mature as any in the TRICARE managed care process, which involves triservice orientation of the military facilities, and a relationship with a managed care support contractor.

Second, we wanted regions where we had both a good mix of different kinds of facilities, different levels of facilities, if you will, and also where we had sophisticated medical centers that could give us

a look at the widest range of services provided to our beneficiaries. In San Antonio, both the Army and the Air Force have flagship hospitals, if that is not mixing a metaphor, and we also have a large retiree population. And in Takoma, Madigan Army Hospital is a large medical center, and we also have several smaller facilities, Navy and otherwise, in that area.

So on the grounds of both maturity and in essence, a kind of scientific selection of demonstration sites, those two regions stood out.

In those two regions, we would estimate that in the areas within those regions that we choose as demonstration sites, there are probably up to 60,000 dual eligible Medicare and military retiree individuals, and the demo will probably involve 15,000 of them, in terms of its actual execution.

Chairman THOMAS. Notwithstanding the fact that as you describe it, it is a mature managed care area that we are operating in in both regions 6 and 11, we do not have the ability to determine whether we can be smart shoppers in the area among contractors, is that true?

Dr. JOSEPH. That is correct, sir. We have existing managed care support contracts in both, and I think I carefully said "more mature." I do not think any of our TRICARE regions at this time would qualify as what people sophisticated in the health care business would call a mature HMO region; but they are most mature of our system, and meet most of the criteria of development of utilization management, quality assurance, oversight of the contract, and so forth.

Chairman THOMAS. Was there any discussion about the fact that the demonstration might not be as completely useful as possible since you have preselected the contractor in the area and will not have an opportunity to do some sharp shopping for price?

Dr. JOSEPH. I do not think so. We believe, and I can furnish you those figures if you wish, that the bargaining and negotiation over the development of those contracts were within the last 2 years in both instances, has resulted in contracts that are quite favorable on a cost basis to the government.

Chairman THOMAS. Now, we have had some discussion about the costs, and I believe that the information that we have in front of us from CBO covers the bill as it is written, and it is not theoretical, is that correct, Mr. Van de Water?

Mr. VAN DE WATER. The estimate which we prepared, Mr. Chairman, is for the bill that was reported by the National Security Committee last week, H.R. 3142. The proposals that Dr. Vladeck and Dr. Joseph have made do not comport in some significant respects with the bill as reported by the Committee. In particular, the administration's proposal is more limited with respect to the number of locations at which the demonstration could be carried out. As Dr. Vladeck said in his statement, there would also be a $65 million limit on Medicare's gross reimbursements to the Department of Defense. That is an important—a significant—difference. Therefore, although we have not seen the legislative proposal which goes along with the administration's plan, our estimate of it would not be identical to our estimate of H.R. 3142.

[The following was subsequently received:]

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

September 17, 1996

Honorable Floyd Spence
Chairman
Committee on National Security
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate of H.R. 3142, the Uniformed Services Medicare Subvention Demonstration Project Act, as ordered reported by the House Committee on National Security on September 12, 1996.

The bill would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

June E. O'Neill

Enclosure

cc: Honorable Ronald V. Dellums
Ranking Minority Member

Congressional Budget Office
Cost Estimate

September 17, 1996

1. BILL NUMBER: H.R. 3142

2. BILL TITLE: Uniformed Services Medicare Subvention Demonstration Project Act

3. BILL STATUS: As ordered reported by the House Committee on National Security on September 12, 1996.

4. BILL PURPOSE: The bill would create a demonstration project to allow Medicare to reimburse the Department of Defense (DoD) for health care that Medicare beneficiaries receive in military treatment facilities through the managed care option of the Tricare program.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

   The table below summarizes the budgetary effects of the bill. It shows the effects of the bill on direct spending and authorizations of appropriations.

(By fiscal year, in millions of dollars)

	1996	1997	1998	1999	2000	2001	2002
DIRECT SPENDING							
Spending Under Current Law							
Estimated Budget Authority	198,191	217,200	238,144	259,683	281,215	304,913	330,923
Estimated Outlays	196,051	215,516	236,419	257,411	279,466	303,179	328,522
Proposed Changes							
Estimated Budget Authority	0	150	200	200	50	0	0
Estimated Outlays	0	150	200	200	50	0	0
Spending Under the Bill							
Estimated Budget Authority	198,191	217,350	238,344	259,883	281,265	304,913	330,923
Estimated Outlays	196,051	215,666	236,619	257,611	279,516	303,179	328,522
SPENDING SUBJECT TO APPROPRIATIONS ACTION							
Spending Under Current Law							
Estimated Auth. Level[a,b]	15,117	15,117	15,117	15,117	15,117	15,117	15,117
Estimated Outlays	15,166	15,196	15,092	15,080	15,084	15,084	15,084
Proposed Changes							
Estimated Auth. Level[c]	0	-150	-200	-200	-50	0	0
Estimated Outlays	0	-100	-200	-200	-100	0	0
Spending Under the Bill							
Estimated Auth. Level[a,b]	15,117	14,967	14,917	14,917	15,067	15,117	15,117
Estimated Outlays	15,166	15,096	14,892	14,880	14,984	15,084	15,084

a. The 1996 figure is the amount already appropriated

b. Amounts for fiscal years 1997 through 2002 are authorizations subject to appropriations action and assume that appropriations under current law remain at the 1996 level. If they are adjusted for inflation the base amounts would increase by about $450 million a year, but the proposed changes would remain as shown in the table.

c. These estimates excludes the costs to administer and evaluate the demonstration program.

6. BASIS OF ESTIMATE:

The bill would require that the demonstration occur in two or more geographic regions over a three-year period beginning on January 1, 1997. The estimate assumes

that the project is limited to three of the Department of Defense's administrative regions--fewer than the bill would allow, but more than anticipated in a recent memorandum of agreement (MOA) between DoD and the Health Care Financing Administration (HCFA). The MOA defines a demonstration at several specific sites, but CBO assumes that under legislation that would give broader authority the MOA would be revised.

Under the bill, Medicare would reimburse DoD for expenditures above a base level of effort, which would be determined by DoD and HCFA in order that the demonstration project not raise overall Medicare costs. (The MOA contains a similar objective but would attempt to achieve it in a different way.)

Direct Spending

Even though the bill aims at no change in Medicare's or DoD's costs, CBO believes Medicare costs would rise by about $200 million a year. This increase would stem from informational and administrative problems in determining what each agency would have spent under current law.

The stipulation that the project be budget neutral for both DoD and Medicare would be extremely difficult to implement. Although one could argue that the measurement problems could go either way, there are at least three reasons to believe that Medicare's costs would rise under the subvention demonstration program.

First, knowing how many Medicare beneficiaries will seek care directly from DoD is difficult enough in the short term, and that uncertainty only grows over time as populations change and the availability of discretionary funding for DoD's health care programs varies. DoD does not have complete information about the extent to which its beneficiaries currently receive additional care from other sources, such as Medicare. Thus, establishing a baseline level is subject to considerable uncertainty about the numbers of beneficiaries, the extent of their receipt of care from non-DoD sources, and their response to being included in the Tricare enrollment system. Despite the current lack of an enrollment system, data from DoD indicate that it provides all health care to the equivalent of 68,000--or about 30 percent--of the 220,000 Medicare-eligible retirees or dependents living in the three regions. Probably many more people receive at least some care from DoD, but the number averages out to being the equivalent of all care for 68,000 people. If healthy retirees are undercounted in the baseline level, they would become the financial responsibility of HCFA under the bill, even though they now get most of their care from DoD.

Second, DoD and HCFA face different incentives and access to information. As a result, DoD would have an advantage in the negotiations with HCFA over the baseline level of care that would work against budget neutrality. The demonstration would tend to attract beneficiaries who had previously used a military treatment facility. DoD would therefore have information on potential participants' medical histories and would have a financial incentive to steer relatively healthy, lower-cost people to the demonstration. Moreover, DoD has a greater incentive to shift its costs to Medicare than HCFA has to prevent shifting. Because annual discretionary appropriations currently limit DoD's health care funding, the department would have to eliminate personnel or otherwise reduce its program in the face of losses from an inaccurate baseline level (alternatively, it could expand its programs if it can shift costs to Medicare). However, HCFA pays Medicare costs from a permanent and indefinite appropriation that is very large and would not readily reveal a loss stemming from a demonstration program such as this one. Even after the fact, it would not be easy for the General Accounting Office or any other auditing agency to determine the financial outcome of the demonstration because it, too, would have to rely on estimates and assumptions about events and behavior that would have otherwise occurred under current law.

Third, because Medicare's current method of paying risk plans does not adequately adjust for differences in health status among beneficiaries, Medicare's costs would rise if relatively healthy beneficiaries who would otherwise receive care in the private sector on a fee-for-service (FFS) basis choose to receive it in DoD's managed care (MC) program. (The demonstration program would pay slightly less for participants who would otherwise be enrolled in a managed care plan under Medicare.) The sector in which participants would otherwise be enrolled has important implications for the bill's potential costs. Maximum enrollment in the demonstration project would depend on an estimate of whether the participants would otherwise be enrolled in FFS or MC. If the estimate was that a large number of MC enrollees would participate, the maximum enrollment permitted under the bill would be high. If participants actually would have been FFS enrollees, however, the demonstration would incur costs for a large number of participants.

On balance, CBO estimates that DoD could shift 50 percent of its costs under the demonstration to Medicare because of measurement problems and institutional features. First, a 20 percent to 30 percent error could easily occur in measuring current efforts, and uncertainty about the future could add another 20 percent to 30 percent at least. Second, the differing incentives and access to information would lead to errors that compound rather than offset.

This estimate also assumes that the demonstration project would take place in three of DoD's administrative regions--Region 6 (Texas), Region 11 (Washington/Oregon), and Region 12 (Hawaii/Pacific). Those regions contain approximately 220,000 retired military personnel and their dependents who are entitled to Medicare insurance coverage in addition to being eligible to receive care in DoD medical facilities. The estimate assumes that 30 percent of the eligible population in those regions would ultimately enroll in DoD's managed care program to continue to receive their care from DoD. Finally, Medicare is assumed to reimburse DoD at a rate of $5,425 per capita in 1997, a rate that would rise to about $6,775 in 2000.

Spending Subject to Appropriations Action

In terms of its relationship with DoD, HCFA would pay more to DoD than it now pays to the private sector, and DoD would be free to spend the extra reimbursement on things other than medical care for the beneficiaries eligible for Medicare.

The increase in mandatory spending would allow discretionary authorizations to decline by the same amount because DoD would be able to spend the receipts from Medicare. The same factors that would lead to higher Medicare costs would obscure whether or in what amounts this demonstration project was providing net additional resources to DoD. Whether discretionary savings would actually occur would depend on annual appropriation action.

On the other hand, discretionary costs would rise to cover HCFA's and DoD's administrative costs to manage and evaluate the demonstration project. These costs would probably amount to a few million dollars.

7. PAY-AS-YOU-GO CONSIDERATIONS:

The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

(By fiscal year, in millions of dollars)

	1996	1997	1998
Change in Outlays	0	150	200
Change in Receipts		Not Applicable	

8. ESTIMATED COST TO STATE, LOCAL, AND TRIBAL GOVERNMENTS:

The bill contains no intergovernmental mandates as defined by the Unfunded Mandates Reform Act of 1995 (Public Law 104-4) and would have no significant impacts on the budgets of state, local, or tribal governments.

9. ESTIMATED IMPACT ON THE PRIVATE SECTOR:

This bill would impose no new federal private-sector mandates as defined in Public Law 104-4.

10. PREVIOUS CBO ESTIMATE: None.

11. ESTIMATE PREPARED BY:

Federal Cost Estimate: Michael A. Miller (226-2840)

Impact on State, Local, and Tribal Governments: Pepper Santalucia (225-3220)

Impact on Private Sector: Neil Singer (226-2900)

12. ESTIMATE APPROVED BY:

Paul Van de Water

Paul N. Van de Water
Assistant Director
for Budget Analysis

Chairman THOMAS. Well, notwithstanding the $200 million number, what we have is a stop loss of $65 million, is that correct?

Dr. JOSEPH. Well, sir, if I might add to that, I think there are two provisions——

Chairman THOMAS. I am just trying to understand the statement that Bruce made about the $65 million amount.

Mr. VAN DE WATER. May I comment on that, Mr. Chairman?

Dr. JOSEPH. That is only a partial—that is only a part of the stop loss that exists. As both Bruce and I said in our testimony, there is also a reconciliation process to assure no further loss, and there is also the adjustments to items within that 93 percent of AAPCC, that would further ensure against loss.

Chairman THOMAS. And how—would it in fact extend to a change in the 93 percent, plus the deducts during the reconciliation process? My concern is locking in legislatively a new number, and then reconciling it around that number, when in fact, the number may be the problem.

Mr. VLADECK. There are two issues. One is that the reconciliation process, as I understand it, actually focuses less on what Medicare has paid than on the level of effort. This level of effort refers to the maintenance of the Department of Defense's level of expenditure on behalf of its beneficiaries, before and after the demonstration.

Chairman THOMAS. You have to be comfortable that in fact they have carried out their level——

Mr. VLADECK. That is correct. Basically, the primary purpose of the reconciliation process, is to assure that there has not been a shifting of cost from preexisting patterns of expenditure by the Department of Defense to Medicare in the course of the demonstration.

Second, our agreement requires an annual review by the two Department Secretaries with the assistance of a neutral third party, if called for, of the way in which the payment methods and the percent of AAPCC are working. The agreement also ensures an opportunity to reconsider the level of payment for the subsequent year.

Although the agreement ensures a projected level of Medicare payments under the demonstration, it also provides for a mechanism which may be adjusted over the life of the demonstration in the event experience runs very different from expectations.

Chairman THOMAS. Well, and that is of concern as CBO has indicated in their analysis on page 4 where it says "Moreover, DOD has a greater incentive to shift its costs to Medicare than the Health Care Financing Administration has to prevent shifting."

I am concerned about cost shifting. I am very concerned about the adverse risk selection concerning people who are in fee-for-service versus the attraction of the military retiree on a managed care structure, especially, since you are moving into an area that has managed care, a more mature, as Dr. Joseph indicated, a more mature managed care structure. Many of these people who may be moving into the TRICARE HMO may be coming from another HMO, so that you have a significant march of people, not just from one HMO to another HMO, which might affect the risk mix, but also fee-for-service into this new military-based HMO which might in fact deal with risk selection as well.

Is this part of the demonstration project to determine the universe where they came from and the impact, not just on DOD but on the area itself in terms of health care delivery?

Mr. VLADECK. We are explicitly concerned in the evaluation, and this is an issue that has come up before in the history of the subvention discussions. We are concerned about the impact of the demonstration project on other providers of care to Medicare in the area. If every potentially eligible military retiree sought all of their care through the TRICARE system, that would clearly have an impact not only on the other Medicare HMOs in the community, but also on the community hospitals and on some of the physicians' networks.The project's impact on other providers is an explicit part of the demonstration.

Let me just add one other point if I may about the specifics of our agreement.

Eligibility for the demonstration is limited to military retirees who have either just become Medicare eligible, or who have already established user——

Chairman THOMAS. The July 1, 1996, date, right.

Mr. VLADECK [continuing]. Of military facilities. In terms of a significant shift in the patient population in San Antonio, or Takoma, we would not anticipate that, because this segment of the population is already in the system.

Chairman THOMAS. Except for those who become eligible after June——

Mr. VLADECK. Except for those who become eligible in the course of the demonstration.

Second, the TRICARE system's lock-in is analogous to other Medicare risk contractors. For instance, when beneficiaries elect the TRICARE option, beneficiaries would be eligible for Medicare reimbursement only within the TRICARE system, unless they had emergency out of area kinds of services. Both of these issues affect the nature of the risk to Medicare that would be presented by this demonstration.

I have not had a chance to discuss these issues with Mr. Van de Water before this hearing. This is not the time for us to get into details, but I believe concerns with earlier legislation and H.R. 3142 have been addressed. Some of these concerns were quite appropriately raised by CBO and have been addressed, or at least carefully considered quite a great deal as we refined this project. We will need to have further conversations with CBO to see if we can come to some closer meeting of the minds about the potential budgetary impacts.

Chairman THOMAS. And finally for this round, you indicated—both Dr. Joseph and you have indicated—that there has been a degree of spadework done over a long period of time moving to this legislation. The Chairman and the Ranking Member of the Veterans' Affairs Committee are offering a proposal which would extend it into the veterans.

Do you, Mr. Vladeck, believe that you can come to a conclusion with them in the next several months, or early next year to create what would be in essence a parallel project for the Veterans Administration as well?

Mr. VLADECK. We actually have a parallel project and a parallel understanding with the Veterans Affairs. In many ways, the Veterans Affairs' health care system is less sophisticated than the Department of Defense's system. For example, the VA subvention would involve a fee-for-service component as well as a capitated component.

We also are not as far along in being able to estimate the existing level of effort in the VA. However, the administration has proposed parallel VA legislation, and it is not identical to the DOD proposal, because the two systems are not identical.

Chairman THOMAS. And is that a yes, you would have no problem at all having a program up and running by the beginning of the year or shortly thereafter?

Mr. VLADECK. I believe that if we were to enact the corrected version of H.R. 3142, or whatever tomorrow, we could have a demonstration up and running with the Department of Defense by January 1. I am not confident that we would be able to start quite as quickly with the Veterans Affairs. We have a little bit more preparatory work to do with the VA.

Chairman THOMAS. What does that mean?

Mr. VLADECK. For example, they have not yet——

Chairman THOMAS. One year, two years, three years?

Mr. VLADECK. We could begin it during the next fiscal year, fiscal 1997.

Chairman THOMAS. Mr. Van de Water, any comments?

Mr. VAN DE WATER. Only that Dr. Vladeck is correct. Based on what we have seen in the testimony and our cursory review of the very extensive memorandum of understanding, the administration certainly has made attempts to deal with the problems that we have raised. I do not think that we would find that the cost of the administration's proposal is quite down to zero, but my initial reaction is that it would be somewhat less than H.R. 3142, as reported by the Committee.

Chairman THOMAS. Well, don't we have a requirement for budget neutrality here?

Dr. JOSEPH. In the agreement, sir, yes.

Chairman THOMAS. To what extent, notwithstanding the cap structure, do you believe any of these changes have moved us toward budget neutrality?

Mr. VAN DE WATER. Yes. We believe that the changes have moved in that direction. But as you——

Chairman THOMAS. Has it reached budget neutrality?

Mr. VAN DE WATER. Probably not.

Chairman THOMAS. OK. We will have to examine the "probably not" aspect, then.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

If I understand this, Dr. Joseph, your staff, I guess, has said that you are prohibited by statute from using CHAMPUS appropriations to assist people over 65, but you could change that statute, couldn't you? You could ask us to change that law, could you not?

Dr. JOSEPH. The Congress could certainly change that law.

Mr. STARK. All right. And then you got $9 billion more than you asked for, than the President asked for, in your budget, and you

could just spend some of that $9 billion to take care of these people, right?

Dr. JOSEPH. Well, sir, I do not have the $9 billion——

Mr. STARK. Yes, but you are getting it. So, I mean, now you are back here—the trust fund is going broke and you want us to give you money, and you got $9 billion extra. I think that is pretty gutsy. But you say that it will help you prepare for wartime readiness.

Now, explain to me, I happen to be in this age category, how my health care is going to help you make us ready in wartime. Would you explain that to me?

Dr. JOSEPH. I certainly would, and I would like to respond to your first comment afterward, if you would allow me to.

I think it is clear that for good medical care in wartime, we need highly accomplished orthopedic surgeons——

Mr. STARK. That is right. The Governor of Pennsylvania when we had the Gettysburg invasion called out the militia, all the people 15 to 60, and I suppose you have got a bunch of old folks, too, that you are going to call up. I will not come anymore. But, you know, I guess that—my point—doctor, this—look, come on——

Dr. JOSEPH. I would be happy to respond to your question, Mr. Stark, if you will allow me to.

Mr. STARK. You guys——

Dr. JOSEPH. Otherwise, I will not.

Mr. STARK [continuing]. Do not waste my time. The military did not want the Hebert School when Hebert forced it on you, now it has become an institution, and you want the Medicare Trust Fund to bail out your budget when you could pass this law in the Defense Committee. There is no reason on God's green Earth why Medicare should get in there and bail you guys out. This does not make sense. It is the dumbest thing I ever heard. And I hope that you will go back to the Secretary and the President, and tell them so. I will if you don't. It does not make any sense. Six hundred million dollars, and you guys are wasting money away on weapons systems that will not work. We have senior citizens who are not getting good medical care, and you want to reach in here—you ought to be ashamed of yourself. This just does not make any sense at all. And believe me, the President ought to be ashamed of himself. We have made a case in our party for defending Medicare, and here you guys are wasting money hand over foot. I see these stupid generals flying these helicopters every morning, you would think you would have generals smart enough to learn how to drive their own cars.

So I am afraid you ought to go back and redo this. You want this bill changed, change your own laws, and then you got all the money you need, and you can leave the Medicare Trust Fund alone.

Thank you very much, Mr. Chairman.

Chairman THOMAS. The gentleman's time is not expired.

Mr. HOUGHTON. Well, we will go back and do some more.

Chairman THOMAS. The gentlewoman from Connecticut.

Mrs. JOHNSON. I just want to clarify a few facts, and raise some concerns.

I understand this demonstration is aimed at people who are eligible for care in the military hospitals, and are Medicare eligible, is that correct?

Dr. JOSEPH. Yes, ma'am.

Mrs. JOHNSON. And it has to be people who have already received some care before June 30 in the military hospitals?

Dr. JOSEPH. That is correct.

Mrs. JOHNSON. Now, first of all, DOD is already being reimbursed for these folks. I mean, you have been providing care for them.

Dr. JOSEPH. We have been providing care for them on a space available basis. We certainly have not been reimbursed, certainly not fully reimbursed for them. That is the issue. Back in the old days, 20 or 30 years ago when there was plenty of open space in military hospitals, and plenty of excess capacity, those beneficiaries who were entitled to care on that space available basis, found it quite easy to get that care. As resources have shrunk down, and——

Mr. STARK. You are spending more money now than you were 20 years ago.

Dr. JOSEPH. Well, we have closed—I am not sure Mr. Chairman, whether I should persist in trying to answer Mrs. Johnson's remark and come back to Mr. Stark. I would be happy to do either. We have closed 30——

Chairman THOMAS. In the response to Mrs. Johnson, if you will be specific in terms of numbers and dollars, that would be inclusive.

Dr. JOSEPH. We have come down since 1988, 30 hospitals out of approximately 150. We have come down almost 30 percent in personnel, and there has been—we have closed hospitals on bases such as you yourself were referring to in your initial comments. And on the other hand, the portion of our beneficiary population which comprises this retiree group, particularly the over 65 retiree group, is our fastest growing portion of the population. So what has happened in recent years is that it has become more and more difficult for beneficiaries who were entitled to care on a space available basis to actually go in and get that care.

Now, we are not budgeted, we are not funded, for that care on a space available basis. Over the years, we have taken it out of hide, so to speak, and it used to be easy to do that.

Mrs. JOHNSON. One moment. Let me try to get this clear, Mr. Secretary.

Nationally, that is absolutely true. Nationally we have reduced the number of military hospitals, and we have an increasing number of retirees.

But in the areas where you are going to pilot this, for instance, in Bremerton, you had a growing number of retirees, but we also have been allocating more and more money to the hospital there to take care of them.

In other words, right now, we are paying for everybody who has been cared for before July 1, and the only people who are going to be eligible is that same group of people.

Dr. JOSEPH. No, ma'am, we would say that we have not been paying for all the people whose care has been supplied on a space available basis.

Mrs. JOHNSON. OK. Explain that.

Dr. JOSEPH. The facilities, the uniformed personnel, contract personnel, and the moneys to buy supplies and equipment, are not based on the care that is provided on the space available basis to those eligible beneficiaries. They are based on——

Mrs. JOHNSON. In other words, are you saying that the reimbursement for retirees treated on a space available basis has been inadequate?

Dr. JOSEPH. It has been—it is inadequate to provide that care, that is correct.

Mrs. JOHNSON. Of course, we do have that same complaint from many Medicare hospitals, that our reimbursement is inadequate to their costs, and we have gone through terrible problems with that over the years, to try to identify adequacy.

What I hear you saying is that you want us to reimburse because Medicare reimburses better than DOD reimburses, and therefore you get a more adequate benefit, is that really it?

Dr. JOSEPH. No, ma'am, I think that is—excuse me—I do not believe that is what we are saying. What we are saying in its simplest terms are that a space available beneficiary who believes quite correctly that at some time in the past was promised free lifetime care from the Department of Defense——

Mr. STARK. When was that?

Dr. JOSEPH. I beg your pardon, sir?

Mr. STARK. When was that? When were they promised that?

Dr. JOSEPH. In the recruiting brochures that——

Mr. STARK. But not in the law?

Dr. JOSEPH. But not in the law.

Mr. STARK. Yes, we should put those recruiting sergeants in jail. They were not promised that. That is not in the law.

Mrs. JOHNSON. Mr. Secretary, have you looked at the numbers as to what it would cost to allow every military retiree who used to have access to a military hospital, and therefore was covered by military appropriations to let every one of them have access to Medicare part B without penalty, and then, if the DOD thinks that it should be picking up what would be the effect of Medigap premium, then we should do that, see? But the demo you are talking about is never going to help people who do not live near a military hospital, because they are never going to qualify. This is not going to eventually affect all retirees because the eligibility criteria are too narrow.

Dr. JOSEPH. I do not think the eligibility criteria are too narrow, and our position would be that——

Mrs. JOHNSON. Well, I know in Connecticut with the reduction, there are plenty of people who now live too far from military hospitals to use them for their regular care, and what they need is access to some plan in our area, and better access to the VA hospital.

Dr. JOSEPH. And under our managed care system, our TRICARE system, that is precisely what the managed care support network provides. It provides access to care provided by the contractor——

Mrs. JOHNSON. In other words, you would see retirees throughout——

Dr. JOSEPH. [continuing]. Outside the——

Mrs. JOHNSON [continuing]. The country rather than getting access to Medicare part B, getting access, and paying their own part B premium, and their own Medigap premium, getting access to TRICARE, which would be essentially a zero premium Medicare HMO, correct?

Dr. JOSEPH. Well, if that is what they chose, number one. Number two, it would be be zero premium, because it is not for the eligible retirees. Number three, to go back to your previous——

Mrs. JOHNSON. It's not for whom?

Dr. JOSEPH. I beg your pardon, ma'am?

Mrs. JOHNSON. It is not for which retirees?

Dr. JOSEPH. It is not a zero premium. There is an enrollment fee for the retirees.

Mrs. JOHNSON. But is it an annual enrollment fee?

Dr. JOSEPH. Yes, ma'am.

Mrs. JOHNSON. Is it equal to the part B premium?

Dr. JOSEPH. It is not equal to the part B premium. It is somewhat less than the part B premium. But if I may, just to pursue that——

Mrs. JOHNSON. But it covers both part B services and Medigap services?

Dr. JOSEPH. It does not cover the current complete range of Medicare provided services. That is why the demonstration is written the way it is.

Mrs. JOHNSON. Does it cover some Medigap services?

Dr. JOSEPH. It covers some Medigap services, yes. And that is——

Mrs. JOHNSON. So it would be less than the part B premium for a larger than Medicare plan?

Dr. JOSEPH. And that is the point I was trying to get to before, that the eligible—the dual eligible retiree today can choose to go downtown to an HMO or to a private physician, and that health care provider is reimbursed for the care. That the same eligible retiree can choose, and very often does, to come back into the military hospital where for a whole series of reasons, he or she may well rather be, get that care if they can get it on a space available basis, and there is no reimbursement to us for it.

Chairman THOMAS. On that point, in the Washington area, are there any HMOs that are zero premium? Or do you have to pay, given the AAPCC in the area?

Mr. VLADECK. I am sorry, Mr. Chairman, I did not fully hear that.

Chairman THOMAS. Do you have to pay for an HMO out-of-pocket in the Washington area? Is there any HMO or——

Mr. VLADECK. I believe that we have zero premium Medicare plans. I know that we do in Maryland.

Chairman THOMAS. I did not say Maryland or——

Mr. VLADECK. I do not know about the District.

Chairman THOMAS. We do not have—that region is not in the two regions. It is the Seattle area that we are dealing with.

Mr. VLADECK. That is correct. I believe that we have zero premium plans in San Antonio and not in Seattle, that is correct, sir.

Chairman THOMAS. All right. Now, back to my original question——

Mr. VLADECK. Let me amend——

Chairman THOMAS [continuing]. There are no zero premium plans in the greater Seattle area?

Mr. VLADECK. There are now zero premium plans in the Seattle area; but there have not been any historically. In the last couple of years, there have been new entrants into the Seattle market who are offering a zero premium Medicare plan.

Chairman THOMAS. And my assumption is that the military retirees will not have to pay out of pocket?

Dr. JOSEPH. In the current demonstration agreement, there is no enrollment fee for the demonstration. However, the enrollees would pay the part B premium in the demonstration.

Chairman THOMAS. No, they would in a zero premium as well. That is nonresponsive. My concern is that we are creating a demonstration program in an area, and I do want to see the data, that shows how many people are signed up for zero premium HMO notwithstanding the fact that it is offered versus the number of people who are paying out of pocket who are nonmilitary retirees for an HMO program in the greater Seattle area for which military retirees will receive a program with no out-of-pocket payment. And that is a concern.

Mr. VLADECK. Mr. Chairman, if I may, and partially in response, or in additional response to Mrs. Johnson's question, there are a significant number of military retirees who for reasons of geographic accessibility, continuity of care, availability of particular specialties' services, or for reasons of absolute preference, continue to receive care on a space available basis through the military treatment facilities. These retirees choose this option even when they have a Medicare card with which they could get care from other providers in other institutions.

Although we have yet to completely convince CBO, this demonstration proposal is to see if we can find a way to ensure that military retirees who are Medicare beneficiaries and prefer to receive their services through the military system can continue to do so. This project will be conducted in an environment in which the expectation is that the availability of military facilities for people who are not enrolled in the TRICARE Program will diminish over time.

We have already had some instances in some parts of the country in which military hospitals were closed. Beneficiaries who were accustomed to using military facilities were able to get care elsewhere, but in many cases at the cost of some considerable inconvenience, disruption of services, or disruption of the continuity of care.

I think what our duly eligible beneficiaries are concerned about is that over time, as the military and the military health care system evolve, the military may be without some sort of subvention arrangement. It may also be less and less possible for these beneficiaries to continue to receive care from the providers from whom they have been receiving care with a very high level of satisfaction.

This is why the subvention demonstration project is defined in relatively narrow terms. For instance, participation is limited to beneficiaries who are already in the system. The project will also consider the issue of whether, given the two different ways in which the Federal Government finances health services for these beneficiaries, we can change the mix of financing to some extent. However, we hope that any change will have no net increase in cost to the Federal Government and will continue to protect the availability of these services to our dual beneficiaries.

Mrs. JOHNSON. Just to return to my question, I understand what you are trying to do, and I think there is some good rationale for doing it across the country, both for the retirees, and for veterans. But for your own enlisted people, you have done this sort of cold turkey. Now, dependents only have space available. It is a terrible system. It was not working. I am delighted you have offered TRICARE.

But why do you not just say to retirees, "Look, you can join this in order to have access to the military hospitals," and then just that part of the budget that you have used for reimbursing military hospitals, you just segregate those dollars and they go to pay TRICARE premiums. I do not see why you do not just make it competitive. I mean, military retirees can choose TRICARE, and if the military hospital is good enough to get the TRICARE business, or let them choose another managed care plan, let them have their choice of managed care plans including TRICARE. Put the military hospital with its space available limitations up against other hospitals in the other areas.

But our only concern is that our veterans have access to care, in this case military retirees. But I do not see that the system you have set up about current level of efforts and all that stuff, I mean, I hear what you are saying, but I do not know if we are going to do this. I cannot imagine doing this. I cannot imagine expanding this demo to nationwide with this kind of complexity. Now, the way we do it for other retirees has worked abominably. We capped Medicare, Medicare is a capped program. It has a target. If seniors use more services than the target anticipated, we cut rates. And that is what you are doing to TRICARE. You are saying the cap is 65 million, if you go over it, you eat the cost. And that is the risk you take.

Now, this does not work very well in Medicare, because we do not have anyone to take the risk, except ourselves, so the rates go down. That is what happens. And people lose access.

But if you make a mistake, and your 65 million is too low, it is fine to say we have capped it. The fact is people are going to get lousy care, because the risk will be too great.

So it seems to me that giving retirees the choice of TRICARE or of other managed care plans in the area, serves them far better and particularly in terms of the national demonstration project, because you are not going to have a lot of people, retirees, who are going to live near military hospitals. As you said, we have already closed 30 of them, and I think you are demonstrating the wrong thing. You are demonstrating just military retirees, near military hospitals, only ones who have been served, and all we are going to do is try to shift the real cost of that service to Medicare.

Dr. JOSEPH. Ma'am, giving the military—giving the dual eligible beneficiary that choice that you described is exactly what the demonstration does.

Mrs. JOHNSON. So you are going to give them more than a TRICARE plan? Can they choose any plan?

Dr. JOSEPH. They have the option to either stay with or join any of the Medicare options they already have, plus——

Mrs. JOHNSON. They have a Medicare fee-for-services option. In these areas, do they have Medicare HMOs?

Mr. VLADECK. Yes, they do, and in each of the metropolitan areas in the demonstration, there are a range of Medicare HMOs, including several with zero premium.

Mrs. JOHNSON. And then they will have a TRICARE HMO?

Dr. JOSEPH. And they will have a TRICARE HMO option.

Mrs. JOHNSON. Now, the ideal thing would be to give them the other HMOs. I mean, that is what we are trying to do in Medicare Plus is to give them other HMOs that guarantee the proper services.

Dr. JOSEPH. I do not understand how they would not have that option.

Mrs. JOHNSON. Well, they would have that option under Medicare Risk Programs, and under yours. What we are saying is that there are a lot of PPOs out there that are very good, and they ought to have that option, too, because it might provide better services than we are able to provide under HMO models, which both of these are.

And so if you are going to demonstrate, why do you not demonstrate HMO access, and PPO access as long as the PPOs guarantee the services that you have to have under Medicare or for retirees?

Dr. JOSEPH. Well, I think there is another aspect of this you might also consider. I heard this morning some preliminary figures that looked at a sample of Medicare eligible DOD retirees hospitalized in a San Antonio military hospital, and the preliminary numbers I got were that 30 percent of them were also enrolled in other health care for which Medicare was paying. So you are paying for it twice now.

Mr. VLADECK. We do have exactly that concern. It is part of the evaluation. But I would only say on the PPO issue, Mrs. Johnson, as you know, we are trying to do the most straightforward kinds of demonstrations we can. We are testing the availability of Medicare and PPOs through our Choices Demonstration Program.

Mrs. JOHNSON. But we did discuss that, that you needed authority in the Choices Demonstration. We are not going to pass that authority this year, so why do you not get the authority to at least test that in this demo as you are doing it——

Mr. VLADECK. No, Mrs. Johnson, I believe you may not be remembering correctly. We believe that we have the authority for the Choices Demonstrations. We are proceeding to enter into these contracts right now.

Mrs. JOHNSON. Well, my recollection was that you can proceed to a certain degree, but there are areas, ways, in which you cannot proceed because you do not have the legal authority. Why do you not get that whole legal authority to do that in this closed dem-

onstration so you can pilot, really, all the managed care plans out there, because for the same premium, they are growing and expanding, and offering far more benefit. And we ought to have that option for our retirees as well, rather than restricting them in a sense to government controlled options.

Mr. VLADECK. Well, Mrs. Johnson, if I may, I think doing so puts us on the track of the question and the discussions which we have had with this Committee and the leadership as to whether we wanted to take the part of the budget bills, specific to Medicare demonstration projects and moving these separately from the reconciliation process or in a separate process this year.

Mrs. JOHNSON. I understand that, but if you are doing——

Mr. VLADECK. I think we all decided not to do that.

Mrs. JOHNSON. If you are doing a demo that is Medicare eligibles, the goal is to give Medicare eligibles as much choice as they want, and as they care to take advantage of. And if you are going to give them now Medicare risk products, and Medicare fee-for-service, and the military HMO product, why not at the same time offer them any other product in the Bremerton area?

Thank you.

Chairman THOMAS. Thank you gentlelady.

Dr. Joseph, you have talked about the dual eligible. You have that now, obviously. We are dealing with dual eligible, correct?

Dr. JOSEPH. Yes, that is correct, sir.

Chairman THOMAS. And the military pays a portion? Let us take somebody in the Seattle area right now. Does the DOD pay a portion of their Medicare eligibility? Do they assume a portion of the cost?

Dr. JOSEPH. No, sir.

Chairman THOMAS. Medicare is carrying that price totally?

Dr. JOSEPH. Yes, sir.

Chairman THOMAS. Can that military retiree avail themselves of the military hospital on a space available basis?

Dr. JOSEPH. Space available basis.

Chairman THOMAS. And some are?

Dr. JOSEPH. And many are. As many as can get in are, yes, sir.

Chairman THOMAS. You are not now being reimbursed by Medicare?

Dr. JOSEPH. That is correct.

Chairman THOMAS. What you want to do is create not a fee-for-service, but an HMO structured reimbursement from the Medicare?

Dr. JOSEPH. Exactly, sir, under the belief that we can do that at a lower cost to Medicare than Medicare is currently carrying.

Chairman THOMAS. And this demonstration project is to simply take the Medicare portion of the dual eligible and send it through the DOD?

Dr. JOSEPH. This demonstration is to give a choice to those Medicare eligibles, to come into DOD on a space guaranteed basis with their care financed with those moneys that Medicare would expend for them otherwise.

Chairman THOMAS. And how did we arrive at a 93-percent reimbursement rate?

Mr. VLADECK. I think it is fair to say, Mr. Thomas, that it was essentially a negotiated figure. The Department of Defense initially suggested it. We subsequently suggested a lower percentage——

Chairman THOMAS. Suggested pulling the GME out of it? Who suggested pulling the GME out of it? Who suggested that?

Mr. VLADECK. We did that.

Chairman THOMAS. You did that. And then you negotiated the second and the third year at 90 percent?

Mr. VLADECK. That is correct.

Chairman THOMAS. What happens if you are wrong?

Mr. VLADECK. Well, again, that is why we have a process to annually review the demonstration to determine if it is working and the opportunity——

Chairman THOMAS. But those percentages are locked into the legislation. They are not negotiable.

Mr. VLADECK. I believe the review process is also ensured by the legislation.

Mrs. JOHNSON. Would the gentleman yield?

Mr. VLADECK. It is the reconciliation process that would then——

Chairman THOMAS. I understand, but the reconciliation process will take place outside of the 93 and 90 percent. What you have just told me is that perhaps 93 is too high, and you will then pay back some money, notwithstanding the fact that you keep the 93 percent in place. Or more appropriately, in the second and third year, since you knew from the first year that maybe the 93 percent was too high, you may work out a reconciliation process in which you reconcile dollars but you are legislatively locked into the 90-percent payment. Why do you lock in a specific payment rate? Why do you not make that part of the reconciliation so that we can have a true understanding of what that amount would be?

Mr. VLADECK. Mr. Chairman, if we did in fact do that in the way in which the legislation was drafted, then we should not have drafted it that way, and we need to correct it.

Dr. JOSEPH. It is a 3-year demonstration period.

Chairman THOMAS. That is the reason I have been pointedly making the comment that a Committee without the jurisdiction to adjust the Medicare reimbursement rate passed legislation which readjusted the Medicare reimbursement rate, and changed what was included in the AAPCC for this demonstration project, which I believe, Mr. Vladeck, HCFA was very pleased to use as a wedge in attempting to get in reality numbers which do not now exist, and for which you would have to go through this Committee to get. By doing this, you do not. My concern is the amount that you have locked in is in fact more than you should be paying, and I am very, very, concerned about the math and the structure for which DOD will account for its portion of the dual eligibility aspect to be fed back through. I know you have got a number of checks on that, and one of the reasons I would like to go ahead with the project is to begin to look at these kinds of numbers. They may not be sufficiently compelling, but it is very interesting in terms of what those numbers might be.

I hope that the 93 for the first year, and the 90 for the second and third year were not completely the subject of negotiations. I assume you have some facts, charts, understanding, of regions 6 and

11 as to what might be an appropriate average adjusted per capita cost payment with the takeouts, carve-outs that have been involved.

Do you have data to support your——

Mr. VLADECK. We do not have data specific to the area, Mr. Chairman. We have some research which we have recently published, and it is consistent with the earlier research done by Mathematica Incorporated. This research suggests that on average, 95 percent of AAPCC for the Medicare Risk Program is probably too high given the actual selection of risk experienced by Medicare HMOs through 1994, rather something between 90 and 91 percent is probably a more appropriate estimate of the relative risk. This is where that number comes from.

Chairman THOMAS. Explain to me the logic of locking in a specific reimbursement rate, different in the last 2 years than the first year, but providing a reconciliation structure if in fact that payment is too high.

Mr. VLADECK. Well, it is not the payment which the reconciliation addresses, and that is——

Chairman THOMAS. What happens then if the payment is too high?

Mr. VLADECK. If the payment is too high, again, the two Department Secretaries would have the opportunity under the agreement to annually revisit the payment rate. We had ensured this provision in the agreement. If the legislation is drafted differently, then we need to correct it.

Chairman THOMAS. Why do we not eliminate any specific numbers in the legislation so that you can work it out and adjust it so it can be a true demonstration project. If you believe the current rate is too high, you can move it to wherever you want with the figures, and if they are substantiated, it would certainly be a very useful argument to present as to what the appropriate AAPCC percentage should be for HMOs.

Mr. VLADECK. Mr. Chairman, it was our perception that a specification of the reimbursement mechanism in the legislative proposal would facilitate favorable Congressional Budget Office scoring of the legislation. However, our perception appears to have been incorrect.

Chairman THOMAS. And you felt that the discussion in the National Security Committee on the AAPCC rate, and the 93 percent shifting to 90, and the withhold on the DSH payments was an enlightening one? I am sure they went into that discussion on the way you had structured it.

Mr. VLADECK. Mr. Chairman, I was not present for that discussion. I must say, however, that——

Chairman THOMAS. A discussion, anyone who was present there?

Dr. JOSEPH. The technical discussion you describe was not—did not take place.

Chairman THOMAS. I did not think there would be.

Mr. VLADECK. I am not familiar with the way in which Congress establishes the order in which Committees with overlapping jurisdiction act on proposals, but as I am sure you can understand, we never had any belief, desire, or illusion that this legislation would go forward without the Committee on Ways and Means acting on

it. Please understand that we have no confusion or illusions about jurisdiction over the Medicare Program, and—from our perspective, the timing of the two, of the work of the two Committees, is unrelated to our understanding of your jurisdiction over anything having to do with Medicare.

Chairman THOMAS. Would you assume that the numbers that you worked out with DOD on this particular subvention program would be appropriate numbers for the veterans VISN Program?

Mr. VLADECK. Yes, we have talked about the same kind of numbers for the capitated part of the veterans program.

Chairman THOMAS. And have your discussions reached the stage that you would have geographic regions in mind similar to the way in which you selected regions 6 and 11 for veterans, or is that a bit more informally spread out?

Mr. VLADECK. Well, that is just a part of the discussion that is not as far along with the Veterans Affairs as with the DOD. We have not yet gone to the level of specifying sites for the demonstration with the VA.

Mrs. JOHNSON. I would like to clear up one issue. Can the TRICARE plans contract with any hospital in the area they choose to?

Dr. JOSEPH. The managed care support contractor develops a preferred provider network, and essentially has freedom of choice in the development of that network. I can consider a situation that if we thought that a provider was not——

Mrs. JOHNSON. Yes, there is a problem here you are overlooking. The TRICARE managed care provider will not be able to contract with the medical center in Washington, because they do not have any ability to compensate for the costs of teaching medical education, because you have taken that out. Have you made any provision for where TRICARE plans need to use teaching hospitals for those teaching hospitals to get a special separate supplemental payment to cover the cost of medical education?

Dr. JOSEPH. Actually, Mrs. Johnson, the most recently concluded managed care support contractor in the upper Midwest and Rocky Mountain West, the alliance of providers in that network includes a number of the university teaching hospitals in those States, so I do not think that you are—and in other regions as well, there are university medical centers who are part of the provider network. So your point is not correct.

Mrs. JOHNSON. Well, it may be correct that we are letting managed care hospitals negotiate and include medical centers in their negotiated rate, but it is also true that that rate does not include the medical education provision, or if it does, it goes into profit, and it is absolutely true that this is stripping dollars out for medical centers across America.

So I am concerned that you would by law take the medical education portion out and then not have any way to feed it back into our teaching centers. If a patient needs to go to that component of a managed care system, it is not healthy for the managed care system to be reimbursing the teaching hospital the same way it reimburses other hospitals, and this is a bomb waiting to explode in the Medicare system as HMOs take more and more of the business.

So I do not want to see that bomb planted in your demo, and I would want to see some provision for an additional payment from HCFA, for any patient referred to and treated in a medical center. That is an issue I would consider very open in this legislation.

Thank you.

Chairman THOMAS. Dr. Joseph, I am interested in your response to Mrs. Johnson about the fact that the statement that she made was not true. Having expanded on it, do you believe that her statement is not so?

Dr. JOSEPH. My comment that her statement was not correct was with respect to the fact that we do provide services through academic health centers in our existing managed care support contracts.

Chairman THOMAS. What we have in front of us is a demonstration project that specifically pulls out of the reimbursement those payments with no structure for feeding it back through—all of the direct medical education, the disproportionate share and 40 percent of the indirect.

Dr. JOSEPH. The pullout in the demonstration is I believe a different issue than the one Mrs. Johnson raised. The pullout in the demonstration is with respect to what Medicare reimburses to the DOD for our direct medical—graduate medical education, and related costs.

Chairman THOMAS. And if you do contract with a teaching hospital in the greater Seattle area, how do they get their payment?

Mrs. JOHNSON. Does Medicare have any obligation to reimburse in addition to what they are reimbursing you outside of your reimbursement system? See, if this demonstration project does not address that, I understand for you, it does not matter. For health quality in America, it matters a lot. Not only do those medical centers have teaching costs, they have the highest disproportional share, often because they have the really poor patients who are terribly, terribly, ill, and require intensive care.

So you really have to look at that from the larger policy area, Mr. Vladeck, and I think we need to look at that if this is going to go forward.

Mr. VLADECK. Mrs. Johnson, that is exactly why the impact of this demonstration on the other providers of service in the communities served is so central a part of our evaluation.

Mrs. JOHNSON. But Mr. Vladeck, we are already seeing that this is harming our medical centers. Would it be responsible to put a 3-year demonstration project in place that clearly denied them reimbursement for 3 years for anyone covered under this when we already see it? I hear it out there in the real world from my medical centers that managed care is negotiating out their medical reimbursement dollars, and they are hurting.

So I think we cannot ignore it in structuring this demonstration project.

Mr. VLADECK. Well, if I may, Mrs. Johnson, our expectation is that the bulk of the inpatient hospital services in this demonstration will be provided in the military hospitals which do conduct medical education activities, supported by appropriated funds.

Therefore, the issue of taking these funds out for purposes of this demonstration is an issue of avoiding double payments.

Mrs. JOHNSON. Well, that is why I asked whether these TRICARE plans only were going to deal with military hospitals. I understand that military hospitals have different funding streams. Nonetheless, you need to make provision in this for when nonmilitary hospitals provide sophisticated care, when medical centers that provide medical education provide sophisticated care, they need to be guaranteed a medical education reimbursement because we did not pass the Medicare Preservation Act which began to separately fund medical education. We have no system for separately funding medical education.

So it would be irresponsible to have a demonstration project that took those dollars out, and then did not give them back to the very institutions that we wrote the law to fund.

And likewise, in disproportionate share. You cannot get care—maybe not the teaching hospital, but if TRICARE includes any county hospital which may or may not be teaching, it has a high disproportionate share, and you cannot just ignore that. So I do want to look at the reimbursement structure for the nonmilitary hospitals that TRICARE contracts with, and make sure that they get a fair level of reimbursement. That is my only point. And I think that has to be addressed before this goes forward. This is the problem with a nonreimbursement-oriented committee because this is a terrible quagmire now in our law. But other Committees do not talk about it. I do not blame them. It is terribly boring. But it is terribly important.

So I think we have to get HCFA back involved in a more honest reimbursement structure, reimbursement payment system, for the nonmilitary hospitals involved.

Thank you.

Chairman THOMAS. If in fact we are using military hospitals as the anchor, and you assume the single contractor you have already negotiated with will provide a lot of the ancillary necessities for Medicare beneficiaries—skilled nursing facility, home health care, and so on—what comfort level do you have that the military hospitals are in fact able to provide the full medical hospital component, geriatrics, and so forth, for the retirees, and that you may not have to contract out, and what provision are you going to include for those individuals—and I wish some of my colleagues from the other side of the aisle were here—are you going to include an "any willing provider" structure in your HMO package called TRICARE?

Dr. JOSEPH. On your first point, I think we feel confident and in part, it is a matter of the beneficiaries who have voted with their feet to try and get into the space available structure, that those services which we do provide, and in our larger hospitals, that really is a full range of services from a quality—from a quality point of view, or entirely adequate. We have—we can provide you with lots of material that supports that assertion.

As to your second question, Mr. Chairman, I do not believe we have in any willing provider a clause in any of our TRICARE managed support contracts, but I need to check that to be sure, and we will get back to you. I do not believe——

Chairman THOMAS. And you are utilizing the military hospitals as the primary anchor.

Dr. JOSEPH. Yes.

Chairman THOMAS. I guess my concern would then go back partially to the Ranking Member's question earlier, to the degree this is a successful program, and your military hospitals cater to a larger number of military retirees, and your hospitals begin to—perhaps specialize is too strong a word—but clearly meet the needs of competition, because as you said, these military retirees are going to vote with their feet, and if you do not maintain military hospitals at least on a minimum par with what is going on in the private sector for retirees, you may in fact be devoting authorized appropriated dollars through the DOD to change the military hospitals gradually or significantly to meet those military retirees' needs, to maintain the program for the reimbursement from the regular Medicare Program; and the last time I checked, in terms of military preparedness, geriatrics was not a significant aspect of military preparedness for field operations, which was one of your earlier rationales for doing it.

Dr. JOSEPH. Well, it is still one of my very strong rationales, and I think that your statement and mine both bear a little closer examination. To go to war, we need well prepared neurosurgeons, chest surgeons, orthopedic surgeons. I will leave out the primary care issues for the moment. To be a well prepared neurosurgeon, or a chest surgeon, you have to do neurosurgery or chest surgery on a frequent basis; you have to do it with complicated cases; you have to do it with sick people; and particularly relevant to the wartime requirement setting, you have to do it with patients who have multiple, multiorgan system problems. I think you would agree with that.

You do not find that range or level of intensity of problems in healthy 23-year-old active duty military persons. So I could draw out many more examples. I think there is a very strong case to be made. I am not trying to——

Chairman THOMAS. I understand the direction you are going. I think your arguments are valid in my instances. The problem is this, when you convert from peacetime to military medical needs, in the old system, the large universe of your patients went with you. You were tied to the military, you were like the camp structure, you packed up and went with them.

What you are now proposing is to move far more radically into taking care of those who do not move with you when the camp moves for military purposes and you have structured your hospitals and those doctors who do all those cases are still going to have to do all those cases if you are going to maintain your military retiree profile through your structure that you have established, and then you are going to come back and ask for even more people when you have got to decamp and go on to a military structure. And my concern is, you are building in an establishment structure which you cannot take with you, which is the primary argument you have made, even in terms of working on those patients. Those patients are not going with you. They are going to be back there, they are going to have demands on the system, and they are going to want people in the hospital taking care of them.

Dr. JOSEPH. No, sir. Two points. One point is that the reserve medical structure, and now the responsibilities of the managed care

support contractor are to backfill those requirements when a medical contingent moves out, and deploys.

In fact, again, I can give you specific figures referring to the deployment in Bosnia. There was basically no sag in our ability to maintain access, both in Germany, and in the United States because of that. That backfill structure is very important to us.

My second point, the other side of that practice, availability to have sick complicated patients to keep that surgeon sharp, the other side of that is the ability to recruit, to retain, to keep professionally satisfied the quality of people that we want and need in the system. And in some contrast to previous decades—and again, I can give you specifics on this if you wish—we have by any standards of measure and accreditation, an extraordinarily well qualified medical and health professional cadre in the military.

Without the kind of broad population experience, interest, if I may sort of in the jargon, we would not be able to recruit and retain that quality young orthopedist, or critical care nurse, or neurosurgeon. That is the other side of the requirement to have a full up round, busy complicated, medical practice, in our setting.

Chairman THOMAS. Now, that is a rationale that has not been completely explored, and I understand that argument.

I guess we have come largely full circle, because on your previous arguments, I did not understand why when you are going to rely on the private sector to backfill, and that was——

Dr. JOSEPH. And reserves, sir, excuse me.

Chairman THOMAS. I understand. The point is, why not simply allow the military retirees to be what triggered this whole Medicare discussion in the first place; that is, 65 years old and Medicare eligible. All of the others are secondary criteria, and you are trying to create a new structure, which will take the secondary criteria and elevate it to the primary criteria. We are concerned that these people ought to go rather than to have the backfill structure available when you pull up your operation and leave, they should be at the backfill structure to begin with, private sector.

Your argument about attracting people because their medical practice is more interesting because we have been able to fund military retirees coming back to the bases and therefore it is a little bit like bombers and airplane pilots, they get to fly multiengine jets and transports, which has a direct applicability to the private sector in getting a pilot's ticket to fly, and these doctors will come out of the military more fully prepared to enter the private sector having had this kind of training.

That is an argument that we will have to look at through all of the numbers that are being generated, because if in fact, all of this synergistic positive stuff that you are talking about can be carried out at no additional cost, or preferably, at a savings, then I am interested in looking at it.

My problem is right now, the way the numbers go together with dual eligibles, and what you are asking for and what you may run through your appropriated structure to take care of it, and especially CBO's analysis about the question of adverse risk selection from the fee-for-service into this kind of a program does not give me a level of confidence that in fact it will be budget neutral, zero cost, on this demonstration project, or if in fact, this were fully im-

plemented, and we have got to work with these numbers to get a little higher comfort level than I have right now.

Dr. JOSEPH. If I may, Mr. Chairman, just add one factor to that chain you drew, I think quite accurately, of this complicated synergistic stuff, you have left out one very important thing, it is that the dual eligible beneficiaries want to be cared for in the military health system, and that is what starts that change.

Chairman THOMAS. You should not have placed that on the table, Dr. Joseph. The problem we have has been too many people "want." We do not have enough money to fund the needs. We are going to have to go back in and make some very, very, difficult judgments about what people are going to be able to receive as far as benefits, how much they are going to have to pay. And for you to come before this Subcommittee dealing with Medicare and say you want to structure this program because somebody wants to do it this way is in no way a rationale that this Subcommittee, this Full Committee, or this Congress, will entertain. If it saves money, if in fact there are benefits to it without costing money, then we can talk about moving forward with the program.

But to come here and justify a program because somebody who has a particular position in life wants it, and therefore they should get it even if it costs more money, is not a rationale that should be provided at all.

Dr. JOSEPH. No, sir. A poor choice of words on my part. The needs remain the same wherever the dual beneficiaries get their care——

Chairman THOMAS. And our goal is the most cost effective way of delivering it, and——

Dr. JOSEPH. Yes, sir.

Chairman THOMAS [continuing]. All your other arguments ought to be presented. Do not present that one.

Dr. JOSEPH. I think wisdom says I will hold my response to that, but I think it is an accurate response.

Chairman THOMAS. I understand. And coming where you are coming from, I understand that as an argument as well. Because just as unions like the idea of what we proposed, a seamless transfer from the workplace to retirement so that they could maintain their seniors' affinity to the hiring hall and the structure that it provides in a social as well as an economic and health care way is an argument that is applicable to the military as well. And I understand that. But that is way down on our list of making changes in the system.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Yes, I just wanted to pursue your comments about preparing a medical capability to serve an at war force in peacetime. I think this is a very big problem. I think you are right about that. And I am glad to see you sort of beginning to plan. I do not think that this demonstration goes very far to satisfy that, because you are limiting it to people who have already had care in the military hospital.

Now, if they have had a transplant, they are unlikely to have another one, or if they have had hip replacement. I mean, what you really need is new people coming in. So this demonstration is not central to the solution to that problem. Eventually, what you are

going to need is to have some arrangements with other hospitals in the area where your surgeons work there, or they feed people in, because you are absolutely right, if your people are not doing complicated surgery regularly, when they get out in the battlefield circumstances, they will not be good. And we cannot afford that.

So I appreciate the problem, and some aspects of how this will address it, but it does concern me that this demonstration is limited only to those who have already used military hospitals.

Now, I know you are trying to control costs, but could we not figure out some way that those who have been cycled out, new ones could come in?

Dr. JOSEPH. Well, I think I am really stealing a little bit from Mr. Vladeck's expertise here. But the purpose of that was to assure that the demonstration itself did not attract into the military so-called "ghosts," people who had never, or did not use it before, and now would use it. And with respect to your first point, I would have to respectfully say that if I have routine care or care for my mild hypertension last June, and now I have carcinoma of the pancreas, that does not make me any less—that is not any less interesting a patient or important a patient to the MTF.

Mrs. JOHNSON. There is an impact on the nature of your population, since it is the same, and as you do more and more medical service to it, you get less and less experience. That is the only point I was making. And I think you ought to at least consider how you could write this so that as people either die off, or cycle out, or move and go someplace else, maybe you get some refreshment of your pool. I understand the risk selection problems.

Thank you very much for your patience.

Chairman THOMAS. I want to thank you folks. We are supposed to be budget neutral in this. And any numbers that you can get to us as quickly as you can, Bruce, so that we can get a comfort level—obviously, the third gentleman at the table that I called up is someone that I am looking for a comfort level from, Mr. Van de Water. CBO has done an outstanding job of trying to stay on top of this changing legislation. The fact that we have a $65 million stop loss in there does not give me a comfort level of budget neutrality. You need to look at these numbers. If you need a letter to do it, we will authorize it. And I guess at the same time, if you can piggyback the veterans bill so that we can see from any kind of a proposed timeline, we will have to look at this legislation which looks to me like it was written primarily by taking the Hefley legislation, pulling out DOD, and writing in "Veterans Administration." That is a quick way to write a bill. I do not know if it produces the result that we are looking for with the VA.

Bruce, I guess we will be asking HCFA also if you have been carrying out those negotiations to give us some comfort level on as accurate a timeline as possible for moving it into a similar program. I assume through their VISN managed care structure, and we have got to do this in a relatively short period of time so that we can try to make some decisions.

Thank you very much.

The Subcommittee hearing is adjourned.

[Whereupon, at 4:30 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF KAREN IGNAGNI
PRESIDENT AND CEO
AMERICAN ASSOCIATION OF HEALTH PLANS

The American Association of Health Plans represents 1,000 HMOs, PPOs, and similar network health plans. Together, AAHP member plans provide care for over 100 million Americans nationwide.

Over the past two years, the number of beneficiaries enrolled in Medicare HMOs has grown by twenty-five percent. Today, nearly 4.4 million Medicare beneficiaries have chosen to enroll in Medicare HMOs. HMO Medicare enrollees benefit from the many advantages offered by our plans, including an emphasis on preventive services and early intervention when health conditions arise, affordable and predictable out-of-pocket costs, little or no paperwork, and access to a coordinated care system. These advantages are the foundation for the success of the present Medicare HMO contracting program and reflect our philosophy of care: quality, affordable health care from health plans where the patient comes first.

The Department of Health and Human Services (HHS) and the Department of Defense (DoD) have entered into a Memorandum of Agreement (MoA) on the terms of a demonstration project under which military retirees who are Medicare-eligible would be permitted to elect enrollment in DoD's TriCare program. The demonstration is intended to test Medicare subvention -- Medicare reimbursement to DoD for services provided to Medicare-eligible military retirees in military treatment facilities (MTFs).

The American Association of Health Plans has serious concerns about this demonstration. Our concerns focus on MTFs' readiness for a managed care demonstration, the standards of care placed upon MTFs under the demonstration, and the impact of the cost of the demonstration on the Medicare Trust Funds.

First, before the military enters the Medicare risk contract business, DoD and HHS need to ensure that MTFs are adequately prepared to meet the challenges of serving Medicare beneficiaries through a risk contracting program. MTFs are not accustomed to operating as an HMO, nor are they experienced in meeting the needs of an older population. As our health plans can attest, managing a Medicare risk contract can be complex. Many of our health plans have spent years developing prevention services, education and outreach programs, and provider networks tailored to the needs of Medicare beneficiaries.

As the range of offerings to Medicare beneficiaries expands, it is critical to maintain strong and comparable standards for all options. Medicare beneficiaries need assurances that all plans they are choosing among have comparable standards related to access, quality of care, and consumer protection. Beneficiaries enrolled under the proposed demonstration should have the same consumer protections guaranteed to over 4 million Medicare beneficiaries enrolled in the risk contracting program. While the Memorandum of Agreement between HHS and DoD holds Military Treatment Facilities (MTFs) accountable to many of the same requirements placed on Medicare risk contractors, in some cases, the MoA appears to place lesser standards on these facilities. In fact, under the MoA, DoD is required to meet or *will be deemed to meet*, the applicable and agreed upon requirements similar to those required of Medicare risk HMOs. AAHP opposes a demonstration that would use deeming to excuse the military health system from meeting the same standards placed on Medicare risk contractors.

For example, AAHP is especially concerned regarding the MoA's requirement for a DoD quality assurance program. Medicare risk contractors must have an ongoing, internal, quality assurance program that includes a written quality assurance plan, a process for review by the plan's Board of Directors, and an active quality assurance committee. The MoA states that DoD has a "corporate program for ensuring quality of care in the MHSS" thus satisfying quality assurance program requirements. We have concerns that DoD's quality assurance program is not sufficient to monitor the quality of care provided to Medicare beneficiaries at different MTF locations. Such a centralized program lacks the dedicated personnel to conduct continuous quality assurance activities that stress health outcomes. This section of the MoA appears to place a lower standard on DoD than on Medicare risk contractors and raises concern that MTFs lack the strong quality assurance and utilization review programs necessary for effective care management.

Under the demonstration, DoD must maintain its current expenditure level (adjusted for

inflation) for dually eligible military retirees in the geographic area of the demonstration. AAHP has serious concerns about the methodology that DoD plans to use to estimate its baseline "Level-of -Effort" (LOE) for the demonstration, making it difficult to assure cost neutrality. The Memorandum of Agreement itself discusses the difficulties of estimating service utilization and costs of outpatient care for Medicare beneficiaries at military facilities. We do not believe that HCFA has sufficiently studied or addressed the possible disruptive impact that the payment or benefit design of this demonstration will have on markets covered by the demonstration. The payments to MTFs may permit them to offer significant incentives to beneficiaries to elect the option available under the demonstration rather than existing options offered by Medicare risk contractors. Unless this is an explicit goal of the demonstration, this impact should be of concern to all parties.

During his statement before the Subcommittee on Health, House Committee on Ways and Means on September 17, 1996, Bruce Vladeck, HCFA Administrator, commented that the payment methodology under the demonstration reflected HCFA's thinking on the direction of payments to Medicare risk contractors. The payment levels established for the purposes of the demonstration were the result of negotiations between DoD and HHS and reflected the unique characteristics of the MTFs and the link between DoD and Medicare funding streams. AAHP strongly cautions against using a demonstration of this type to establish future policy on AAPCC payments to Medicare risk contractors that are substantially dissimilar in their delivery networks, quality assurance programs, and financing structures to MTFs.

Although this demonstration program was not enacted by Congress, this type of demonstration program will likely be considered during the next session. The Association is looking forward to working with members of the committee to ensure consumer protections and a sound financing mechanism for any future demonstration.

STATEMENT OF CDR MIKE LORD, USN (RET.), AND LCDR VIRGINIA TORSCH, MSC, USNR MILITARY COALITION

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE:

The Military Coalition (TMC) would like to express appreciation to the Chairman and distinguished members of the House Ways and Means Committee's Subcommittee on Health for allowing TMC to express its views on this health care imperative for retired service members and their families. This statement provides the collective views of the following military and veterans organizations which represent approximately 5 million current and former members of the seven uniformed services, officer and enlisted, active, reserve and retired plus their families and survivors.

- Air Force Association
- Army Aviation Association of America
- Association of Military Surgeons of the United States
- Association of the United States Army
- Chief Warrant Officer and Warrant Officer Association, United States Coast Guard
- Commissioned Officers Association of the United States Public Health Service, Inc.
- Enlisted Association of the National Guard of the United States
- Fleet Reserve Association
- Jewish War Veterans of the United States of America
- Marine Corps League
- Marine Corps Reserve Officers Association
- National Guard Association of the United States
- National Military Family Association
- National Order of Battlefield Commissions
- Naval Enlisted Reserve Association
- Navy League of the United States
- Reserve Officers Association
- The Military Chaplains Association of the United States of America
- The Retired Enlisted Association
- The Retired Officers Association
- United Armed Forces Association
- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- Veterans of Foreign Wars

INTRODUCTION

For nearly two centuries, uniformed services retirees have been led to believe that they have a right to medical care in military facilities following retirement. In brief, this lifetime right had its genesis in 1798, when service members in the U.S. Marine Corps, and then the U.S. Navy, made a monthly contribution to the Hospital Fund to pay for such care for a period of more than 145 years -- a contribution that continued after retirement. Records indicate that money from the Hospital Fund was used to build the Brooklyn, Philadelphia and Chelsea Naval Hospitals. When the contribution was discontinued by Congress in 1943, Congressional hearings made clear that members were to retain the right to care. It is equally clear that members of the other services have always been led to believe they would be provided care for life in military treatment facilities. The assurance of such care was one of the important factors in inducing service members to endure the extraordinary demands and personal sacrifices inherent to a career in uniform.

In 1965, Congress enacted Medicare legislation. One year later, as a means of further improving the military health benefit for non-active duty beneficiaries, Congress established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In adopting this legislation, which terminated CHAMPUS eligibility at age 65, the House Armed Services Committee reasoned "... **military retirees would continue to have two medical programs upon reaching age 65 -- the use of the military medical facilities on a space-available basis and the Social Security Medicare program. Under the circumstances, it appears that the two remaining medical sources would provide a fair program of assistance.**"

If retired service members did not have an implied right to hospital care, the government would have no responsibility to provide such care. The fact is, however, that for more than three decades, key officials have acknowledged the government's responsibility in this area. It was affirmed clearly by Dr. William Gorham, the Deputy Assistant Secretary of Defense for Special Projects, Office of the Assistant Secretary of Defense for Manpower, during hearings on the 1963 military pay bill. During this hearing the following exchange took place between Representative Charles Gubser of California and Dr. William Gorham:

MR. GUBSER: ***Now I realize that the Department of Defense as of the early part of this month has initiated a study by which they are going to thoroughly explore the question of retired persons. Are you at liberty to say whether or not the fact that this study has been instituted is a recognition that there is a responsibility to retired persons on the part of the government?***

MR. GORHAM: ***I don't think there is any question about that, Mr. Gubser.***

MR. GUBSER: ***I am not asking for a prediction, because you don't know what that study is going to reveal, but would you presently anticipate that insofar as medical care is concerned is there going to be something provided for retired personnel in the future?***

MR. GORHAM: ***Yes.***

MR. GUBSER: ***In other words, we are not going to be put in the position of raising their retired pay in this bill and then taking it away by taking away fringe benefits?***

MR. GORHAM: ***Absolutely not.***

In a statement announcing the above-mentioned study, the Department of Defense said,

> *"Health care for retired military personnel and their dependents in military hospitals is a traditional military benefit. In the statute which specifically authorizes this benefit, Congress indicated that its purpose is '...to create and maintain high morale in the uniformed services'."*

In the completed version, the study clearly established the Government's moral obligation to provide medical care to military retirees and their dependents. Considerable evidence of the government's commitment is cited in the Department of Defense's study, **Medical Care for Retired Military Personnel and Their Dependents,** dated June 1964. On page 21 of that study are the following quotations from official service recruiting publications:

> *"And let's not forget those many other benefits of this act which go a long way toward providing the SECURITY that both you and your family want, and lifetime security and protection for you and yours --- even after retirement through guaranteed medical care at military facilities."*
> *(From "Army Benefits" Department of Army, 1956,611-180-RPC)*

> *"He retires -- while still a young man -- equipped to start a second career. He has retirement pay, benefits and full medical care." (From "Your Son's Future", Department of the Army 1962, me 62--125B, 250M)*

> *"As a Navy man, you ..... receive free medical and dental care now and after retirement." (From "Figuring Your Future", Department of Navy NRAF--26502)*

> *"Just think when you do retire or go into Fleet Reserve, you retain almost all of the benefits you enjoyed while on active duty, including HOSPITALIZATION for you AND YOUR DEPENDENTS for life." (From Navy Career Appraisal Team Representation Guide", Department of Navy, NAVPERS 15897-A)*

The Department of Defense study also concedes that there is a legal obligation on the Government's part to provide care to those retirees who paid into the old Naval Hospital Fund.

Subsequent hearings before the House Armed Services Committee, March 1966 shed more light on the commitment.

> *"After careful study of the Secretary of Defense's proposal to provide medical care for retired military personnel and their dependents, we find that the proposal does not address itself to the correction of the inequities of the space-available language of Chapter 55, Title 10, U.S.C., specifically, Sections 1074(b), 1076(b), and 1083. The problem of medical care for retirees came about because of a legislative misinterpretation of the language in those two sections. The Special Subcommittee in its report (No. 67), dated 30 September 1964, stating the Subcommittee's findings of its comprehensive hearings recommended: That amendatory language be added to the Dependents' Medical Care Act, making it unmistakably clear that the so-called space-available concept may not be used as a vehicle to limit or eliminate space available for retired military personnel and their dependents in military facilities."*

> ***Therefore, the language should be changed from its present, permissive nature by substituting the word SHALL for the word MAY in those sections. This change would clarify and establish the right to such care for military retirees and their dependents.'***

In 1965, Congress enacted Medicare legislation. One year later, as a means to further improve the military health benefit for non-active duty beneficiaries, Congress established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In adopting this legislation, the House Armed Services Committee reasoned:

> ***"(a) The benefits of this legislation should be considered a transitional civilian program for retirees, who now enter the rolls at about age 44, until they become eligible for Social Security Medicare at age 65.***
> ***(b) ... military retirees would continue to have two medical programs upon reaching age 65 -- the use of the military medical facilities on a space-available basis and the Social Security Medicare program. Under the circumstances, it appears that the two remaining medical sources would provide a fair program of assistance." (Emphasis added)***

More recently, this obligation was reaffirmed in remarks made by Dr. Stephen Joseph, Assistant Secretary of Defense for Health Affairs, at a hearing before the House Government Reform and Oversight Committee's Subcommittee on Civil Service. On September 12, 1995, Dr. Joseph acknowledged that recruiters and commanders had led members to believe that they had a lifetime commitment to military health care. While Dr. Joseph did not stipulate that the commitment was a contractual obligation, he stated that there was an implied moral commitment to provide health care to those currently serving and those who retired following their service careers. A review of recruiting and retention literature further corroborates the commitment to lifetime health care by the Services to all uniformed services beneficiaries. The following provides indisputable evidence that the free lifetime medical promise was being made as late as 1993.

Marines, Life in the Marine Corps- **(Undated, but in use)**

> ***"Benefits... These are only a few of the great extras you'll find when you join the Marine Corps. And the nice part is, should you decide to make a career of the Corps, the benefits don't stop when you retire. In addition to medical and commissary privileges, you'll receive excellent retirement pay..."***

Air Force Pre-reenlistment Counseling Guide. **(Chapter 5 Medical Care, Section 5-2.f., dated 1 April 1986)**

> ***"One very important point, you never lose your eligibility for treatment in military hospitals and clinics."***

United States Coast Guard Career Information Guide. **(USGPO 1991-)**

> ***"Retirement -- Most career Coast Guardsmen retire after serving between twenty and thirty years of service. Current retirement programs allow you to collect about half of your base pay at twenty years and up to three-fourths base pay at thirty years.***
>
> ***"Retirement benefits mean more than pay too. You continue to receive free medical and dental treatment for yourself plus***

medical care for dependents. You also remain welcome at military commissaries, clubs and exchanges. Free space-available travel on some military flights allows retirees to travel to exotic foreign lands..."

Guide to the Commissioned Corps Personnel System, March 1985

"Noncontributory medical care during active duty and retirement for both officer and dependents."

Army Recruiting Brochure, "Army Benefits
(RPI 909, November 1991)(Still in use by recruiters in 1993).

"Superb Health Care. Health Care is provided to you and your family members while you are in the Army, and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement." (Emphasis added)

As further evidence of the lifetime health care commitment, it is instructive to reflect on a 1991 study by the Congressional Research Service, titled Military Health Care/CHAMPUS Management Initiatives , prepared by David F. Burrelli, an analyst in National Defense, Foreign Affairs and National Defense Division, on May 14, 1991.

".....The Dependents' Medical Care Act (P.L. 84--569; June 1956; 70 Stat. 250) described and defined retiree/dependent eligibility for health care at military treatment facilities (MTFs) as being on a space-available basis. Thus, for the first time, the dependents of active duty personnel were entitled to health care at MTFs on a space-available basis. Authority was also provided to care for retirees and their dependents at these facilities (without entitlement) on a space-available basis.....Although no authority for entitlement was extended to retirees and their dependents, the availability of health care was almost assured, given the small number of such persons. Therefore, while not legally authorized, for many the "promise" of "free" health care "for life" was functionally true. This "promise" is widely believed and it was and continues to be a useful tool for recruiting and retention purposes

MEDICAL COVERAGE SECOND TO MOST?

Unfortunately, the American public -- and many in Congress -- have the misperception that uniformed services retirees have better-than-average health care benefits. This is correct in terms of the quality of care for those who are able to access military treatment facilities. However, for an ever increasing number of beneficiaries, particularly those age 65 and older, this access is a myth. The Department of Defense is virtually the only large employer that terminates its retirees' health coverage when they turn 65.

In contrast, nearly all of the largest U.S. corporate and government employers provide their retirees substantial employer-paid health coverage in addition to Medicare. Data from a 1994 survey by Hay Associates (one of the nation's most-respected firms in the area of employee benefits), indicates that the majority of corporate employers provide at least some employer-paid coverage in addition to Medicare -- and the larger the employer, the more they provide. The Department of Defense -- America's largest employer -- does not stack up well in this department. The gap is even wider when the uniformed services' health care package is compared to the benefit afforded to employees who have retired from the very largest private sector corporations. For example, the four largest

U.S. corporations either fund virtually the entire health care premium (including heavily subsidized prescription drug benefits) or cap their retirees' out-of-pocket medical expenses at modest levels.

Health Plans of the Four Largest U.S. Corporations for Their Retired Medicare-Eligible Employees

		Employer Subsidized Health Plan					Other Subsidized Coverage		
Corp.	No. of Ret	Ret	Fam	Employer Paid Share of Premium	Retiree Deductible Single/Fam	Retiree Cost Share	Rx Drug	Dental	Vision
GM	350,000	Yes	Yes	75-80%	$300/600	Zero*	Yes	Yes	Yes
Ford	90,000	Yes	Yes	100%	$200/250	20% off visits; $500 out-of-pkt cap for all other	Yes	Yes	Yes
IBM	74,000	Yes	Yes	100%	$250 ($340 hosp)	20% outpatient 0% inpatient	Yes	Yes	Yes
GE	80,000	Yes	Yes	100%	N/A	20% of Medicare copay	Yes	No	No

* GM plan pays all charges above Medicare payment

In a similar vein, the United States Government provides significantly subsidized health care insurance coverage for retired Federal civilian employees and their families -- including retired Members of Congress and retired Congressional staff members. Yet, over the years, Administration and Congressional cost containment efforts have progressively stripped older uniformed services retirees of nearly all DoD-funded health benefits.

For generations, military health care has been touted as second to none. It is past time to recognize that, compared to what is provided by other large employers, Medicare-eligible uniformed services beneficiaries' health care has become second to almost all others. Service members who have given their country decades of service and sacrifice deserve better.

TRENDS FOR ACCESS TO CARE IN MILITARY TREATMENT FACILITIES (MTFs) (1996-2000)

The greatest problem facing all retirees and their families who rely on military medicine for their health care is the increasing decline of access to care in military treatment facilities (MTFs). A Congressional Budget Office (CBO) report (Restructuring Military Medical Care, July 1995) states that although 70% of the total eligible uniformed services population currently lives within 40 miles of a military hospital, only 55% of the age 65 and older Medicare-eligible population live this close. This situation will be exacerbated by continuing base closures which have closed or will close 39 MTFs and downsize many others. GAO reports that the military drawdown has also resulted in an 8 percent reduction of military medical personnel since 1991 and will further reduce it by another 8 percent by the year 2000.

Approximately 1.168 million uniformed services beneficiaries age 65 and older are entitled to Medicare insurance coverage (projected to increase to 1.436 million by 2002). They are also eligible to receive health care in DoD operated

military treatment facilities, but only on a "space available" basis. Although exact figures are not available, DoD estimates that an equivalent of about 30 percent, or 324,000 of these dual-eligible beneficiaries, regularly use the military health care system. DoD pays an estimated $1.4 billion per year out of its annual appropriations to deliver health care services to this population. Most of the remaining beneficiaries use providers in the civilian community under standard Medicare.

To meet the needs of CHAMPUS-eligible beneficiaries, DoD, with Congressional direction, is implementing the Tricare program throughout CONUS by September 1997. Tricare Prime is designed to provide improved access to health care in MTFs for CHAMPUS-eligible beneficiaries at a lower cost for many than under Tricare Standard. If these expectations are met, Tricare will provide improved access to health care in MTFs for CHAMPUS eligibles who enroll in Tricare Prime. However, Medicare-eligible beneficiaries have been set out adrift and will be denied the opportunity to enroll in Tricare unless Congress intercedes. Space-available care in the MTFs is becoming increasingly limited for those beneficiaries who do not, or cannot, enroll in Tricare Prime because hospital commanders are required to provide care in the MTF on a priority basis to Tricare Prime enrollees. An aggravating side effect is that as space-available care becomes limited, so too will access to the military pharmacy - a major loss for Medicare-eligible beneficiaries who do not have CHAMPUS and its prescription benefit as a fall-back.

The Military Coalition has already begun to hear reports about the decrease in availability of care for those who do not or cannot enroll in Tricare Prime. For example, military beneficiaries who currently receive care in the Eglin AFB, FL Family Practice Clinic Program recently received notices from the Eglin AF Hospital that unless they enrolled in Tricare Prime, the hospital would not be able to guarantee that it could continue to offer beneficiaries regular participation in Family Practice Clinic. A Medicare-eligible retiree who has always been able to receive care on a space-available basis from the McDill AFB hospital was told in June that he can no longer make any appointments for medical care because he is not eligible to enroll in Tricare Prime. Another 70 year-old retiree who had a heart attack and numerous catherizations and desperately needed to see a cardiologist at the Naval Medical Center San Diego (NMCSD) received a letter from that facility that said ".. Unfortunately, current staffing in that clinic [cardiology] does not allow us to make available all of the care we would like to provide... I must therefore regretfully inform you of the need to disengage you from NMCSD for this care ..."

Communications like these reflect a dispassionate callousness, though unintended, that is demoralizing. The retirees bearing the brunt of these decisions are those who served without equivocation in WW II -- Iwo Jima, Bataan, Corregidor and Normandy to name a few, and they cannot fathom why Uncle Sam would now turn his back on them during their twilight years. Regrettably, the Coalition receives these reports on almost a daily basis.

Not only is the health care lockout for Medicare-eligible retirees seriously eroding morale, it is in some cases, spawning drastic action. For example, two class action lawsuits are already underway with more sure to follow. The bad press associated with these actions will deny us the services of our best recruiters - the retired community - and is sure to adversely impact on the propensity of young men and women to serve in the uniformed services.

MEDICARE SUBVENTION

The Military Coalition has sought legislation for the past six years, and mounted a particularly intensive effort in the 104th Congress, to change Section 1876 of the Social Security Act (42 U.S.C. 1395) to allow the Health Care Financing

Administration (HCFA) to reimburse DoD for the care provided to Medicare-eligible uniformed services retirees and their spouses in the Military Health Services System (MHSS), a concept called Medicare subvention. Current law prohibits Medicare payments to federal providers of health care services and, therefore, precludes the Department of Defense from being reimbursed for the care provided to Medicare-eligible uniformed services beneficiaries. If DoD is reimbursed for such care, it should be able to allow Medicare-eligibles to enroll in Tricare Prime and otherwise use the full range of services available through the Military Health Services Systems. Since DoD's care is less costly than private sector care, Medicare subvention will actually save Medicare money--a win-win-win situation for Medicare, the taxpayers, and Medicare-eligible beneficiaries.

We've said this earlier, but it's worth reemphasizing. **Without subvention, beneficiaries under age 65 who are enrolled in Tricare Prime will be pushed out of the program when they become Medicare-eligible at age 65 and join those already disenfranchised**. Further, as military and civilian networks are sized to meet the health care needs of the enrolled population, access to "space available" care in MTFs will diminish greatly. The net effect is that older retirees and their spouses will be shut out of a system of health care they thought would always be there for them, unless Congress amends the law to permit Medicare subvention.

Legislation:

The Military Coalition has sought Medicare subvention legislation for the past six years and was finally successful in January 1995 when Rep. Joel Hefley (R-CO) introduced HR 580 to implement subvention nation-wide. However, the Congressional Budget Office (CBO) contended that H.R. 580 would increase Medicare expenditures by $1.4 billion (the amount that DoD now spends to provide "space available" care to Medicare-eligible retirees) and the bill was not considered in committee. To overcome this impasse, DoD has agreed to maintain its current level of funding effort for Medicare-eligible beneficiaries currently provided space available care in the military health care system, and to seek reimbursement only for beneficiaries who are now using their Medicare benefits in the civilian sector at Medicare's expense. Four bills have now been introduced to test this new concept of Medicare subvention.

Despite the obvious safeguards to preclude Medicare from paying any costs for retirees currently using military medical facilities, the CBO has scored these proposals as having a negative impact on Medicare. From our perspective, the CBO cost rationale relies on faulty premises to make its case. The following examples, extracted from a March 4, 1996 letter from Dr. Steven Joseph to HCFA are illustrative:

- **CBO Analysis:** -- The CBO paper states that 50 percent of the costs will be shifted from DoD to the Medicare program and implies that, irrespective of law, DoD will move to shift and increase Medicare's costs for the Health Care Financing Administration (HCFA).

  DoD Analysis -- As clearly delineated in both Senator Dole's legislation and the DoD/HCFA draft demonstration legislation, the demonstration cannot increase costs for either Medicare or DoD. To increase costs would clearly violate the law. DoD does have adequate management controls to assure that costs do not increase.

- **CBO Analysis:** -- CBO implies that DoD and Medicare might both agree to allow DoD to shift costs to Medicare.

  DoD Analysis -- Clearly, Medicare has a disincentive against allowing DoD to shift costs to Medicare and has the authority to end the

demonstration. Even if Medicare were to change its mind and allow DoD to shift costs, the DoD/HCFA draft demonstration legislation tasks the General Accounting Office to provide an independent audit of the demonstration to the Congress. This GAO audit would determine whether or not DoD and/or HCFA were in violation of law.

- **CBO Analysis:** -- DoD will enroll a disproportionate share of healthy Medicare-eligible individuals and/or current MTF-reliant Medicare-eligible individuals. Both of these groups currently cost the Medicare program very little. If DoD enrolls these individuals and exceeds its current level-of-effort, the Medicare program would be obligated to pay DoD the adjusted AAPCC rate which is much higher than current Medicare costs for these individuals.

  DoD Analysis -- Since DoD'S baseline costs are based on the current Medicare population served by MTF's and the baseline is based on dollars expended and not enrollees served, DoD does not get any benefit in the demonstration from having served healthier beneficiaries during the baseline period. As for the operational part of level of effort and the cost per enrollee, DoD will be reimbursed at the adjusted AAPCC rate and, like any private HMO, will be reimbursed by enrollee cohorts (reducing the opportunity for "skimming"), and will offer Medicare an additional two percentage point discount. In addition, because DoD as a federal agency cannot make a "profit" off another federal agency, DoD and Medicare will reconcile their costs each year to ensure that Medicare costs are not increasing due to favorable selection.

- **CBO Analysis:** -- The estimate assumes an annual rate of increase ranging from 7.4 to 8.5 percent.

  DoD Analysis -- The above annual rate of increase is three to four percentage points higher than the DoD medical program budget for the years 1997-2001.

To overcome the problems created by CBO's scoring and to eliminate other potential roadblocks, an amendment has been adopted in the FY 1997 Defense Authorization Bill which directs DoD/HCFA to develop a detailed plan by September 6 to implement Medicare subvention in one or more Tricare regions. Once the plan has been submitted, and the House and Senate Oversight Committees and the CBO have had a chance to closely examine it, the intent is to have additional legislation enacted in September to actually authorize a Medicare subvention test in 1997.

The Coalition was elated to hear that on September 4, DoD and HCFA signed the agreement to test Medicare subvention. We are encouraged that with timely submission of this plan, we now have a chance to get implementing legislation introduced in the House and Senate and signed into law before Congress adjourns for the year.

The Coalition has had the opportunity to review the proposed test and is generally pleased with its parameters, although the proposed test represents a significant compromise from the initial thrust of the Medicare subvention initiative advocated by The Military Coalition. Traditionally, when Medicare subvention was defined, it was in the context of having Medicare reimburse DoD for care provided to Medicare-eligible beneficiaries on both a capitated and a fee-for-service basis. Under this fundamental definition of subvention, when a Medicare-eligible beneficiary is enrolled in Tricare Prime, that individual would be able to use the entire network of providers, as well as the MTF. Those not enrolled would be allowed to use MTFs on a space available basis with Medicare reimbursing DoD for the cost of such care that they would otherwise bill to

Medicare for visits to private sector providers. The Coalition recognizes that in order to move forward at all, a compromise may be required. Accordingly, under the plan contemplated by the Authorization Bill, the Medicare subvention test would extend only to Medicare-eligible beneficiaries who agree to enroll in Tricare Prime. However, the conference agreement directs DoD/HCFA to submit a study to Congress (by January 3, 1997) on the feasibility of extending the subvention concept to fee-for-service care, too (i.e., case-by-case health care provided to service retirees and family members who are not enrolled in Tricare Prime).

Mr. Chairman, after reviewing the DoD/HCFA proposal, the Coalition believes DoD has bent over backwards to accommodate HCFA's concerns. For example, DoD has agreed to accept a discounted capitation rate as reimbursement, and has agreed that the rate can be further reduced by backing out the costs of Graduate Medical Education, Indirect Medical Education, capital building, and disproportionate share hospital costs that go into the formula for the capitation rate. DoD has also agreed to exclude its costs for outpatient pharmacy services and the USTF program from its level of effort computations, which is also advantageous to HCFA.

These concessions clearly reinforce the most fundamental point we wish to underscore again. Medicare cannot be financially damaged by subvention. The test is just that, a test, with a sunset period and a statutory guarantee that Medicare will not lose. Therefore, Mr. Chairman, the Coalition requests your assistance in ensuring that the Medicare subvention test is implemented without delay. The Coalition respectfully requests this Committee to support implementing legislation to actually authorize the test in time to allow final passage prior to adjournment of the 104th Congress. DoD has indicated it is prepared to go forward with its implementation plan on a moment's notice. Conducting a test demonstration will be the only way to resolve the funding question and validate the financial viability of subvention.

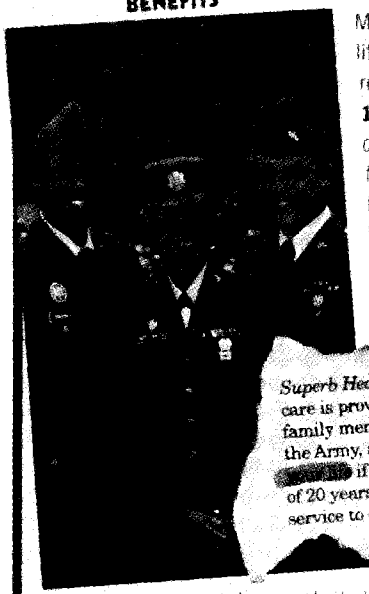
Before closing Mr Chairman, the Coalition would also like to see one important provision incorporated into final implementing legislation. Medicare-eligible beneficiaries who participate in the test must be afforded some protection in case the test must be ended prematurely for some reason. Therefore, **Tricare Prime must be designated a Medicare at risk HMO** so that Medicare-eligible beneficiaries will be able to renew their Medigap supplemental policies without incurring pre-existing condition limitations. Without this designation, Medicare-eligible beneficiaries will not be able to drop their supplemental policies, and will be financially penalized compared to other Medicare-eligibles who join other Medicare at-risk HMOs. The requirement to keep supplemental insurance would also likely decrease the incentive to participate in Tricare Prime.

CLOSING COMMENTS

This Committee has a great challenge to restore the health benefit to a level equal to what most employees of large corporations have and to that available for all retired federal civilians have. The Coalition stands ready to work with this Committee to reform military health care without jeopardizing military readiness or the national security. But, the time has now come to honor the commitments that were made to those who served their country when they were called to do so. Mr. Chairman, the Coalition is grateful for your continuing support and appreciates the opportunity to present its views on this topic which is so vital to retired service members.

Documenting the Lifetime Health Care Commitment

ARMY BENEFITS



Many contend that the government never promised lifetime health care to service members. The record shows otherwise:

1798: Marines and then sailors are required to contribute 20 cents per month to the Hospital Fund for their future health care. The practice continued for 145 years until 1943, when, at the height of World War II, Congress decided it was unfair to impose health care charges on members whose duties were so hazardous.

1956: The first documented evidence of the services advertising "free health care for life" in recruiting and retention literature. Such advertisements continued until 1993 (see graphic), when retiree protests that DoD was reneging on the promise led the Army to change the wording in its brochures.

1966: Congress declines to extend CHAMPUS eligibility beyond age 65, asserting that the abundance of space available medical care in military facilities plus Medicare offered uniformed services retirees a viable "two-track" health care system.

1991: Congressional Research Service report concludes that the "free health care for life" promise was functionally true and had been used to good advantage for recruiting and retention.

1995: Stephen Joseph, M.D., assistant secretary of defense (health affairs), testifies before Congress that DoD has an "implied moral commitment" to provide health care to all eligible beneficiaries.

STATEMENT OF
COLONEL CHARLES C. PARTRIDGE, U.S. ARMY (RET.), AND
CHIEF MASTER SERGEANT JAMES LOKOVIC, USAF (RET.)
NATIONAL MILITARY/VETERANS ALLIANCE

Mr. Chairman and distinguished members of the Committee, the National Military and Veterans Alliance would like to express its appreciation to you for holding these important hearings. The testimony provided here represents the collective views of our members.

The Alliance includes 13 military and veterans organizations. These organizations represent over 3,500,000 members of the seven uniformed services, officer and enlisted, active duty, reserve, National Guard and retired plus their families and survivors. These organizations are listed below:

Air Force Sergeants Association
American Military Retirees Association
American Retirees Association
Korean War Veterans Association
Military Order of the Purple Heart
Military Order of the World Wars
National Assn for Uniformed Services
Naval Enlisted Reserve Association
Naval Reserve Association
Non Commissioned Officers Assn
Tragedy Assistance Prog for Survivors
Veterans of Foreign Wars
Women Marine Association

Surveys of military personnel and their families consistently show that medical care along with adequate pay and inflation protected retired pay and commissaries are the top concerns of the military community. In fact, with base and hospital closures and reductions in medical personnel, the increasing lack of available health care is a major concern to active and retired personnel alike.

The promise of lifetime medical care for career service members, their families and survivors is contained in law and tradition and dates back to the 18th century. Later, in 1885 the 48th Congress provided in a War Department Appropriations Bill that, "The Medical Officer of the Army and Contract Surgeon shall, whenever practicable, attend the families of officers and soldiers free of charge."

Prior to the early 1950s the promise to provide military medical care for retired military personnel was not questioned because throughout their military careers and in retirement, medical care was provided in military treatment facilities for personnel who

could use those facilities. During the early 1950s and since that time the services used the lifetime promise of free medical care as a recruitment and retention incentive for the large military force required to fight the Cold War.

In 1956 Congress made space available medical care an entitlement for active duty dependents by the enactment of The Dependents' Medical Care Act (P.L. 84-569; June 7, 1956; 70 Stat. 250). Authority was also provided to care for retirees and their dependents at these facilities (without entitlement) on a space available basis.

Also in 1956, Congress concluded that the direct care medical system was inadequate to care for the dependents of active duty personnel and enacted legislation authorizing the defense department to contract with private sources to supplement the inadequate in-house care for dependents of active duty members who due to travel distances or other reasons could not use MTFs. This was the forerunner of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) enacted by Congress to be effective in 1967. With the enactment of CHAMPUS, military retirees, their families and survivors were included.

The CHAMPUS program was designed to provide a quality health care benefit comparable to "Federal Employees Health Benefits Program hi-option Blue Cross/Blue Shield or hi-option Aetna health insurance", (The Military Medical Act, P.L. 89-614).

• CHAMPUS required the Defense Department to pay 80 percent of medical costs for active duty dependents and 75 percent of the cost for retired members under age 65, and their dependents. CHAMPUS beneficiaries were required to pay the remaining balance of the cost of the medical care they received from private sector providers.

• Changes in the CHAMPUS program over the years have been disastrous for beneficiaries. In many areas, physicians consider CHAMPUS beneficiaries as charity patients. This is embarrassing and insulting to our military personnel and their families.

Exhibit A is an extract of some of the promises made in recruiting and retention literature over the years. Despite these promises, the availability of health care continues to be a problem. Deep cuts in both military and civilian medical personnel have left military medical treatment facilities (MTFs) severely understaffed. Physicians are preparing examining rooms and performing administrative tasks which means they see fewer patients than do private sector physicians who have adequate nursing and administrative help available to them. Meantime, patients not seen in MTFs must be referred to more expensive CHAMPUS or *TRICARE* contractor care.

To correct the problem facing military medical beneficiaries today no single option will solve the problem of providing medical care to DoD's diverse beneficiary population. However, improving access to cost effective, top quality care while meeting wartime training and mobilization requirements can be accomplished at reasonable cost. The proposal we have been asked to comment on today is:

Medicare Reimbursement (Subvention)

The promise of lifetime medical care in exchange for a career of military service has been proven and acknowledged. Despite this, military retirees, their families and survivors are the only Federal employees who lose their entitlement to medical care from their employer at age 65 upon becoming eligible for Medicare. This is age discrimination on a huge scale which disenfranchises hundreds of thousands of retired veterans and their families.

Retirees especially resent the fact that after earning what they thought was free lifetime medical care by a military career of 20 to 35 years they are now being turned away from that care. They cannot use a military hospital with Medicare paying part of the costs even though they paid mandatory Medicare payroll deductions from their active duty military pay since January 1, 1957, and most of them participate in Medicare Part B paying $42.50 per month or $510 per year per person. In addition, many have purchased Medigap supplemental policies at $100 or more per month or $1200 per year. The ultimate irony is that the MTFs bill their Medicare supplemental

insurance plan but not the basic Medicare benefit.

Over the past two decades the Congress and various Administrations have expressed interest in requiring the Health Care Financing Administration (HCFA) which administers the Medicare Trust Fund to reimburse the military treatment facilities for care given to Medicare-eligible beneficiaries.

In 1995, Dr. Joseph, ASD(HA) and Dr. Bruce Vladeck, Director, HCFA, agreed to conduct a joint DoD/HCFA HMO Medicare Demonstration Project. Unfortunately, the Department of Health and Human Services perceived legal restrictions which prevented these agencies from conducting the test without legislation.

Senator Gramm introduced legislation calling for a demonstration project S. 1487; shortly thereafter, Senator Dole introduced S. 1639. Companion bills were introduced by Representatives Hefley H.R. 3142 and J.C. Watts, H.R. 3151. These bills followed earlier legislation by Representatives Cunningham and Hefley which would have provided for Medicare reimbursement. In June of this year President Clinton, in a meeting with The National Military/Veterans Alliance and other association representatives, expressed the determination to "make a Medicare reimbursement demonstration project happen". Even with this clear direction, objections and delays by the Department of Health and Human Services have slowed progress and forced compromises by the Department of Defense that are not in the best interests of beneficiaries. In addition, cost analyses by CBO have inhibited development of a demonstration project that will meet the needs of military beneficiaries. However, congressional support has been made abundantly clear (See Exhibit B). We know this committee has long supported Medicare reimbursement and we urge you to support a demonstration project. There are features which we believe should be incorporated into Medicare subvention as the demonstration proceeds. We understand that DoD and HCFA have worked for over a year on this and have a carefully structured plan. We understand the need for each Department to represent its interests. However, this demonstration and departmental considerations should not be used to rule out innovations that could improve care for beneficiaries and provide beneficiaries with

choice and flexibility. Therefore, Congress should ensure that legislation does not restrict the opportunity to test innovative ideas and in fact we urge you to include language that would assure both HHS and DoD that you encourage testing innovative solutions and that they have the authority to do so.

Some features which we recommend be incorporated into Medicare subvention include:

- A fee-for-service option. The current demonstration would limit participation to those who are willing to give up their Medicare benefit except as part of the DoD TRICARE-Prime program. We believe those who do not want to enroll in TRICARE-Prime should be allowed to use military treatment facilities on a space available basis and the MTF should be allowed to bill Medicare for treatment at a DoD/HCFA negotiated rate.

- Waive TRICARE-Prime enrollment fee for Medicare eligibles. Currently, Medicare HMOs require no enrollment fee for beneficiaries. We believe "fee stacking" by requiring participation in Part B Medicare and payment of TRICARE enrollment fees will place the TRICARE-Prime out of reach for some beneficiaries. A couple would pay $1,020 for Medicare Part B plus $460 for the enrollment fee for a total of $1,480 per year. This would be before co-payments and other fees required under the TRICARE program.

- Solve Medicare Part B premium problems. Waive Medicare Part B penalties for Medicare eligibles who do not have Medicare Part B, but would like to enroll in Part B and participate in the joint DoD/Medicare demonstration project.

- Authorize TRICARE-Prime network contractors to act as Primary Care Managers for Medicare eligible beneficiaries. Currently DoD believes that to do so would require rebidding the TRICARE contract. For purposes of the demonstration project, the requirement to rebid the contract should be waived so that the subvention concept can be tested in areas where there are no MTFs. Unless this is done, there will be no test involving contractors as PCMs in areas outside of MTF

catchment areas.

- Ensure that Medicare eligible beneficiary enrollees are given the same priority care that other enrollees receive.

- Include authority for all uniformed services Medicare eligibles to participate, not just those of the Armed Services.

- Provide clear guidance and safeguards to make participation in the demonstration and any follow-up program completely voluntary. Some retirees are in satisfactory health care programs and would object to any provision that would require participation in a Medicare subvention program.

In the course of our Medicare subvention campaign some officials have asked if enacting Medicare subvention will settle the military medical care issue. The answer is no. It is one element of the military health care system that should be fixed but it does not completely solve the problem.

Medicare subvention will benefit some 35% of Medicare eligible beneficiaries. However, 65% will receive no benefit. For this huge majority of older military retirees and their families, there is no military medical benefit despite the promises. Therefore, in addition to Medicare subvention, military retirees need a solution not tied to location of MTFs nor dependent on DoD's ability to set up managed care networks. Such a solution exists. It has been proven to be cost effective and it's beneficiaries are satisfied with it. That is the Federal Employees Health Benefits Program. The Alliance (except the Non Commissioned Officers Association) strongly recommends that retired military beneficiaries be allowed to participate in FEHBP as an option.

Mr. Chairman, military beneficiaries want choice and flexibility in their health program. Some like HMOs, some like the freedom of a fee-for-service system, some like the options provided by preferred provider organizations. They want the freedom to choose as other federal employees have. We believe it can be done without sacrificing cost effectiveness.

Finally, the Military/Veterans Alliance thanks this committee for its support of Medicare reimbursement, for holding this hearing and its interest and concern for our service members, their families and survivors.

EXHIBIT B

MEDICARE REIMBURSEMENT (SUBVENTION)

I. On 23 March 1995, Dr. Stephen C. Joseph, M.D., M.P.H., Assistant Secretary of Defense (Health Affairs) before the Subcommittee on Personnel, Committee on Armed Services, United States Senate, made the following statement in his testimony...

> "With continuing reductions in military medical facilities and end-strength, our 'space available' will decline. As this occurs, there is little doubt that our Medicare-eligible patients will be forced to seek care from civilian providers under the Medicare system. First, this may turn out to be more costly for the government. Second, we believe there is a moral obligation for DoD to care for these former members of the Armed Forces and their families and survivors. Third, this older group of patients presents the wealth of clinical workload needed by our military medical personnel to maintain their skills for readiness missions."

II. Over the past years Congress has expressed interest in requiring the Health Care Financing Administration (HCFA) which administers the Medicare Trust Fund to reimburse the military treatment facilities for care given to Medicare-eligible beneficiaries. The following are two recent examples:

- Sec. 726, FY93 National Defense Authorization Act (P.L. 102-284):

  "It is the sense of Congress that-

  (1) members and former members of the uniformed services, and their survivors, should have access to health care under the health care delivery system of the uniformed services regardless of the age or

health care status of the person seeking the health care;

(2) such health care delivery system should include a comprehensive managed care plan;

(3) the comprehensive managed care plan should involve medical personnel of the uniformed services (including reserve component personnel), civilian health care professionals of the executive agency of such uniformed services, medical treatment facilities of the uniformed services, contract health care personnel, and the Medicare system;

(4) the Secretary of Defense, the Secretary of Health and Human Services, and the Secretary of Transportation should continue to provide active duty personnel of the uniformed services with free care in medical treatment facilities of the uniformed services and to provide the other personnel referred to in paragraph (1) with health care at reasonable cost to the recipient of the care; and

(5) the Secretaries referred to in paragraph (4) should examine additional health care options for the personnel referred to in paragraph (1) including, in the case of persons eligible for Medicare under title XVIII of the Social Security Act, options providing for-

(A) the reimbursement of the Department of Defense by the Secretary of Health and Human Services for health care services provided such personnel at medical treatment facilities of the Department of Defense; and

(B) the sharing of the payment of the cost of contract health care by the Department of Defense and the Department of Health and Human Services, with one such department being the primary payer of such costs and the other such department being the secondary payer of such

costs."

- Sec. 718, FY96 National Defense Authorization Act (P.L. 104-106) "Sense of the Congress Regarding Access to Health Care Under TRICARE Program for Covered Beneficiaries Who are Medicare Eligible.

(a) Findings - Congress finds the following:

(1) Medical care provided in facilities of the uniformed services is generally less expensive to the Federal Government than the same care provided at Government expense in the private sector.

(2) Covered beneficiaries under the military health care provisions of chapter 55, United States Code, who are eligible for Medicare under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) deserve health care options that empower them to choose the health plan that best fits their needs.

(b) SENSE OF CONGRESS - In light of the findings specified in subsection (a), it is the sense of Congress that-

(1) the Secretary of Defense should develop a program to ensure that such covered beneficiaries who reside in a region in which the TRICARE program has been implemented continue to have adequate access to health care services after the implementation of the TRICARE program; and

(2) as a means of ensuring such access, the budget for fiscal year 1997 submitted by the President under section 1105 of title 31, United States Code, should provide for reimbursement by the Health Care Financing Administration to the Department of Defense for health care services provided to such covered beneficiaries in medical treatment facilities of the Department of Defense."

ARMY

BENEFITS

ARMY BENEFITS

HEALTH CARE, HOUSING, SHOPPING AND SCHOOLING

Superb Health Care. Health care is provided to you and your family members while you are in the Army, and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement.

Housing, shopping, schooling and recreational facilities. The Army provides them all – plus excellent pay – to give you a high standard of living in an attractive and wholesome environment.

Maybe the most personally rewarding Army feature of all is the special pride you'll feel performing a valuable service for your country.

Ask your Army Recruiter for more details on all these benefits and how they can benefit you.

ARMY. BE ALL YOU CAN BE.

MILITARY MEDICAL CARE PROMISES

Army Recruiting Brochure, "Superb Health Care. Health care is provided to you and your family members while you are in the Army, and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement." [RPI 909, November 1991 U.S.G.P.O. 1992 643-711]

Life in the Marine Corps, p. 36. "Benefits...should you decide to make a career of the Corps, the benefits don't stop when you retire. In addition to medical and commissary privileges, you'll receive excellent retired pay..."

Guide for Educators and Advisors of Student Marines, p. 35. "Retired Marines are generally eligible to receive any type of health and dental care at those facilities provided for active duty personnel."

Navy Guide for Retired Personnel and Their Families, p. 51. "Covered under the Uniformed Services Health Benefits Program (USHBP) are retired members, dependents of retired members and survivors of deceased active duty or retired members. This care is available anywhere in the world either in a uniformed services medical facility (meaning Army, Navy, Air Force and certain Public Health Service facilities) and under the part of the USHBP called CHAMPUS." [NAVPERS 15891D November 1974]

The Bluejackets Manual, p. 257. "What Navy Retirement means to you - pay. Continued medical care for you and your dependents in government facilities." [1969]

Air Force Preretirement Counseling Guide, Chapter 5 Medical Care 5-2f.. "One very important point, you never lose your eligibility for treatment in military hospitals and clinics." [1 April 1986]

Air Force Guide for Retired Personnel, Chapter 1. "Treatment authorized. Eligible retired members will be furnished required medical and dental care." [1 April 1962]

United States Coast Guard Career Information Guide, USGPO. "Retirement...You continue to receive free medical and dental treatment for yourself plus medical care for dependents." [1991]

U.S. Coast Guard Pamphlet Be Part of the Action, "Reap the Rewards...You can earn retirement benefits - like retirement income...Plus medical, dental care..." [1993]

Hearings on CHAMPUS and Military Health Care, HASC No. 93-70, 93rd Congress "...the government has a clear moral obligation to provide medical care to retired personnel and their dependents...this Committee has found numerous examples of recruitment and retention literature which pledged.. medical care for the man and his family following retirement." [Oct-Nov 1974]

STATEMENT OF

DAVID M. TUCKER, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

FOR THE RECORD OF THE

HEALTH SUBCOMMITTEE

OF THE

COMMITTEE ON WAYS AND MEANS

REGARDING H.R. 4068

"THE VETERANS MEDICARE SUBVENTION DEMONSTRATION PROJECT ACT"

SEPTEMBER 17, 1996

Mr. Chairman, and members of the Subcommittee, the Paralyzed Veterans of America (PVA) appreciates this opportunity to share our views regarding the creation of a demonstration project to explore the feasibility of allowing the Department of Veterans Affairs (VA) to retain Medicare reimbursement for health care provided to Medicare-eligible veterans in certain geographic areas. Allowing the VA to retain third-party reimbursements in general, and Medicare reimbursements in particular, remains an important goal of PVA. Medicare subvention is a significant tool in enabling the VA to meet the health care challenges of the present, and the challenges facing it in the future. Of primary concern to PVA is the retention and improvement of specialized services, such as spinal cord injury and disease medicine, that are the hallmark of the VA system, and the key to its survival. Medicare subvention is an important step in this process.

Specialized services within the VA are a unique resource, one not easily obtained nor matched in the private-sector health care universe. The VA's noted leadership in areas such as spinal cord medicine and sustaining care is a resource that should not be squandered, and a leadership that should not be forsaken. PVA has worked tirelessly and diligently to protect specialized services within the VA reform movement, and we shall continue to do so. We shall continue in our endeavors to promote over-all reform in the VA medical system. We must take steps to ensure that this system provides eligible veterans with the health care they deserve, while ensuring that the VA becomes ever-more effective and efficient in the provision of this care.

We believe that Medicare subvention will strengthen the VA system, yet not cause harm to the Medicare trust funds. In fact, the demonstration project established by H.R. 4068 would help protect these precious trust fund dollars. By establishing the rate of reimbursement at less than that established for private-sector providers, Medicare would preserve resources while ensuring that veterans receive needed health care. We believe that the VA will be able to provide cost-effective care to Medicare-eligible veterans while providing veterans with care that is often not matched in the private sector.

Although PVA believes that Medicare subvention will result in ultimate cost-savings to American taxpayers while ensuring the best possible care to veterans, especially those veterans in need of specialized services, we are also cognizant of the fact that data to support these contentions are scarce. It is for this reason, and also to ensure that current and future veteran users are afforded the very best medical care, that we support the demonstration project as established in H.R. 4068. Let it be demonstrated that Medicare subvention works for the betterment of veterans, and does indeed lead to efficiencies in the allocation of federal health care dollars. The evaluation process contained within H.R. 4068 should provide us with these answers. Once we are assured that this demonstration project is successful let us not hesitate to move boldly forward.

H.R. 4068 provides reimbursement only for new users of the VA medical system within the demonstration areas. This ensures that the federal government is not billed twice for care granted to veterans. By encouraging new users, the entire VA health care system would be strengthened, while not reducing the quality of care given to veterans who currently rely upon the system. H.R. 4068 is a strong step forward in the ongoing attempt to reform and revitalize the VA health care system while guaranteeing that veterans, especially veterans in need of specialized services, receive the very best health care that their service to this country has earned.

Mr. Chairman, and members of the Subcommittee, PVA strongly urges the passage of H.R. 4068. PVA stands ready to assist this Committee, Congress, and the Administration as we explore ways to improve health care for veterans, never forgetting their service, and their sacrifice, as we move forward to meet the challenges of the coming century. PVA appreciates this opportunity to present our views regarding this vital issue.

STATEMENT OF HON. WILLIAM SARPALIUS
SISTERS OF CHARITY OF THE INCARNATE WORD
HEALTH CARE SYSTEM

Dear Mr. Chairman:

I appear before you today at the request of the Sisters of Charity of the Incarnate Word Health Care System in Houston, Texas and the other six Uniformed Services Treatment Facilities (USTFs). I want to express the strong support of the Sisters of Charity and the other USTFs for the Medicare Subvention Demonstration Project proposed by the Department of Defense (DoD) and the Health Care Financing Administration (HCFA).

I want to take this opportunity to make two important points. First, if the USTFs are included, the USTFs will make the demonstration a success and lower health care costs for both DoD and the Medicare Trust Funds. Second, I want to explain the importance of this demonstration project to military beneficiaries and the Sisters of Charity and the other USTFs.

Before I comment on these two points, I want to describe the possible plight of an enrollee in the Texas USTF as an example why subvention is needed. Mrs. IO is 64 years old and soon will become Medicare eligible. If she was enrolled in TRICARE Prime, she would be forced out of Prime when she reaches 65 and would face significant out of pocket costs.

As you know, Medicare does not cover prescription drugs and this individual, because of her medical condition, needs prescriptions costing over $200 per month. On a limited income, this is a real burden. Fortunately, she is enrolled with the USTF Program so her enrollment will not be canceled, as would have happened if she was enrolled in TRICARE Prime without Medicare Subvention.

However, Mrs. IO's situation is repeated many times and other military beneficiaries will face her problem. If Medicare subvention is enacted and the USTFs are included in the demonstration, other individuals will be able to join the USTF program, with the cost of their care split between Medicare and DoD. Subvention will allow Medicare-eligible military beneficiaries to obtain the benefits they earned, often at great personal sacrifice.

The USTFs can make the subvention demonstration a success. The USTFs have the administrative and medical systems in place now and can accommodate additional military beneficiaries who want to join. The experience of the USTFs make these facilities logical additions to the demonstration. In fact, Pacific Medical Clinics in Seattle has been consulted by Madigan Army Medical Center in Region 11 during its planning for implementation of the subvention demonstration.

As private sector organizations, although with a special designation as USTFs and a fifteen year commitment to military beneficiaries, these organizations have significant experience with Medicare HMO risk contracts and all aspects of managed care. In addition, the USTFs are full service programs serving not only military beneficiaries but also many other individuals through Medicare, Medicaid and various HMO and commercial insurance plans. St. Joseph's Hospital, operated by the Sisters of Charity, is the second largest Medicare provider in Houston.

The USTFs have a unique position in the Military Health Services System (MHSS). The USTFs are deemed to be facilities of the Uniformed Services for purposes of Chapter 55 of Title X. Because of the leadership of this subcommittee, the FY 1997 Defense Authorization legislation, approved by both Houses of Congress and now awaiting the president's signature, continues the special status of the USTFs as designated providers within the MHSS.

This legislation is based on a set of Guiding Principles accepted by both DoD Health Affairs and the seven USTFs. Principle #6 states that the USTF can enroll additional DoD beneficiaries because of Medicare Subvention, "if there is a demonstration project in place between DoD and HCFA that is operational in an area in which the USTF is located."

The USTFs, at the request of the staff of the Senate Finance committee, have submitted proposed language describing how the USTFs would fit into subvention demonstration legislation that committee is preparing. A copy of this proposed language is included with my written testimony.

This demonstration is important for both DoD and the USTFs in Texas and Seattle. These USTFs should be included in the demonstration because TRICARE is operational in their regions. These two USTFs now serve the largest number of Medicare eligible military beneficiaries in their regions. The USTF in Texas serves 5,919 individuals 65+ and the USTF in Seattle serves 5,719. These individuals and their current costs would be part of DoD's continued level of effort and are not part of the

demonstration. However, any new enrollees at these two USTFs who are 65 or older would be in the demonstration as well as current enrollees who become Medicare beneficiaries.

The demonstration project will allow the Sisters of Charity and Pacific Medical Clinics to continue to accept military beneficiaries as new enrollees into their programs, avoiding the unfortunate situation I described earlier. If the USTFs are not in the demonstration, many DoD beneficiaries will not have access to military facilities, and will use their Medicare benefits, at higher costs to the federal government and significantly higher costs to themselves, which many cannot afford. Without the USTFs, these individuals will not have access to the benefits they earned as military personnel in service to their country.

It is only right and just that these individuals, who did so much for their country, have access to the benefits they earned. Space is limited in military treatment facilities (MTFs) in the Seattle area for Medicare beneficiaries and there are no MTFs in Houston. The USTFs in these locations can accommodate additional military beneficiaries, allowing these individuals access to the benefits they so richly deserve.

Besides allowing the military beneficiaries access to their benefits, participation of the USTFs in the demonstration will lower health care costs for both Medicare and DoD. For beneficiaries enrolled in the subvention demonstration, the USTFs will accept the same payment Medicare pays to HMOs. Thus, the Medicare trust funds will save on all individuals who enroll in this demonstration at the USTFs.

Unlike other TRICARE programs, the USTFs will be fully at risk for the cost of care provided to individuals in the subvention demonstration, just as the USTFs are now fully at risk for other enrollees in the USTF Program. There cannot be any cost overrun for DoD or HCFA. The USTFs are fully at risk, not with risk corridors, not with any risk sharing between the USTFs and DoD; there is no cap on potential risk for the USTFs.

Because the USTFs are fully at risk, the subvention demonstration, that includes the USTFs, will allow a reduction in the federal budget. This is a significant benefit for the federal government and is indicative of the direction health care financed by the federal government is going: reliance on the private sector which is fully at risk.

To illustrate the risk the USTFs have assumed, I return to the example I cited earlier in my testimony. This individual has serious health problems but, fortunately, she is enrolled in the USTF at St. Joseph's Hospital in Houston and thus does not face significant out of pocket costs. However, the cost of the her care during the past twelve months is $44,817.41 and the USTF has received capitation payments in the amount of $2,730 from DoD as compensation for this individual. The Sisters of Charity have assumed this risk for Mrs. IO and consider this as part of their mission to care for those in need.

In closing, I want to thank the Members for the opportunity to address this subcommittee on the important issue of Medicare Subvention and the inclusion of the USTFs in the project. The involvement of USTFs will benefit both the USTFs and the federal government. More importantly, this subvention demonstration and the participation of the USTFs will be a very significant benefit for the many military beneficiaries in Texas and Seattle.

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