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(Volume 1 of 6)

104th Congress
1995-1996

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MEDICARE AND PRIVATE SECTOR HEALTH CARE QUALITY MEASUREMENT, ASSURANCE, AND IMPROVEMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MARCH 21, 1995

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MEDICARE AND PRIVATE SECTOR HEALTH CARE QUALITY MEASUREMENT, ASSURANCE, AND IMPROVEMENT

TUESDAY, MARCH 21, 1995

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

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

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 13, 1995
No. HL-5

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARING ON MEDICARE AND PRIVATE SECTOR HEALTH CARE QUALITY MEASUREMENT, ASSURANCE, AND IMPROVEMENT

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will hold a hearing on quality measurement, assurance, and improvement in the Medicare program and private sector health plans. **The hearing will take place on Tuesday, March 21, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

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

BACKGROUND:

Congress established the Medicare utilization and quality control peer review organization (PRO) program under the Tax Equity and Fiscal Responsibility Act of 1982, replacing the former professional standards review organizations. PROs are generally charged with reviewing services furnished to Medicare beneficiaries to determine if the services met professionally recognized standards of care and were medically necessary and delivered in the most appropriate setting.

In 1989, Congress established the Agency for Health Care Policy Research (AHCPR) to conduct and support research on the outcomes, effectiveness, and appropriateness of health care services and procedures. Congress specifically directed AHCPR to establish priorities for research reflecting the needs of the Medicare program, and a portion of AHCPR's authorized funding is supported by the Medicare trust funds. AHCPR's authorization expires at the end of fiscal year 1995.

In recent years, quality assurance efforts have moved toward development of accurate measures of quality that can be used to continuously improve care and assess the performance of health care providers and plans. In 1990, the Institute of Medicine issued Medicare: A Strategy for Quality Assurance, which, among other recommendations, called for a new focus in the Medicare program on the "collection, analysis, feedback, and dissemination of data and in the initiation of creative quality interventions."

In the private sector, the growing role of managed care has generated intense interest in establishing credible performance measures to allow employers and other purchasers to make informed health care decisions based on quality as well as cost.

In announcing the hearing, Chairman Thomas stated: "As we look for ways to increase health plan choices for beneficiaries, I am very interested in hearing from the experts how we can best assure professional, quality care as well as provide to the beneficiaries the information they need to make good health care decisions. I also look forward to hearing from the Administration about their on-going efforts, including the research agenda of the Agency for Health Care Policy and Research and its relationship to improving care for Medicare beneficiaries."

FOCUS OF THE HEARING:

The hearing will focus on exploring innovative quality measurement, assurance, and improvement systems that can be applied to the Medicare program, reviewing the effectiveness of current quality assurance programs for Medicare fee-for-service and Health Maintenance Organization beneficiaries, reviewing the activities of the AHCPR, specifically regarding outcomes research and its application to the quality improvement in the Medicare program, and assessing quality assurance and improvement initiatives in the private sector.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, April 4, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

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

*****

Chairman THOMAS. The Subcommittee hearing will be in order. Welcome to the hearing regarding quality measurement, assurance and improvement in the Medicare Program and private sector health care plans. I consider the subject of today's hearing to be critical to the development of a successful approach to providing more health plan choices to Medicare beneficiaries.

To be more specific, the Congress and the administration, I believe, have an obligation to Medicare beneficiaries to assure that they get professional quality care. That applies to care providers through the fee-for-service system, as well as through health maintenance organizations and any other health plan arrangements. I also believe that we must go beyond that.

As we give beneficiaries more health plan choices, we must also give them information about the quality of care provided under those choices so that they can make good decisions for themselves.

As we all know, the private sector is leading a revolution in health care delivery as more Americans enroll in HMOs and other managed care arrangements. As purchasers have become more aggressive about controlling costs with managed care, they have also pushed for accurate, objective and consistent measures of quality. These measures would allow providers to better review their performance and continuously improve their care, while also giving purchasers the information they need to make informed decisions based on quality as well as costs.

I hope today's hearing will allow us to learn about private sector efforts to measure and improve quality and what this may mean for the Medicare Program. Let me mention that we have Dr. Phil Lee here today as one of the administration's witnesses along with Mr. Vladeck, who has been with us several times.

Some of my colleagues may not realize that the original authorization for the outcomes research agenda for the Agency for Health Care Policy and Research was initiated by Republican members of the Health Subcommittee, that is the former Ranking Member Bill Gradison of Ohio, whose picture I saw in the paper recently, and is funded in part by Medicare trust funds.

We did this to assure the research agenda had a focus on issues important to Medicare beneficiaries. I am anxious to hear from Dr. Lee about the Agency for Health Care Policy and Research agenda and how clearly it might help us improve care for Medicare beneficiaries. Also, I hope Mr. Vladeck's testimony on the Medicare peer review organizations will provide a useful baseline for our coming efforts to promote better quality measurement, which is, after all, the foundation for better quality care for Medicare beneficiaries.

I call on my colleague and Ranking Member from California, Mr. Stark, for an opening statement.

Mr. STARK. Thank you, Mr. Chairman. I thank you for scheduling this hearing to express your support for actions to protect and if possible to improve the quality of care which Medicare beneficiaries receive. There are several actions we can take to meet these goals. We can, first of all, avoid careless slashing of Medicare funding for purposes unrelated to the Medicare Program such as giving tax breaks to very wealthy seniors and other budget balancing gimmicks.

Second, we should work to prohibit those things we already know have a detrimental effect on quality, contracts with health plans which cherry pick and leave the sickest to fend for themselves, and therefore put undue burden on public hospitals, or contracts with health plans that are recklessly certified or poorly supervised by State governments largely because of a lack of Federal standards with which we can measure how well the State governments are indeed supervising these plans.

We ought to be very definitive about physician incentive payments in managed-care plans that end up turning them into Mary Kay cosmetic contests to see how doctors can withhold needed health services. It is difficult to measure the quality of a physician's service if the physician is told by some gatekeeper that he or she cannot provide the service to begin with.

Third, we should do whatever we can to enhance the state of the art of quality assurance through research. There is probably not now a method by which anyone would be willing to empirically judge the quality of a plan. It will take many more years of research and study to come up with guidelines with which we will be comfortable.

It is somewhat ironic we are holding this hearing when last week the Budget Committee suggested we should stop funding the Agency for Health Care Policy and Research, the very agency which might eventually help us come up with a system whereby we could achieve the Chair's goals.

The bottom line, Mr. Chairman, is if we are serious about protecting and improving the quality of health care in our country, we will require Federal action in a Federal program that now takes care of 35 million Americans, which is the finest health delivery system in the country today and that will require perhaps more Federal resources rather than less.

Philosophically, I know that is abhorrent to some people, but if we mean to protect the care of the elderly, we can't sacrifice it for tax cuts. We will have to be serious about paying for the quality we hope to receive. I look forward to hearing from the witnesses today.

Chairman THOMAS. I thank my friends in California. Let us here what the public is getting for its money. We will hear first Bruce Vladeck and then Dr. Lee. I would indicate to both of you that your entire written testimony will be placed in the record and you may proceed however you see fit to inform the Subcommittee and I will not turn the lights on, but if we can keep a reasonable structure, I am sure there will be questions. Thank you very much for being here.

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

Mr. VLADECK. Thank you, Mr. Chairman and Members. I am pleased to appear again before the Subcommittee and I am particularly pleased to be here this morning to discuss some of what the HCFA, Health Care Financing Administration, is doing to foster and assure the delivery of high quality health care to our

beneficiaries. It also is a special pleasure for me to share the witness table with Dr. Lee.

I hope at the conclusion of this hearing the Subcommittee will have a greater appreciation not only of HCFA's efforts at quality assurance, but also the collaboration between HCFA and the AHCPR, Agency for Health Care Policy and Research, on whom we rely very heavily for the building blocks of our quality efforts.

I will try to condense my statement as much as I can. Let me focus my remarks on changes we have been making to the Peer Review Organization, or PRO Program, and turn more specifically to quality assurance in managed care, which I know is of particular concern to this Subcommittee and to the Chairman.

Our mission is to guarantee health security to the beneficiaries we serve. In order to do that we must collaborate with providers, physicians, suppliers and managed-care plans to assure that services are of high quality and are appropriate. In fact, our approach to quality assurance includes a number of different pieces, including the development of health and safety standards for facilities, the survey and inspection of those facilities, and increasing efforts to educate our beneficiaries as to appropriate care, particularly to encourage them to receive preventive services.

We are engaged with the Agency for Health Care Policy and Research in studies on quality assessment and our increasing emphasis on, and concern with, program integrity activities also have major quality implications, because so often abuse of the programs involves abuse of the beneficiaries as well.

Let me talk first in more detail about the PROs. PROs are private entities, for-profit or nonprofit physician-governed organizations that work under contract to us to monitor and evaluate the care provided to Medicare beneficiaries. PROs have been in place in one form or another since 1972, but in the last three or 4 years we have undertaken a major transformation of their role and their activities.

In the past, PROs monitored quality mainly through intensive retrospective review of individual case records, whether physician charts or hospital charts, selected generally as part of a random sample. We have come to believe that that kind of look-behind case-by-case examination of individual clinical events for errors is less effective in improving the quality of care than is a more global and prospective approach.

By identifying patterns of care and outcomes across a larger sample of patients, we believe that providers can receive insights to systemic problems in how they are providing care. The best way to achieve high quality performance by providers in the long term is not to impose rigid standards from the outside nor to engage in an elaborate game of "gotcha", but rather to encourage them to maintain and strengthen their own internal quality management systems.

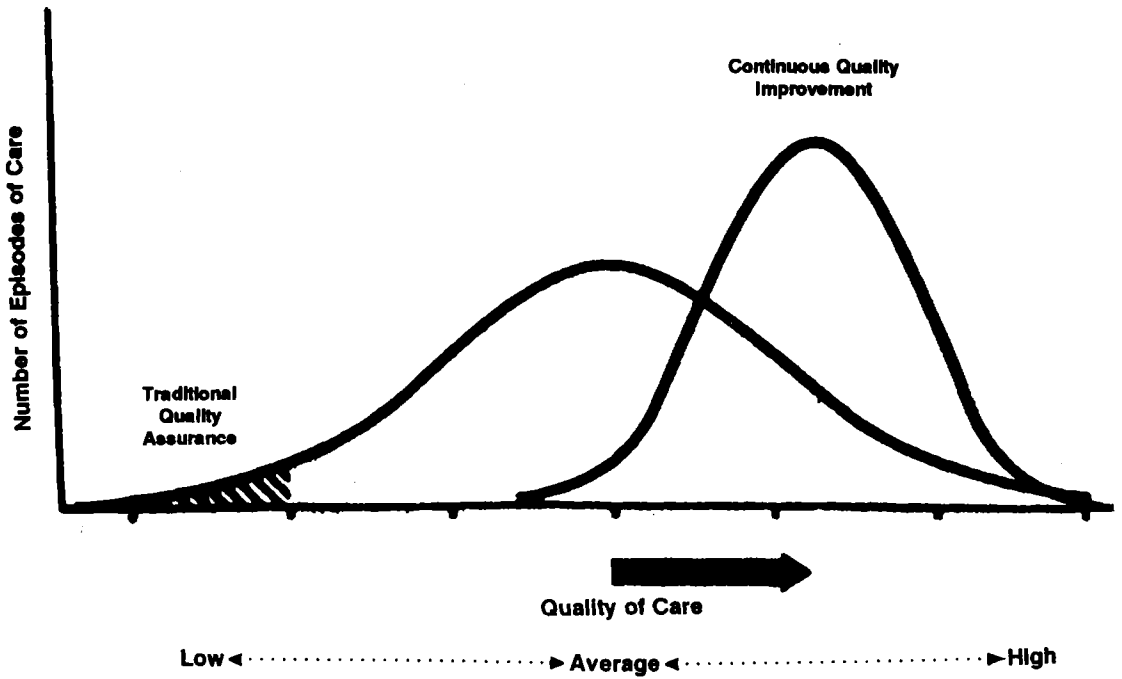
In taking this approach, we have borrowed freely from the best thinking in the private manufacturing and other corporate sectors in the revolution in industrial quality control and quality assurance that has occurred over the last couple of decades.

Perhaps I can best illustrate these concepts with a simple graphic representation. If one plots the quality of care of all health

episodes for all items of service or instances of service to Medicare beneficiaries, on a continuum from low quality on the left to high quality on the right, you get the typical distribution you see in all sorts of aspects of life.

[The following was subsequently received:]

IMPROVING THE MAINSTREAM OF CARE



What the PROs and old-style quality assurance efforts tended to do was to try to identify and focus on that very small left-hand tail of the distribution to catch the egregious cases on that end and then take some punitive action relative to them.

Increasingly, our philosophy is that the appropriate role of ours relative to quality—while not ignoring the problems in the left-hand tail—and the long-term payoff in terms of quality of services to our beneficiaries is to improve the level of quality of care in the program or in any provider by moving the distribution substantially in the direction of higher quality and by focusing more of it around professional norms or consensual levels of very high quality service.

We are less interested than we were in the past in detecting and punishing individual problems and more interested in increasing the standard of the norms of care and moving the general level of performance.

Continuous quality improvement aims to improve performance of all providers, not merely just those on the tail end, and it is done consistent with a philosophy of continuous quality improvement. There is no end point in this process. We hope to improve the quality of care continuously.

We have modernized the management of the PRO program under what we call our HCQIP, Health Care Quality Improvement Program, consistent with this philosophy. Under the HCQIP, we give providers, hospitals, or managed-care plans the tools to achieve internal continuous quality improvement while we can monitor on the basis of data about which there is a high degree of consensus improvements in quality.

Let me give you one example. One of our PROs looked at the claims from 53 hospitals in its State for Medicare patients with coronary artery disease who had undergone catheterization of the left heart and angiography procedures. They found that a number of those hospitals were routinely performing right heart catheterizations as well.

In many cases, the additional procedure was unnecessary and indeed involved some additional risk to the patient, although not an enormously large risk. Working with the hospitals and the State chapter of the American College of Cardiology, the PRO developed consensus criteria within the State for when right heart catheterization was appropriate and when it wasn't and shared those guidelines with providers.

Each of the hospitals then took that into their internal quality improvement processes and the result, within 6 months, was a very substantial reduction in the volume of unnecessary procedures of that sort. That is a prototype of the kinds of projects that PROs are undertaking around the country, some of them—as with the management of post heart attack patients—as part of national initiatives; many more of them in response to locally defined problems and priorities in identifying quality issues.

I want to assure members that the traditional statutory obligations of the PROs to continue to undertake retrospective case reviews in order to validate DRG classifications, to investigate beneficiary complaints, to assist in reviews of problematic providers referred to us from the Attorney General or to investigate alleged vio-

lations of antidumping regulations, have continued and will continue, and the authority of the PROs to impose sanctions in those instances is still in place and is still being used.

Again, I could give you, and would be happy to, a large number of other examples of the kind of work the PROs are doing, but I want to emphasize two things about our changes in the process. First, our management of the PRO program recognizes how heterogenous the health care system is and how different the problems of quality may be from one community to another.

There are differences in prevalence of disease patterns, there are differences in practice patterns, and there are differences in professional expectations. Our expectation of the PROs is that they work with the local physician and other professional communities, with consumer groups and others to identify problems of high priorities in their communities and then pursue them rather than following some national cookbook.

The other point to emphasize is how collaborative we insist this process is. The only way to ensure high quality care to our beneficiaries is to see to it that physicians and nurses and the other health professionals are providing high quality care. We do not ourselves administer injections or perform surgery and it requires a continuing and mutually collaborative partnership with the professional community in order to improve quality.

We are beginning to apply some of these same principles to our oversight of managed-care services. Even with the impatience some have suggested about the size of our managed care activities, we are, by far, the largest buyer of HMO services in the world. Slightly more than three million of our beneficiaries now receive their medical care through HMOs.

We require HMOs with whom we have risk contracts, the bulk of the plans which enroll our beneficiaries, to maintain internal and external quality review processes. We focus particularly on their capacity and the performance of the activities necessary to undertake internal quality assurance and quality improvement activities within the plan.

We also require the PROs to conduct external quality review in risk-contracting HMOs. Traditionally, the PROs' review of HMO patterns has been by the old model in which they looked at a sample of cases and tried to define deficiencies as well as following up on particular complaints and appeals.

We are in the process of transforming that to a system that will be consistent with the growing consensus about the appropriate way to do quality assurance and quality monitoring. It is essential that the system be accountable to consumers so that they can make informed choices, to providers so that they can do continuous quality improvement, and to the payers so they can make sure they are getting value for their money in protecting their beneficiary.

We are working on a number of initiatives in this regard. I need to emphasize, however, that the building blocks of any future system must rely on data on services provided by HMOs. Traditionally, many of the older group model and staff model HMOs did not maintain the level of data about the volume or content of services that we have come to expect in the fee-for-service sector and that are increasingly the backbone of our quality monitoring systems.

We believe that adequate quality assurance requires that managed-care plans collect data comparable to that maintained in the private sector relative to each patient encounter with a provider. We are going to work with the industry, with other large purchasers of care, toward the development of consensus about the content of standard data that need to be maintained by managed-care plans, need to be made available to purchasers, to quality monitors, and to others as the core of such a system.

We are working very closely with the NCQA, National Committee for Quality Assurance, to adopt their HEDIS system, a set of measures of planned performance to the particular needs and characteristics of the Medicare and Medicaid populations. We are somewhat further down the road on the Medicaid version for which we have already identified also sets of clinical indicators, most having to do with maternity services that are particularly important in the Medicaid population that haven't yet been a part of the HEDIS data set.

We are also working with the NCQA and other bodies, as well as the managed-care industry, to adopt the HEDIS, health plan employer data and information set, reports to the Medicare Program. At the same time, we are seeking to develop appropriate quality measurement tools and quality standards for managed care.

In 1993, we contracted with the Delmarva Foundation, which is the PRO for Maryland, and Harvard University to work with a panel of quality experts from around the country to develop new methods for external review based on outcomes measurement and quality improvement.

Dr. Heather Palmer, who is head of that project, is a witness on a subsequent panel and I will try not to step on any of her lines, but we are far down the road in developing mechanisms for analyzing data on core measures and for monitoring the performance of plans.

We are particularly excited about some of the measures for management of chronic diabetes, patients whose problems are precisely those that ought to be best addressed by effective managed-care plans and for whom episodic measures of quality care in either the fee-for-service or capitated sectors have probably been traditionally inadequate.

One of the things that managed-care plans have always pointed to with some pride was their substantially greater emphasis in, and investment in, preventive services and we are looking as part of this monitoring at the use of mammography and other standardized screening tests, and at management of hypertension as illustrations of the kinds of the services where one can measure the level of performance and assess the adequacy of care relative to some benchmarks of industry-wide or community-wide norms.

I would be overstating the issue, however, if I said that we were there, in terms of the development or implementation of these systems. We need continuous quality improvement in our quality assurance efforts just as much as any provider does. We are working in partnership with managed-care plans, with the States, with the medical communities, and with advocates to develop measures to gauge health plan performance whether the plan is a

capitated or fee-for-service plan, and the various pieces are all parts of a longer term strategy that will give us a set of measures of the performance of any plan and give that plan the tools with which to do continuous quality improvement within its own orbit.

Just to make sure that we are not all stepping on one another, next month we are sponsoring an invitational forum to bring together the wide range of public and private entities that are all developing systems for monitoring the quality of care delivered by managed-care entities and other health providers to make sure that we are talking to one another and not creating duplicative or contradictory systems—not to create any sort of monopoly situation, but to see that all of us with the same objectives are not getting in one another's way or imposing excessively burdensome requirements on the plans as part of our efforts to define measures of accountability.

We have a long way to go and I do not want to overstate how far we have gotten. The last point is our reliance on the AHCPR, as the most important objective source of outcome measures and professional consensus about appropriate standards for care on which we increasingly rely for the development and availability of standards around which to conduct these quality assurance and quality improvement activities.

The outcomes research done by AHCPR is a critical building block in our efforts. We have supported and continue to support the authorization of Medicare trust fund moneys to support the work of the agency because of our belief that that work is so integrally connected to the basic purposes for which the trust fund is available.

That gives me a segue to Dr. Lee and his comments on this and other issues, but I would be happy to answer any questions any of you might have. Thank you, again, for the opportunity to appear here today.

[The prepared statement follows:]

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

I am pleased to appear before the Subcommittee today to discuss the Health Care Financing Administration's (HCFA's) evolving role in fostering and assuring the delivery of high quality health care to over 36 million Medicare and 35 million Medicaid beneficiaries.

HCFA's mission -- as the nation's largest health insurer and a major purchaser of managed care services -- is to guarantee health care security to all the elderly, disabled, and disadvantaged populations we serve. Central to this mission is our commitment to collaborate with providers, physicians, suppliers, and managed care plans to assure that the services our beneficiaries receive are of high quality and appropriately meet their health needs.

As the largest payer for health care services in the country, HCFA also has a fiscal responsibility to all citizens to make sure that the dollars we spend are spent wisely. High quality care delivered in the appropriate setting is likely to be cost-effective.

HCFA's MULTI-FACETED APPROACH TO QUALITY ASSURANCE AND IMPROVEMENT

HCFA has reinvented and modernized its quality assurance and improvement activities under our Health Care Quality Improvement Program, or HCQIP. HCQIP gives providers, such as hospitals and plans, the tools to achieve internal continuous quality improvement; allows for the monitoring of how these plans and providers are achieving improved quality; and leads an effort in quality improvement projects throughout the country which allows us to improve care for large populations of patients. HCQIP was launched in April 1993, primarily through a re-engineering of our Peer Review Organization (PRO) contracts, but the program encompasses, or interfaces with, a variety of quality assurance and improvement activities.

Most of our quality assurance activities rely heavily on collaboration with our partners in the private sector and other organizations such as the PHS. Our innovations also strive to reduce unnecessary burdens on the industry.

- Quality assurance at HCFA begins with health and safety standards that form the nucleus of the requirements that all providers must meet to participate in our programs.

- Our survey and inspection activities, and those of private sector accrediting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), who have authority to accredit providers on our behalf, are designed to assure that Medicare and Medicaid-certified providers continue to meet the threshold participation standards of health and safety. Medicare conditions or participation require providers to have an internal quality assessment and improvement program.

- Beneficiary education is an important tool for improving quality. Over the past couple of years, we have embraced an ethic of customer service and beneficiary outreach. This effort includes a commitment to give beneficiaries a better understanding of what quality care is, educate them about their rights as patients to high quality care, and to disseminate reliable information about health plans to foster informed consumer choice.

- We fund empirical studies in state-of-the-art quality assessment, such as a recent grant to the RAND Corporation to develop a clinically-based method for assessing the quality of care delivered to women and children in managed care plans. The results of such studies are incorporated

into our quality monitoring activities.

- Various program integrity initiatives that seek to prevent, identify, and root out fraud and abuse also help improve quality. Fraudulent providers often provide poor quality or inappropriate care, which can be detrimental to beneficiaries' health and well-being.

- In quality monitoring, HCFA uses clinical practice guidelines (guidelines on appropriate medical practice), including those developed by the Agency for Health Care Policy and Research (AHCPR), as well as the private sector.

- Last but not least, we use the Peer Review Organization (PRO) program to monitor the quality of care provided in fee-for-service and managed care facilities. It is also through the Peer Review Program that HCFA sponsors innovative and cooperative improvement projects with partners in the health care community.

HCFA quality assurance activities are as equally prominent in the managed care area as they are in the fee-for-service sector of Medicare. Medicare is a major purchaser of managed care services, with estimated expenditures this year of about $13 billion for the provision of care to over 3 million enrollees, or about 10 percent of our beneficiaries. We are committed to improving the quality of care these beneficiaries receive.

I should note that we and managed care plans recognize we have much work ahead of us to develop reliable, effective, and efficient systems to assess quality in managed care plans. Fortunately, our experience with quality assurance outside of managed care provides us with a solid basis for developing the quality assurance mechanisms needed in the managed care environment. We are moving forward to improve quality in both fee-for-service and managed care with parallel objectives, although applications in managed care take some different forms.

As the Subcommittee has requested, I will focus my remarks on the innovations in the PRO program and then turn more specifically to quality assurance applications in the managed care arena, as this is an area of growing significance to Medicare and of particular interest to this Subcommittee.

THE PRO PROGRAM: A PARTNERSHIP WITH HCFA

We achieve our mission of assuring high quality services to our beneficiaries in partnership with members of the health care community. Nowhere is this cooperation and collaboration better exemplified than in the Peer Review Organization, or PRO, program, which operates in both the fee-for-service and managed care sectors of Medicare.

The PRO program has been in place in one form or another since 1972. While the structures for peer review have changed over the years, the goals of the program, as articulated by Congress, have remained essentially unchanged: to assure that services provided to beneficiaries are medically necessary, provided efficiently in the appropriate setting, and meet professionally recognized standards of care.

PROs are private entities that work under contract with HCFA. In general, a separate PRO operates in each State, although PRO activities are frequently carried out at an even more local level. PROs may be for-profit or non-profit organizations and are guided by boards of directors comprised of licensed clinicians, representatives from State medical societies, hospital associations and medical specialty societies, and consumer representatives. PROs employ physician advisors, epidemiological and statistical specialists, nurse reviewers, and

data technicians.

Innovations in the PRO Program

The Health Care Quality Improvement Program is leading to substantial innovations in the PRO program. In the past, PROs monitored quality mainly through intensive retrospective review of individual case records -- physician or hospital charts -- that were selected as part of a random sample. Upon identifying possible quality concerns, PROs have engaged providers in corrective actions; sanctions have been applied in cases of grossly substandard care or consistent poor quality.

We have come to believe that a look-behind, case-by-case examination of individual clinical events for errors is less effective in improving the quality of care than a more global and prospective approach that identifies patterns of care and health outcomes across a larger sample of patients. The case review approach does not give providers adequate insights into systemic problems in how they are providing care and does little to help guide providers toward fundamental improvements in care.

We have also recognized that the best way to achieve quality performance by providers in the long term is not by imposing rigid standards from the outside, but instead by encouraging providers to maintain and strengthen their own internal quality management systems. In this regard, HCFA has borrowed freely from the best thinking of the private sector, such as the manufacturing industry, which long ago embraced the doctrine of continuous quality improvement (CQI). The new approach we are implementing combines providers' internal quality management systems, driven by clinically-reliable data, with external monitoring and educational support from the PROs.

Quality Monitoring by PROs

Reliable data, which allow us to identify patterns of care, will obviously be at the core of quality monitoring. In the fee-for-service side of Medicare, we will use existing Medicare billing data and clinical data abstracted from medical records. (In collecting these data, HCFA and our contractors observe the same stringent protections for beneficiary confidentiality that have always characterized the PRO program.)

Quality indicators derived from improvement projects, which I will address momentarily, will assist PROs and providers in measuring and monitoring the quality of care provided to Medicare beneficiaries. Upon identifying aberrant patterns of care, PROs can then educate physicians about best practices and help hospitals develop internal monitoring systems that allow them to continuously improve the quality of care provided.

For example, one PRO examined claims from 53 hospitals of Medicare patients with coronary artery disease, who had undergone left heart catheterization and coronary angiography procedures. The PRO found that some hospitals routinely performed right heart catheterizations as well. For many of these cases, the additional procedure was unnecessary and could expose beneficiaries to risks and complications. Working with the hospitals and the State Chapter of the American College of Cardiology, the PRO developed consensus criteria for performing right heart catheterization and shared these guidelines with the providers. The hospitals engaged in various self-education efforts and our follow-up evaluation reveals a significant reduction in unnecessary right heart catheterization procedures.

While our new quality monitoring process will replace much of the traditional retrospective case review, I want to assure the Subcommittee that the PROs will continue to perform traditional retrospective case review, where appropriate, in order to meet

their statutory responsibilities to validate DRG classifications, and to investigate beneficiary complaints, alleged violations of anti-dumping regulations, and referrals from the Office of the Inspector General. Furthermore, the PROs and HCFA will still be responsible for imposing sanctions if education efforts fail.

Cooperative Quality Improvement Projects: Supporting the Goal of Improving Care

In addition to monitoring quality, PROs are also collaborating with providers, researchers, practitioners, and other groups in the health care community on projects that identify opportunities to improve the quality of care provided and allow providers to share lessons of best practices with others.

National and local quality improvement projects reflect our empirically-validated belief that opportunities are much greater to improve the overall health status of our beneficiaries on a broad scale by effecting modest improvements in many mainstream areas of care, rather than by focusing primarily on egregious errors through traditional case review. Projects may be developed by a single PRO, groups of PROs, or nationally.

To date, PROs have reported on hundreds of collaborative improvement projects, the results of which are shared throughout the country. We have received much positive feedback from providers and others in the industry about the value of these projects. HCFA and the PROs, working with providers, are catalysts for influencing the state-of-the-art of medical care so that all patients receive the best possible health care.

Improvement Project Examples

The prototype improvement project, launched in 1993, is the Cooperative Cardiovascular Project, which seeks to improve care for patients hospitalized with acute myocardial infarction, or a heart attack. HCFA developed quality indicators for care of heart attacks using guidelines developed by the American College of Cardiology and the American Heart Association. In pilot projects in Alabama, Connecticut, Iowa, and Wisconsin, the PROs found major opportunities to improve care for heart attack patients. In partnership with hospitals and their medical staffs, and with analytic support from AHCPR's Patient Outcomes Research Teams, we have derived state-of-the art measures of quality for heart attack hospitalizations and have identified best practices. Through the PROs, we are providing technical assistance to hospitals and will be monitoring the results. HCFA is now extending the cardiovascular project to the entire nation.

The project illustrates the major opportunities we have to improve care. Medicare beneficiaries have more than a quarter of a million heart attacks a year. If we can bring the level of care up to best practices, we should be able to save thousands of lives. While the traditional one-case-at-a-time approach was designed to identify egregious errors in care, quality improvement methods can have a much larger impact by effecting smaller changes in a large number of cases.

PROs have also embarked on numerous projects of a more local scope. For example, we are working to improve ambulatory care for patients with chronic disease in both fee-for-service and managed care environments. In the next six months, we will begin pilot projects in several States aimed at improving care for diabetics, using quality indicators based on guidelines from the American Diabetes Association and the Centers for Disease Control. We are also making extensive use of guidelines from the Agency for Health Care Policy and Research (AHCPR) to develop quality indicators for conditions such as unstable angina, prevention and treatment of pressure ulcers, and diagnosis and treatment of benign prostatic hypertrophy.

HCFA is proud of the quality monitoring and improvement innovations we have introduced in the PRO program. I want to re-emphasize three important points about our work in this area:

1. The PRO program consists of private organizations which, through a contractual arrangement with HCFA, monitor the quality of care furnished by providers. Quality monitoring and improvement relies heavily on collaborative efforts among HCFA, the PROs, providers, practitioners, experts, and others in the field.

2. The best way to achieve quality care in the long term is not by imposing rigid external standards on providers, but by encouraging and supporting internal continuous quality improvement activities. We strongly believe that the development and dissemination of clinical practice guidelines and best practices help hospitals render quality care.

3. Cooperative quality improvement projects give HCFA and its partners an opportunity to improve the overall health status of our beneficiaries on a broad scale. These projects have received a warm reception by the industry.

QUALITY ASSURANCE AND IMPROVEMENT IN MANAGED CARE

In 1994, Medicare managed care plan enrollment increased by 16 percent. At present, about ten percent of our beneficiaries have chosen to enroll in HMOs. Based on this recent experience, as well as advances in the marketplace, we anticipate continued, substantial growth in our managed care caseload, even absent changes in current law. We are keenly interested in assuring that as the Medicare managed care program grows and evolves, we have adequate measures in place to assure and improve the quality of the care they provide.

Designing these measures is a challenge, as we must broaden our focus from facility-based care to the activities of an entire network of providers -- including physicians' offices. Further, unlike fee-for-service medicine, where each medical encounter results in a claim, information about particular services provided by managed care organizations is limited. We are facing up to this challenge and working closely with the managed care industry to develop appropriate and meaningful procedures that can be relied on by HCFA, by our beneficiaries, and by the managed care plans.

Internal Quality Assurance Programs

Parallel to the fee-for-service sector, quality of care in managed care systems can be divided into (1) internal mechanisms, that is, each plan's own internal structure and activities for continuous improvement, and (2) external measurements, that is, performance measures imposed by external entities, for example, purchasers. Currently, Medicare risk HMOs must meet requirements for both internal and external quality review. In addition, we are exploring ways to improve external review programs, in partnership with managed care plans, commercial purchasers, and other interested parties and to maintain currency with state-of-the-art internal improvement processes.

With respect to internal structures, the Medicare statute and regulations require all contracting plans to have an internal quality assessment and improvement program, which involves the following:

- an ongoing program with a written plan describing the structure, responsibilities, types of activities, and specific quality improvement projects for the coming year; a committee of practicing physicians and other

representative practitioners with the commitment of adequate resources, including systems and staff; and Board accountability for the program;

- o an approach and activities stressing health outcomes which cover the entire range of care provided, and looks at the effects of provider compensation and incentives arrangements to assure that appropriate services are in fact provided;

- o a systematic, iterative process to identify problems and areas for improvement, make appropriate changes; and monitor changes over time for effectiveness;

- o peer review by physicians and other health professionals of the process of clinical care;

- o systematic data collection of performance and patient outcomes, and interpretation and feedback of these data to practitioners; and

- o written procedures for taking appropriate actions to change areas needing improvement, and a process to determine the overall effectiveness of the program and individual action plans.

HCFA does not do business with managed care organizations unless they have these internal quality assessment and improvement programs in place prior to contracting; we follow-up with on-site reviews of our contractors every two years thereafter. In evaluating an HMO's quality assessment and improvement program, staff review the written plan and the resultant activities, and look for changes and improvements in the delivery of quality medical care. Further, HCFA looks at the involvement of a plan's Board and top management in assessing the effectiveness of ongoing activities, specific actions and the overall program.

HCFA's enforcement authority is broad, from halting enrollment and marketing of non-compliant plans, to intermediate sanctions, to revocation of Federal Qualification and contracts with Medicare. Currently HCFA has three corrective actions underway with contractors, with a fourth investigation in progress, all of which are the result of quality of care deficiencies.

External Quality Assurance Programs

At this time, the PROs conduct HCFA's external quality assurance activities in Medicare risk-contracting HMOs. Since 1987, PRO review has consisted of review of (1) a sample of patient records, (2) a sample of Medicare enrollee deaths, and (3) all complaints PROs receive from Medicare HMO enrollees. If a pattern of quality problems is identified, an action plan is developed by the managed care plan in concert with the PRO. The PRO then monitors performance under the plan to ensure that the necessary improvements have been implemented.

However, HCFA, the PROs, and managed care plans believe that external review of HMOs must evolve into a uniform performance measurement system, rooted in a single set of measures that gauge a health plan's responsiveness to the needs of its membership. This represents a substantial undertaking, and entails a long-term effort we must begin now if we are to attain a seamless data and performance measurement system for quality care for all patients in all plans. HCFA, as the nation's largest managed care purchaser, must be the catalyst for this effort. Such a data system will bring accountability:

- o for consumers, who will have the information they need to make informed, responsible choices;

- for providers, who will have the figures they need for continuous quality improvement and sensitivity;

- and for plans, which will have the numbers to target resources and respond to the needs of diverse populations in Medicare and Medicaid.

The Oregon Scorecard Project, supported by AHCPR, should be helpful as we seek to develop meaningful quality indicators that beneficiaries can understand and use to make good choices regarding their health care.

Encounter Data

The building blocks of any future performance reporting system must be data on services provided by HMOs. While such data are readily available in the fee-for-service sector as a by-product of payment, many managed care plans do not currently have encounter data available due to the nature of prepayment. HCFA believes that adequate quality assurance activities require that managed care plans collect comparable data reflecting the key content of each patient encounter with a managed care provider. With comprehensive and comparable data, plans would be able to provide reports to purchasers addressing a range of purchaser needs.

HCFA is currently working in partnership with the managed care industry, States, and others in several important efforts to define encounter data standards for managed care plans. As the nation's largest managed care purchaser, we demand accountability and continuously improving outcomes from our contractors, just as any private purchaser would require. We recognize that plan collection of encounter data will, in many cases, be burdensome. However, without plan collection of encounter data, a quality improvement reporting system cannot be attained. As this will be a long-term undertaking, HCFA is making every effort to minimize the requirements we place on managed care plans for reports derived from this data. This is exemplified by one of our most exciting initiatives, our partnership with the industry on the Health Plan Employers Data and Information Set, or HEDIS.

Medicaid and Medicare HEDIS

With the rapid increase in the numbers of enrollees in managed care in the commercial sector, plans and employers began working together to develop a new HMO performance measurement tool. HEDIS is a core set of measures designed to help private sector firms gauge the value of the services provided by the firm's health plans. HEDIS includes data on a specified set of quality measures as well as measures of beneficiary satisfaction, financial indicators, and access to care. It is continually revised, with the third version expected next year. It will eventually permit consumers to compare the quality, value, and other merits of competing health plans. HCFA is now working to adapt HEDIS to the Medicare and Medicaid populations.

We are working jointly with the originator of HEDIS, the National Committee for Quality Assurance (NCQA), and with State Medicaid directors, consumers, provider groups, the United States Public Health Service, and the managed care industry on a Medicaid version of HEDIS. HCFA's goal is to adapt this promising commercial sector reporting tool to the needs of the Medicaid program and its beneficiaries. The Medicaid HEDIS project is funded by the David and Lucille Packard Foundation.

The Medicaid HEDIS project has twin objectives:

- First, by the end of 1995, produce a Medicaid-specific performance measurement set that we can provide to State Medicaid programs.

- Second, introduce Medicaid-relevant measures into the next version of HEDIS, version 3.0.

HCFA chose to use HEDIS as the template for our Medicaid effort because the managed care industry has used it for several years, and because the first step toward coordinated, quality care is uniform, consistent data. Furthermore, using HEDIS for Medicaid will build upon an established effective reporting system used by many large employers, while minimizing reporting burdens on our managed care plans.

While still on the drawing boards, HCFA also is designing a "Medicare HEDIS," with the support of the Kaiser Family Foundation. At present, HEDIS specifically excludes HMO enrollees who are age 65 or older. HCFA is working with the NCQA and others to develop a variety of measures for the Medicare population that will be incorporated into a future version of HEDIS. Medicare HEDIS will provide HCFA with a much broader array of vital and actionable information on health plan quality and value, and represents the template for our quality and performance measurement efforts.

The Delmarva Project

In 1993, HCFA contracted with the Delmarva Foundation (the PRO for Maryland) and Harvard University to work with a panel of quality assurance experts to develop a new methodology for external review. The Delmarva contract was intended to help HCFA and the PROs shift from the current mode of HMO oversight to one based on outcomes measurement and improving the quality of care. This project runs parallel to, and contributes to, our Medicare HEDIS effort.

Delmarva's report, released in August 1994, recommended three core performance measures that would apply to all Medicare enrollees in the HMO. The core measures included access to services, an annual influenza vaccination, and screening mammography for women.

We will pilot test some of the recommendations made by Delmarva within the coming months. The pilot will involve several PROs and their HMOs and will test mechanisms for analyzing data on the three core measures as well as measures developed for treatment of diabetes. Using this information, the participants will work cooperatively to develop projects to improve quality of care based on this analysis.

Along with information derived from a similar project underway in the fee-for-service sector (the Ambulatory Care Quality Improvement Project), HCFA expects to learn much about using performance measures to improve the quality of care for beneficiaries with diabetes. The lessons in outcomes measurement we will learn from projects like Delmarva, in combination with the results of our HEDIS efforts, will move us and the managed care industry down the road toward the uniform performance reporting system we all seek.

Coordination Activities

As I stated earlier, our performance measurement goals entail a long-term effort. Our over-arching goal is to work in partnership with the managed care industry, the states, the medical community and advocates alike to develop a single set of measures that gauge a health plan's performance. Our work on encounter data as the building blocks, HEDIS as the reporting template, and on Delmarva as a first attempt at examining compliance with performance measures, are early steps down the road to a performance measurement system that will enable managed care plans to continuously improve their quality of care and empower consumers to make responsible, informed choices.

As an example of this new partnership, HCFA is sponsoring an invitational forum to challenge both public and private entities to address the need for coordinated monitoring of managed care entities and other health care providers, to be held on April 19. We have invited stakeholders in this important industry; these include representatives of HCFA and the Public Health Service (PHS) involved as payers and regulators of managed care, State departments of health, insurance and Medicaid, HMOs, the managed care industry trade associations, accrediting organizations, employer associations, physician organizations involved in quality improvement, and consumers.

CONCLUSION

There are many exciting initiatives in the field of measuring quality of care in the fee-for-service sector and in managed care plans. We know that the activities described here will be refined, improved and modified as we work with our partners in the private sector to advance the state of the art in assessing quality of care. This is an exciting endeavor whose main purpose is to improve the well-being of beneficiaries through continuous quality improvement. This effort, supported by employers, plans, providers, and beneficiaries, still has a long way to go. We look forward to continued progress in this area, and hope to have the Subcommittee's support.

Finally, I would like to encourage the Subcommittee to support continuing the authorization of AHCPR to use Medicare trust fund monies for outcomes research. AHCPR's outcomes research program is a critical building block to HCFA's quality measurement and control activities. I will defer to Dr. Phil Lee, Assistant Secretary for Health at the Department of Health and Human Services, for further comments on this matter.

I would be happy to answer any questions

Chairman THOMAS. Thank you, Bruce. I would like to have Dr. Lee testify before questions. It is my pleasure to welcome Dr. Phil Lee, who is the Assistant Secretary for Health, United States Department of Health and Human Services, to talk about HHS' effort to ensure quality of health care with some emphasis and examination of the AHCPR.

STATEMENT OF HON. PHILIP R. LEE, M.D., ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. LEE. Mr. Chairman, thank you very much. Members of the Subcommittee, it is a pleasure to be here and particularly to be here with Dr. Vladeck. I will be discussing the role of the Public Health Service and the many important ways in which we collaborate with HCFA on joint efforts to ensure the quality of health care provided Medicare and Medicaid beneficiaries.

All the agencies of the Public Health Service are involved in quality activities of one sort or another. I want to focus this discussion on the AHCPR because of our role with the Health Care Financing Administration and the specific authorizations provided under the leadership of this Committee.

Health services research, which is the principal mission of the AHCPR, begins where biomedical research ends. It focuses on questions at two levels, the individuals and the organization and financial arrangements through which care is provided to populations. The goal is to improve the quality, appropriateness and effectiveness of health care services, as well as access to such services.

The agency accomplishes its mission through a broad-based program of health care systems and medical effectiveness research, development of clinical practice guidelines, technology assessment and quality measurement and improvement activities. Congress authorized the AHCPR 5 years ago as the Federal focal point for health services research, especially in the area of quality improvement.

Quality measures are even more important in today's rapidly changing health care marketplace with its growing emphasis on managed-care delivery systems, accountability and value-based purchasing for medical benefits. This is particularly true for Medicare, as increasing numbers of beneficiaries are turning to managed-care plans for care.

Consistent with the intent of Section 1142 of the Social Security Act, the needs and priorities of the Medicare Program are reflected in the AHCPR supported activities. Support under this authorization comes from Medicare trust funds and appropriated funds. The agency focuses on what works and what does not work in real world health care settings. It does this by systematically documenting current practices and examining their effectiveness, developing better measures of quality, and generating information that informs decisionmakers at all levels of the system.

At the individual or patient level, the AHCPR provides valuable information to help consumers make informed decisions about which treatments are best for them. For the buyers of health care such as large corporations, information generated by the agency

helps them evaluate which health care plans offer the highest quality of care at the lowest cost.

At the level of the clinician, the agency's research and guidelines help to improve practitioner decisions by providing information about effective medical treatment and the outcomes of that treatment. For insurers and managed-care plans, the Agency for HCPR sponsors research and guidelines to provide a more rational basis for decisions about treatments and technologies that are most effective and how quality can be achieved. Many important findings have emerged from the agency-supported research that illustrate the value of the AHCPR's work to HCFA programs and particularly to the Medicare beneficiaries.

The patient outcomes research teams, or so-called PORTs of prostate disease focused on transurethral resection of the prostate. Those are called TURPs. It is one of the most common surgical procedures paid for by Medicare. The PORT questioned the effectiveness of this procedure and noted the frequent occurrence of complications, including incontinence and impotence.

As physicians learned more about these findings and as patients learned more about treatment options from their physicians, practice patterns began to change. Now, the majority of men who are fully informed about the potential outcomes of this surgery elect not to have it or to delay it until symptoms become more severe.

Recently, there has been a 30-percent decline in the number of surgeries performed for benign prostatic disease, reflecting the application of this research very broadly through medical practice. This decline is associated with significant cost savings, while at the same time reflecting more effective care that is consistent with patient preference.

Another area of success involves cataract surgery. Over the last 3 years, cataract surgery has declined 7 percent due in part to the findings of the cataract PORT and the Agency for Policy and Research cataract guidelines. The agency's studies helped shift decisions about cataract surgery to the impact of the cataracts on patient functioning and not just on the existence of a cataract.

The Agency has undertaken another study of potential benefit to practitioners, Medicare beneficiaries and the taxpayers in its funding of a large trial to determine whether or not routine medical tests prior to cataract surgery costing $150 million a year are of benefit and are cost-effective. This is a large relatively simple trial.

The agency-supported PORTs have also contributed to the development of HCFA's cooperative cardiovascular project. The project will promote improvements in care by collecting data on patterns of care and outcomes for selected cardiovascular conditions and provide analyses to hospitals and their medical staffs.

These examples have significant relevance for the Medicare Program. If one examines the topics of all AHCPR-supported PORTs and clinical practice guidelines, collectively they address 10 of the 15 most costly diagnosis for which Medicare patients are hospitalized. This represents about 80 percent of the amount billed by hospitals to the Medicare Program.

What about the future? I think recent AHCPR initiatives underscore areas of future progress. The recent agency initiatives

in two areas hold promise for even more progress. First, in the area of outcomes research leading to more definitive information on medical effectiveness; and second through development and testing of clinical quality measures and consumer information to document poor versus good quality and to facilitate the continuous improvement of care overall. Bruce mentioned that in the chart he displayed.

Among the agency's new projects addressing the senior population is a collaborative effort with NIH, the hypertensive lipid lowering heart attack trial. This trial will compare several different medications for control of hypertension and high cholesterol in an effort to improve prevention of heart attacks.

Another PORT project will focus on the treatment of localized breast cancer in elderly women. In an effort to close the loop between availability of information about medical effectiveness and its application in everyday practice, the AHCPR is developing methods for evaluating the performance of health care providers and practitioners. This quality measurement and improvement initiative involves several activities I would like to highlight.

The AMRRC, American Medical Review Research Center, is developing quality utilization review criteria and performance measurement tools based on agency-supported clinical practice guidelines for urinary incontinence, acute postoperative pain, and benign prostatic hyperplasia.

This project involves five Medicare PROs in Massachusetts, Michigan, Pennsylvania, Alabama and Maryland. Work on acute pain guidelines has shown that compliance with the guidelines can reduce costs as well as improve quality of care provided Medicare patients.

In another area, PROs are working independently to incorporate recommendations from the agency-supported clinical practice guidelines into their Medicare review activities. For example, a patient complained that an HMO had denied cataract surgery, which caused a Florida PRO to initiate a statewide quality improvement project.

As a result of this project, three Medicare HMOs changed their surgical criteria to conform with the AHCPR supported guidelines. HCFA and the Connecticut PRO are collaborating to incorporate practice guidelines into the Medicare quality indicator system.

Preliminary analysis from chart reviews for pressure ulcers have shown significant opportunities for quality improvement. Several Agency for Health Care Policy and Research Projects place special emphasis on quality using managed-care settings.

Another area of agency work is in developing accepted criteria for evaluating the validity or usefulness of clinical quality measures which currently do not adjust for special populations or for levels of risk. For example, if a hospital or health plan has a low incidence of low birth babies, is that an indication of the organization's strength in the area of prenatal care or does it mean that it does not reach and treat high risk populations? For these reasons, the agency has undertaken a joint project to identify and describe existing clinical performance measures.

Let me say a word about improving consumer choice. Today's patients are too often faced with difficult choices and too little

information. First, they must decide whether to purchase health care coverage; second, to make a choice that must rely too often on inadequate information.

The patient and their family is frequently left unable to evaluate the quality of the plan or the value of its providers. To assist in filling that void, the AHCPR has undertaken an effort to determine consumer attitudes about the accessibility, quality and effectiveness of the care they receive as well as their satisfaction with that care.

A unique feature of this project is it is being designed to reach a variety of consumer groups, including heavy users of health care, Medicaid recipients and others who might have difficulty negotiating the system. The initial development phase is completed and field testing will begin shortly.

Let me close by noting that the authority for the AHCPR under the Social Security Act needs to be renewed. I believe the evidence is clear that Medicare beneficiaries have been well served by the research and guidelines that the AHCPR has undertaken, but more must be done.

If we are to continue to improve the quality of care for Medicare beneficiaries and other patients, more research is essential. We will continue to work closely with HCFA, physicians, hospitals, health plans, researchers, and consumers to achieve this objective. We look forward to working with the Members of this Committee as well as we seek the reauthorization for these provisions for an additional 5 years. I would be pleased to join with Bruce in answering any questions.

[The prepared statement follows:]

TESTIMONY OF PHILIP R. LEE, M.D.
ASSISTANT SECRETARY FOR HEALTH
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Mr. Chairman and Members of the Subcommittee. I am very pleased to have this opportunity to speak with you today about the role of the Public Health Service (PHS) and the many important ways in which we collaborate with the Health Care Financing Administration (HCFA) in joint efforts to assure the quality of health care provided to Medicare and Medicaid beneficiaries.

There are four main points I want to leave with you today:

First, all elements of the Public Health Service are committed to improving the quality of care provided to all Americans. In many instances improving quality also saves money.

Second, we need a firmer science base and better tools to learn what aspects of health care can be improved and how to accomplish that.

Third, we have a special obligation to consumers -- to listen to their concerns and help them make better choices about their personal health and health care services.

And finally, we are committed to continuing our collaboration with the Health Care Financing Administration in its pursuit of high quality care for its beneficiary populations.

PHS Perspective

The perspective of the Public Health Service with respect to quality assurance and improvement is very broad -- taking into consideration not only personal health care services and their outcomes, but also environmental influences, preventive services, and more traditional public health functions. My goal of reinventing public health is grounded on three strategies:

1) focusing the personal health care system, making it a more active, accountable, and cost-effective participant in achieving health objectives;

2) redefining the public health system to strengthen its capacity to deliver population-based health services and to foster better collaboration with other sectors involved in health; and,

3) strengthening the capability of all sectors to address high priority health problems through support for training, research, and information systems.

In other words, we want to make health matter for all participants of the health care system by supporting and rewarding them for working individually and together to protect and improve the population's health.

Quality is and must remain a driving force for reinventing public health and improving the health care system. This is of particular importance to the Medicare program as an increasing number of beneficiaries move into managed care plans.

Many PHS programs and activities directly address quality measurement and improvement. For example, the National Institutes of Health (NIH) supports basic and clinical biomedical and behavioral science research which answers questions about what causes diseases and how diseases can be prevented and treated. Over the past 2 years, for example, NIH has funded research that reduced heart attacks for post menopausal women through estrogen replacement therapy. NIH has also funded research that has led to advances in the treatment of sickle cell anemia, congestive heart failure, and type I diabetes mellitus.

National Practitioner Data Bank
Another PHS program aimed at improving the quality of services provided to Medicare beneficiaries is the National Practitioner Data Bank. Authorized by the Health Care Quality Improvement Act of 1986, the Data Bank was established to encourage greater efforts in professional peer review and to restrict the ability of incompetent practitioners to move from State to State without discovery of previous substandard professional performance or unprofessional conduct. Certain information such as malpractice settlements, licensure restrictions, etc., is required to be reported to the Data Bank. Hospitals are required to regularly query the Data Bank before granting staff privileges.

Community and Migrant Health Centers.
Many Medicare beneficiaries are served by Community and Migrant Health Centers, another program of the Public Health Service. The quality of care is a very important component of the Community and Migrant Health Center program. Each center must conform to an established set of "Program Expectations", and periodically is subjected to an intensive, three-day on-site "Primary Care Effectiveness Review" in which clinical performance is carefully assessed, with follow-up technical assistance rendered when needed. In addition, the Community and Migrant Health Centers program has developed specific "clinical performance measures", including one targeted exclusively on geriatric care.

Substance Abuse and Mental Health Services
SAMHSA assists States, professional organizations and other groups in program improvement in the area of alcohol, drug abuse, and mental health (ADM) services by bridging the gap between researchers and providers. SAMHSA serves as the conduit for technology transfer to assist service providers in the delivery of safe, appropriate and effective prevention and treatment services. In addition, SAMHSA listens to consumers and their advocates to improve current practices and assess their effectiveness.

SAMHSA's National Advisory Council has strongly supported efforts around quality assurance and ADM services. The Council has passed several resolutions encouraging the development of a single set of national quality of care standards for ADM services and SAMHSA, with Council support, is now in the process of initiating a project designed to develop managed care network accreditation and quality assurance standards.

The many efforts that focus on issues of health outcomes and quality cut across HHS agencies. For example, PHS agencies, including the National Cancer Institute at NIH, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Agency for Health Care Policy and Research, and the Office on Women's Health in my immediate office are assisting HCFA in its campaign to encourage Medicare enrollees to obtain mammograms. This represents the best possible kind of cooperation between our two agencies.

AHCPR - Principal PHS Quality Agency

Within the Public Health Service, the Agency for Health Care Policy and Research's (AHCPR) primary mission is quality measurement and improvement. AHCPR focuses on what works and what doesn't work in real world health care settings -- it has as one of its highest goals to assure that Americans can receive high quality care [in return for the one trillion dollars spent annually on health services]. It does this by systemically documenting current practices and examining their effectiveness, developing better measures of quality, and

generating information that informs decision-makers at all levels of our system.

At the individual or patient level, AHCPR provides valuable information to help consumers make informed decisions about which treatments are best for them. For the buyers of health care, such as large corporations, information generated by AHCPR research helps them evaluate which health care plans offer the highest quality care at the lowest cost.

At the level of the clinician, AHCPR's research and guidelines help to improve practitioner decisions by providing information about effective medical treatment.

For insurers and managed care plans, AHCPR-sponsored research and guidelines have enormous potential to provide a more rational basis for decisions about which treatments and technologies are most effective, and how quality can be achieved. Examples include surgical procedures for cataract and prostate disease, which I will discuss later.

AHCPR's Mandate

The Congress authorized AHCPR five years ago as the Federal focal point for health services research, especially in the area of quality improvement. With strong bipartisan support, consensus was reached on the need for research and development on issues of medical effectiveness and the delivery of health services. It further reflected the need to create a single focus independent of the programmatic or regulatory needs of specific governmental programs. This Subcommittee was a participant in that process.

The Subcommittee recognized the importance of health services research and its critical role in forming the knowledge base for the development of quality measures and quality improvement strategies -- the topic of today's hearing. Quality measures are even more important in today's rapidly changing health care marketplace with its growing emphasis on managed care delivery systems, accountability, and value-based purchasing for medical benefits.

Health services research begins where biomedical research ends. It focuses on questions at two levels: the individual; and the organizational and financial arrangements through which care is provided to populations. The goal is to improve the quality, appropriateness, and effectiveness of health care services, as well as access to such services.

AHCPR accomplishes its mission through a broad-based program of health care systems and medical effectiveness research, development of clinical practice guidelines, technology assessments, and quality measurement and improvement activities.

Consistent with the intent of section 1142 of the Social Security Act, the needs and priorities of the Medicare program are reflected in AHCPR-supported guidelines and other research activities. Support under this authorization comes from both Medicare trust funds and appropriated money.

Contributions of AHCPR

Many important findings have emerged from AHCPR-supported research over the last 5 years that illustrate the value of AHCPR's work to HCFA programs and the health care system in general.

For example, under direction of John Wennberg at Dartmouth College, AHCPR's Patient Outcomes Research Team (PORT) on

prostate disease focused on transurethral resections of the prostate (TURPs), one of the most common surgical procedures paid for by Medicare. The PORT questioned the effectiveness of this procedure and noted the frequent occurrence of complications, including incontinence and impotence. As physicians learned more about these findings, and as patients learned more about treatment options, practice patterns began to change. Now, the majority of men who are fully informed about the potential outcomes of this surgery elect not to have it. Recently, and despite the increased number of Medicare beneficiaries who would be candidates, there has been a significant decline in the number of surgeries performed for benign prostatic disease. More specifically, over the past 3 years, the number of TURPs has declined by over 30 percent. This decline is associated with significant cost savings, while at the same time reflecting more effective care that is consistent with patient preferences.

Cataract surgery has been the most commonly performed surgical procedure covered by Medicare, accounting for over $3 billion in 1991. Its use has declined 7 percent over the last 3 years, due in part to the findings of the cataract PORT and AHCPR's cataract guideline. AHCPR's studies helped shift decisions about cataract surgery to the impact of the cataract on patients' functioning, and not just on the existence of a cataract. The PORT developed a new tool for assessing the impact of cataracts on a person's vision and ability to perform usual activities. The measure (the "VF-14") has been widely accepted by ophthalmologists as an indicator of whether or not a particular patient will benefit from having a cataract removed.

The cataract PORT documented marked variation in the extent of preoperative medical laboratory tests ordered for cataract patients, physicians' reasons for ordering them, and much uncertainty about their clinical utility and cost effectiveness. Nonetheless, routine performance of medical laboratory testing prior to cataract surgery accounts for annual costs of approximately $150 million.

These findings lead to the funding of a "large, simple trial," in which 20,000 cataract surgery patients will be randomized to receive or not receive a routine battery of preoperative laboratory tests. Analyses will determine the health benefits and cost-effectiveness of routine laboratory testing for cataract surgery.

AHCPR-supported PORTs have also contributed to the development of HCFA's Cooperative Cardiovascular Project (CCP) that Bruce Vladek mentioned earlier. The CCP will collect data on patterns of care and outcomes for selected cardiovascular conditions and provide analyses, based on these data, to hospitals and their medical staffs to promote improvements in care. Investigators from AHCPR's PORTs on ischemic heart disease and acute myocardial infarction (AMI) assisted HCFA in designing the project and will provide special support in data collection, analysis, and dissemination strategies.

In addition, a separate grant supported by AHCPR will validate national guidelines for AMI patients for angiography, coronary artery bypass graft (CABG), and percutaneous transluminal angioplasty (PTCA). Acute myocardial infarction is the leading cause of death in the U.S. In 1993, approximately 600,000 Americans were hospitalized for it at a cost of tens of billions of dollars in additional health care costs and lost productivity. In cooperation with HCFA and the CCP, the project will examine the multiple factors associated with processes of care, their relationship to guidelines, and subsequent patient outcomes. Guidelines created from a cost-

effectiveness perspective will be compared with those created primarily from a clinical perspective.

All three of the examples of PORT research I've presented have special relevance for the Medicare program. If one examines the topics of all AHCPR-supported PORTs and clinical practice guidelines, collectively they address 10 of the 15 most costly diagnoses for which Medicare patients are hospitalized, representing about 80 percent of the amount billed by hospitals to the Medicare program. Similarly, these efforts address 9 of the 15 most costly diagnoses for which Medicaid patients are hospitalized, representing about 70 percent of the amount billed to the Medicaid program.

Ongoing and Planned AHCPR Initiatives

Clearly, much has been learned from AHCPR's initial 5 years working toward improved quality of care provided to all Americans and enhanced ability of consumers and purchasers, including HCFA, to monitor performance and select among competing health care plans and providers. Recent AHCPR initiatives in two areas hold promise for even more progress: first, in the area of outcomes research leading to more definitive information on medical effectiveness; and second, through the development and testing of clinical quality measures and consumer information to document poor vs. good quality and to facilitate the continuous improvement of care overall.

Among AHCPR's new projects addressing the senior population is a collaborative effort with NIH to support a large clinical trial, known as the ALLHAT Study (Antihypertensive, Lipid Lowering, Heart Attack Trial). This trial will compare several different medications for control of hypertension and high cholesterol; the goal is improved prevention of heart attacks. Patients will be enrolled from over 200 community-based practices and clinics, including primary care practice networks. The minimum age for enrollment is 60, and at least 50 percent of enrolled patients will be African American. The NIH portion of the study will assess side effects of medications and estimate patient compliance. To broaden the range of outcomes examined, the AHCPR is supporting a companion study to examine the quality of life associated with the various medications and their cost-effectiveness.

A new PORT project focuses on the treatment of localized breast cancer in elderly women. In 1990 an NIH Consensus Panel recommended that breast conserving surgery (BCS) accompanied by lymph node dissection and radiation therapy should be the preferred treatment for most cases of localized breast cancer. Despite these recommendations, the use of breast conserving therapy in women aged 65 and older varies considerably. This project will examine treatment choice, short and intermediate-term outcomes, and cost-effectiveness of three alternative treatments for localized breast cancer in the elderly. Recommendations will be developed regarding the appropriateness of observed patterns of treatment, taking account of circumstances that may differ with patients' age, initial health, and access to different types of providers.

Another new AHCPR initiative will help to close the loop between the availability of information about medical effectiveness and its application in everyday practice. One part of this initiative involves the development of valid and useable measures of the quality of care -- in essence, translating the conclusions from outcomes research, clinical practice guidelines, and technology assessments into quality measures that are easy to apply and understandable by both health professionals and consumers. Another part of this initiative involves the development of sound and credible

methods for evaluating and improving the performance of health care providers and practitioners. The existence of quality measures and information about levels of quality is of limited value unless it is coupled with strategies for quality improvement. Let me share with you just a few of the activities that are already part of this quality measurement and improvement initiative.

The American Medical Review Research Center is developing quality and utilization review criteria and performance measurement tools based on three AHCPR-supported clinical practice guidelines (for urinary incontinence, acute postoperative pain, and benign prostatic hyperplasia or BPH). The project utilizes five Medicare Peer Review Organizations (PROs from Massachusetts, Michigan, Pennsylvania, Alabama, and Maryland) to develop and test the criteria. The PROs also play an integral role in developing, implementing and evaluating alternative educational outreach strategies based on the BPH guideline.

The project has tested these quality measurement tools with a random sample of medical records of Medicare patients and successfully targeted a number of opportunities for quality improvement. Although the acute pain guideline recommends the development of a preoperative pain management plan in collaboration with the patient, only 7.5 percent of the cases examined met that recommendation. Similarly, the guideline calls for the use of a scaled pain assessment instrument, which was found for only 34 percent of the cases. Yet, length of stay was significantly lower among patients whose care complied with these two guideline recommendations. Thus, complying with the guideline can reduce costs, as well as improve quality.

A number of PROs are working independently to incorporate recommendations from AHCPR-supported clinical practice guidelines into their Medicare review activities. For example, a beneficiary complaint that an HMO had denied cataract surgery caused the Florida PRO to initiate a statewide quality improvement project. As a result of this project, three Medicare HMOs changed their criteria for surgery to be less restrictive and to conform with the AHCPR guidelines.

HCFA and the Connecticut PRO have collaborated in the first effort to incorporate practice guidelines into the Medicare Quality Indicator System (MQIS). Preliminary analysis from chart reviews for pressure ulcers, following the AHCPR guideline, showed significant opportunities for quality improvement. These findings will become the focus of subsequent review and quality improvement interventions.

Several projects place special emphasis on quality issues in managed care settings. For example, two grants will use continuous quality improvement and other techniques to implement and evaluate the effects of guidelines on hypertension and depression in HMOs -- the Group Health Cooperative of Puget Sound and the Kaiser Foundation Hospitals. Another project will test the use of CareMaps administered by nurse managers in a hospital-based managed care system. The intent is to increase efficiency without decreasing effectiveness or patient satisfaction.

The Patient Reports on System Performance (PROSPER) is a measurement tool based on objective information, reported by patients, that can be used to assess the technical quality of services provided, emphasizing access, coordination, and continuity of care. Under the leadership of Dr. Heather Palmer, from whom you will hear later, it was designed for demonstration in multi-site HMOs and permits comparison of performance rates across time and sites.

We believe these projects are of special importance, given the rapid changes occurring throughout the health care system, the increasing enrollment in managed care and its associated incentives, and the difficulty experienced by many managed care organizations in generating the information needed for quality measurement and improvement.

Until now, there has been no single source of information available on clinical quality measures, nor have there been any generally accepted criteria for evaluating the validity or usefulness of the various measures. In addition, many measures do not adjust for special populations or for level of risks. For example, if a hospital or a health plan has a low incidence of low-birthweight babies, is that an indication of that organization's strength in the area of prenatal care? Or does it mean that it does not reach and treat high-risk populations?

For these reasons, AHCPR has undertaken a joint project to identify and describe existing clinical performance measures. Conducted by the Center for Health Policy Studies of Columbia, Maryland, and the Center for Quality of Care Research and Education at the Harvard School of Public Health, the project is really a two-step process. The first step, which is completed, is to take what essentially is a snapshot that will tell us what measures exist and are in use -- and to provide structure for this information, organizing it according to performance measurement sets, clinical conditions, and relevant populations. To date, over 1200 individual measures have been identified. Analysis of these measures reveals that those developed under governmental auspices have been more rigorously tested for validity and reliability than those developed by the private sector.

The next step for AHCPR will be to expand, verify, and refine this classification scheme. Ultimately, this effort has the potential to provide the foundation for an ongoing national resource of validated quality measures, which in turn will assist in quality measurement and improvement and lead to better health care. Many organizations could benefit from such a resource, including HCFA, the National Committee for Quality Assurance (from whom you will hear later), and various other public and private sector purchasers and providers. This provides an ideal opportunity for a public-private partnership, which we are currently exploring.

Improving Consumer Choice

Finally, let me turn to consumers. Today's consumers are too often faced with difficult choices and too little information. First, they must decide whether to purchase health care coverage. Second, to make a choice, they must rely too often on inadequate information. The consumer is frequently left unable to evaluate the quality of the plan or the value it provides.

To assist in filling that void, AHCPR has undertaken, with the help of the Research Triangle Institute, an effort to inventory existing questionnaires that gather information about consumers experiences with the health care system. The objective is to produce a set of standard questions for assessing consumer attitudes about the accessibility, quality, and effectiveness of the care they receive, as well as their satisfaction with that care. A unique feature of this project is that it is being designed to reach a variety of consumer groups -- including heavy users of health care, Medicaid recipients, and others who might have difficulty negotiating the system.

The initial developmental phase of this project is complete. On March 10, we announced a solicitation for the next phase, which involves further field testing and evaluation of model questions in a variety of settings. The intent is to try out the questions in real situations where people are making decisions about their health and health care and to systematically examine the results. We will also make the survey available to organizations who want to begin using the model questionnaire more immediately while the formal evaluation is completed. Both these efforts have involved the private and public health care sectors, in hopes of furthering consensus on what might become an acceptable industry standard.

Conclusion

Let me summarize by reiterating four main points. First, all elements of the Public Health Service are committed to improving the quality of care provided to all Americans. Given the rapid changes that are occurring through the entire health care system, we have a special commitment to assure access to and quality of care for vulnerable populations, including the elderly and low income groups. We have already demonstrated that in many instances lowering health care costs can be accomplished while improving quality.

Second, we need a stronger science base and better tools to learn what aspects of personal health care can be improved and how to do it. Just providing more and better information is not the answer. We also need to strive for real world behavior change. Only when that occurs will we see improvements in quality and cost savings.

Third, we have an important obligation to communicate with consumers, to better understand their needs, and to help them make more educated choices about their health and health care services.

Finally, we are committed to working with the Health Care Financing Administration in its pursuit of high quality care for its beneficiary populations. We have been collaborating along many fronts, as I hope my comments have illustrated. And we anticipate many more opportunities for future collaboration.

I can't conclude without noting that the authority for the AHCPR under the Social Security Act needs to be renewed. I believe Medicare beneficiaries, as a special segment of the population, have been well served by the research and guidelines that AHCPR has undertaken. I look forward to working with you to accomplish a timely reauthorization of these provisions for another 5 years.

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

Chairman THOMAS. I thank both of you very much. In accordance with the Chairman of the Full Committee's procedure for recognizing Members for questioning witnesses present at the time the meeting began, we will begin with the gentleman from Nevada, Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman. I want to applaud your efforts, both agencies, on trying to get a handle on what we are doing to try to improve the overall quality of what not only the private sector is doing, but what your agencies are doing as well.

To that end, you put up the bell curve and, obviously, the goal is to shift that to the right. At this point, what kind of evidence do you have that you are shifting the bell curve to the right and, also, have you done a cost benefit analysis of the amount of money that your agency has expended compared to the benefits that we are getting in shifting that to the right?

Mr. VLADECK. I can answer your second question quite easily by saying, no, not at this point, partially because of the time cycles involved. If you are going to measure any lasting benefit, you need to give it a little longer. Partially because it is a complicated thing to do, since we are talking about a large program with many individual projects in it. We have a contract with the Institute of Medicine to examine the overall efficacy of the revised PRO program, but we do not want to get to the game of picking advantageous anecdotes out of this broad range of projects and say this one saved x amount of dollars until we have an agreement with an independent body on what a fair, overall evaluative process would be.

We can point to successes in a number of instances relative to shifting the curve. Again, I think it is fair to say that it takes a while to aggregate those into national numbers or national tendencies. In the instance I cited in one State, we can tell you that the rate of inappropriate right heart catheterizations in 20 hospitals in that State went down about 50 percent. We could also put a savings amount on that although that would not be a fair cost-benefit analysis until you had more data. We can provide some of those anecdotes about shifting the curve. Have they added up to an aggregate effect? That would be a leap that we are not yet prepared to make.

Mr. ENSIGN. That actually was the purpose for my question, because the anecdotes that you bring in suggest the system is working great, but if you are spending a lot more money to get a few of those anecdotes, that should be considered. On paper this sounds great and I applaud the efforts of what we are doing here and want to see it continue, but also to follow up with that, what you are trying to do is measure the private sector. How are you measuring your own success?

Mr. VLADECK. I think over time, particularly as we look at some of the standards of criteria we are seeking to use nationally, we can better measure success. Just to give some simple examples, we will be looking over the next few months at the proportion of beneficiaries who had flu shots during flu season last year.

A lot of PROs put a lot of efforts into outreach to get people to get their flew shots. We have pretty good historical data. We will

see if there is an increase in the number of persons who got the shots. We will have that sort of evaluation.

On our national cardiovascular project, we should have data by the end of this year on the extent to which physicians throughout the country are meeting the three simple sets of guidelines for optimal care of heart attack patients that we are communicating nationally and working with hospitals about.

We will have measures of national outcome for that one particular, although very high-volume, condition by the end of the year as to whether there has been any aggregate change in the behavior of physicians in an area in which there is a lot of professional agreement that if there is change in that direction people will be better off. Just putting a dollar on that is tricky.

Dr. LEE. If you look at some of the areas like the cataract surgery, those reductions are not just related to a few outliners changing their practice. That is related to a change in the practice of many ophthalmologists. We look at the transurethral prostatic surgery. That is not just an outliner phenomenon.

Guidelines on pressure ulcers, we see a number of areas where we believe that we are shifting the curve because the focus has moved completely away from the outlier targeting the individual practitioner and moving to improve both within the hospital and in the ambulatory setting of the whole system.

The results, we feel, from these just focused practice guidelines that have developed following the PORTs, and this has all come in the last 5 years since the agency was created, and it developed a more focused approach on outcomes research—I think it is very encouraging and although we do not want to make estimates of cost savings, one guideline alone on low back pain where the expenditures are estimated to be around $20 billion a year, we believe that we will see very significant savings, one, in the reduction of diagnostic procedures that have proven to be ineffective and in some surgical procedures that have been widely used that have been found in the acute low back situation not to be an appropriate approach.

We will be following that over the coming years to determine the level of savings that are achieved, but the quality of care for the individuals is the other significant factor in that.

Chairman THOMAS. The gentleman's time has expired. Mr. Stark will inquire.

Mr. STARK. Thank you, Mr. Chairman.

Regarding this issue of reliable quality measures, I presume that that applies presumably to managed care under the indemnity program. I presume that there really is, other than the possibility of outcomes research overutilization and that sort of thing, not much more you can do. How long do you think it would take whether it is government or the private sector or university research to develop a reliable quality measure, and I guess that would—that would not mean that it would result in a report card that the average senior could use to their advantage to pick or choose—how is that going to take us or is it available now?

Mr. VLADECK. I do not think the kind of report card on which I would suggest any consumer reliance is there now. Like all good report cards there is a lot of consensus that the ones we develop

for managed-care plans need to have a number of subjects and be multidimensional and we are further along on some of the measures on which we can grade plans than on others.

For example, we have a lot of data, although not a lot of standardization, on customer satisfaction surveys. AHCPR is working on a project to help develop standard norms of customer satisfaction surveys so that there can be some reliance on the objectivity of the information. That is within a year or 18 months, perhaps.

We have been developing standards on how quickly people get appointments, how quickly they get seen, how quickly the phones get answered. That is not a long-term project. On some of the other measures of how well the plan takes care of diabetes patients, or how well the plan appropriately refers people for home care, for example, we are further away from having the criteria by which we could issue grades. I think we are talking about some number of years, not decades in that regard, but I would be reluctant to say it is 4 years rather than 3, or 3 years rather than 5. It will take us within that range of years.

Dr. LEE. It also depends on what kind of investment we make in doing that and developing the encounter-based systems within managed care. In the absence of those, it will be very difficult and slow in coming.

Mr. STARK. Doctor, isn't there a major difference between applying the standards you could apply to magazine subscriptions, how fast you answer the phone, how long you wait, that doesn't have a lot to do with the kind of treatment you are going to get.

If you wait an extra half hour, you may be mad, but if they cut off the wrong leg you will be a lot madder. It seems to me that reviewing how patients are treated, particularly those that live, is one very complex issue as opposed to just how quick the bills go out and whether they spell your name right, whether people are friendly or the rest rooms are clean—those same things could apply to movie theaters in the mall.

The real question is how do you study whether the person was treated properly or referred to the right specialist? Will that take longer? Are not the only standards we have now that are helpful to the seniors, is the 50/50 rule and their ability to leave, to go back into Medicare if the plan goes broke, or it turns out to be a bunch of high binders, they can go back into the fee-for-service. Is that the only protection seniors have today?

Mr. VLADECK. I think it is an important protection, as I suggested in my testimony, although it is not invoked often enough. The PROs do have authority to respond to complaints and investigate individual instances of inadequate care and to review at the second level appeals for inadequate care and they do that.

In addition, we in the past, in previous administrations, did not adequately carry out our responsibilities for systematic reviews of the performance of managed-care contractors in the Medicare Program and we have a number of such reviews underway and are identifying major areas of deficiency that need correction.

I do think the ability to disenroll essentially on a month-by-month basis is an important consumer protection, perhaps regardless of the amount of information the consumer had before choosing

to enroll in the plan, and certainly not one that at the current state of information we would suggest doing away with.

Dr. LEE. We are also working with the private sector to improve the consumer surveys, and to get better outcome studies. You also have to do medical record reviews in these situations until you have a better encounter-based system, but there is a fair amount of research that has been done and I think if we give it adequate support, we can within a relatively few years give the elderly and others who choose a managed-care plan more assurance.

Gail Warden will be here later, who may be able to amplify on that issue as well.

Chairman THOMAS. The gentleman's time has expired.

Mr. Crane will inquire.

Mr. CRANE. Mr. Vladeck, did I understand you to say that you have a study in progress right now at HCFA to compare managed-care plans' performance with fee-for-service?

Mr. VLADECK. No, sir. If I misspoke, I apologize. We are trying to use the same performance measures that we are developing for managed-care plans for performance of the fee-for-service sector as well so that within a period of several years we will have one set of expectations, one set of performance standards, one set of criteria, but we are not doing that yet.

Mr. CRANE. Is that the target date of 4 years that you referred to?

Mr. VLADECK. Target date implies more precision than I am prepared to give. That is the rough range of the amount of time by which we think we will be able to have standards that can be applied fairly to both the fee-for-service and the managed-care sectors, yes.

Mr. CRANE. Very good. Thank you.

Chairman THOMAS. Mr. Christensen?

Mr. McDermott?

Mr. MCDERMOTT. Thank you, Mr. Chairman. I understand that Mr. Kasich is planning to wipe out the quality review part of your operation, Dr. Lee, and I wonder; if that is wiped out, what protection will there be for senior citizens?

Dr. LEE. I do not see that it will be done anywhere else either in the private or the public sector. Because the benefits of this type of research obviously benefit all patients, Medicare patients particularly because of the focus that we have had, but in the absence of that in terms of benefits both in terms of quality, learning about costs and then producing a more cost-effective system. Private plans individually do not have the resources to make the kind of investment that we can by investing collectively through the AHCPR to then benefit both fee-for-service plans, managed-care plans, hospitals, practitioners, consumers—we just do not have in the private sector—within a competitive system, we would not be generating this type of research any more than we would be able to generate support for basic biomedical research.

Mr. MCDERMOTT. What you are saying is that without this agency there will be no coordination of quality of care in this country between plans or between operations?

Dr. LEE. The private sector is doing a lot of coordination, but in terms of generating the knowledge that we need which we can then

apply in these various settings that would not be done. There are not sufficient resources within the individual health plans to do that.

Mr. MCDERMOTT. The PRO can enforce its standards in Medicare situations; is that correct?

Mr. VLADECK. That is correct.

Mr. MCDERMOTT. The PRO cannot enforce their standards in the private sector.

Mr. VLADECK. That is also correct.

Mr. MCDERMOTT. I picked up yesterday's paper—I was reading a long story in the "New York Times" about Milliman-Roberts, a Seattle firm that put out a cookbook about how to run the most efficient HMO. Milliman and Roberts advises in cataract surgery; do one eye, do not do both eyes, because if the patient does not have a job that requires two eyes, you can get by with doing one eye. That is the way to save money in an HMO.

How do you put together—they said they have sold 6,000 copies of this cookbook to various insurance companies—how do you put together your quality assessment with the fact that Milliman and Roberts is being followed like Julia Childs' book throughout the entire insurance industry? How do you measure the quality when that is what is going on?

It seems to me things are going to two different directions, one to save money and another where you are trying to judge quality. Have you seen the book?

Mr. VLADECK. I saw the newspaper story and am sending away for a copy of the book. I think the issue is that we seek to develop standards of appropriate care, or of high quality care, on the basis of the best professional judgments we can get, informed by the most systematic data we can get, without in particular instances reference to whether that is going to save money in the short term or not, because of our sort of simple faith that in the long term better care is better economics. To take an area in which we wanted to develop guidelines while the work of AHCPR was still in progress, we sat down with the American College of Cardiology and other groups of physician and nursing experts on the management of cardiac disease indicators for our cardiovascular project having to do with the use of high-tech medicine such as putting patients on an aspirin regimen if it is not contradicted by coagulation problems. We ran a process in which we tried to get a high degree of professional consensus to have the physicians look at the data in the literature on what was efficacious and what wasn't—Medicare doesn't pay for outpatient aspirin. We do pay for inpatient aspirin. We do not care in that regard.

The fact is that those patients ought to be on aspirin therapy if they do not have bleeding disorders. That was not a doctor working for an actuarial firm setting standards. There was a very high level of professional consensus among leaders in the profession.

Mr. MCDERMOTT. The bottom line question is if you have a standard and Milliman and Roberts has recommended something to Kaiser Permanente, who wins in terms of the care of a senior citizen?

Mr. VLADECK. What I think the way in which the system will evolve is that the medical staff or the members of that Permanente

group will be asked to go through a process of evaluating our guidelines and Milliman and Roberts' guidelines and everyone else's and create a record to show that they, as appropriately credentialed physicians, came to their own conclusions with their patients about what the right norm was. That is the direction in which we are headed.

Dr. LEE. Their guideline does not follow the clinical practice guidelines of the panel chaired by an ophthalmologist at the University of Vanderbilt. A million copies of this guideline have been circulated to the profession through a variety of channels and I would hope when you have this kind of an evaluation, it would beat out that kind of so-called cost-effective recommendation with physicians.

I cannot believe that they would adopt a recommendation like that in the face of this highly professional document, carefully analyzed review of the literature which does not recommend one eye at a time.

Chairman THOMAS. The gentleman's time has expired.

This obviously is an area that we are going to continue to investigate because no one wants cookbook medicine. Obviously, you don't have an infinite number of choices which give you a positive quality cost ratio.

Our first concern is to get a structure in place and then not to lock it in rigidly. Problems do not go away; they just change.

The gentleman from Texas.

Mr. JOHNSON. I wonder, when you develop guidelines, how is the Federal Government involved in this directly and why can't our universities and medical schools figure it out instead of Uncle Sam telling them—

Dr. LEE. We only provide funding to support the process. These where not Federal guidelines. They are guidelines with support of the agency but done in the private sector.

Mr. JOHNSON. Why can't the private sector do it?

Dr. LEE. There are a number of guidelines developed by various professional organizations. Many of the subspecialties develop guidelines, and those are in wide use. It was felt, and I think it is the evidence to date suggesting the popularity of this approach, which is a multidisciplinary approach. It isn't just the ophthalmologist looking at the cataract. It is family practitioners and that multidisciplinary part, I think, has been one of the benefits of this federally supported effort. It is a private activity, with a very modest amount of Federal dollars supporting the efforts.

Mr. JOHNSON. I have watched HCFA in action and it seems to me that you guys are more interested in administrative standards, is the I dotted and the T crossed, rather than the quality of medicine, per se.

Mr. VLADECK. I am familiar with the general perception, sir, but I need to talk about specific examples. It is precisely to try to move away from that kind of specification of great detail about expectations about performance, that we are doing with the PRO program. We are not going to have a HCFA guideline or a nationally established guideline for management of heart attack patients.

We are going to communicate through a variety of mechanisms to hospital medical staffs and HMOs some reported consensus of health professionals about the treatment of those resources.

Mr. JOHNSON. So, you are not going to have a national health standard, per se?

Mr. VLADECK. No.

Mr. JOHNSON. That is great, but who is going to determine who makes the decision of who is right and who is wrong and how are you going to control HMOs in that regard?

Mr. VLADECK. The determination, in most instances, because there are clear-cut cases if a patient requires an amputation of the left foot and you amputate the right foot—

Mr. JOHNSON. No, but we read about that happening.

Mr. VLADECK. In most cases the appropriate person to judge the appropriate treatment of a patient, whether in a fee-for-service or a managed-care plan, at the point of service, is the individual practitioner taking care of that patient. What we want to expect and require is that that practitioner is working in an environment where he has available to him or her data about his pattern of practice compared to that of his or her peers, elsewhere in the community and elsewhere in the State, where he has data about how that pattern looks compared to some professionally accepted norms. We have a high degree of confidence that giving folks that kind of information is the best way to improve the average quality of care being provided.

Mr. JOHNSON. The government is an information supplier, period?

Mr. VLADECK. Also, we are a requirer that people engage in quality improvement activities. We are just not going to define what an appropriate or correct level of quality is.

Dr. LEE. Supporting the research, look at Jack Wemberg's work on prostate enlargement. That went on over a number of years. Then we had the PORT that reviewed all the literature and then we developed the practice guideline. It is clear that practitioners all over the country are using that without a national standard saying this is what you have to do.

Mr. JOHNSON. Thank you.

Chairman THOMAS. The gentlewoman from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. It has been very helpful to hear you talk about the Department's involvement in the development of your ability and our ability as a Nation to oversee quality in health care and to develop a better way of monitoring health actions and evaluating their impact on health.

I was particularly interested in your comments in regard to the relationship between the work that you are doing and funding and involved in and the work the private sector is involved in because there isn't a managed-care company that isn't as concerned as we are about what kind of quality these integrated systems of care are actually delivering.

It was interesting to hear about the information forum that you are going to hold next month. Could you elaborate a little bit more on the kind of things that the private sector is doing in terms of developing their ability to determine whether integrated systems of

care are delivering quality of care and the kinds of things you are doing?

Are you pursuing different or similar lines? Are you overlapping? Are you in different directions? In the course of that, the impression I am getting from the real world is that private sector care systems are developing a far greater ability to allow physician involvement and to honor physician decision. They are not doing the kind of thing they were doing 5 years ago where someone on the telephone told them whether or not they could provide *x* kind of care.

It is a much more developed and sophisticated system that allows a lot more physician involvement, both in guideline development and in care decisions. Just in looking at what you are doing versus what the private sector is doing, since a lot of what you are doing is governing physicians and fee-for-service structures, what is comparable, what is different, how you have to proceed since you are governing a fee-for-service system in a way that is different than the private sector is proceeding because they are looking at systems of care—I am interested in greater depth on the public-private comparison.

Mr. VLADECK. We spend a lot of time talking to private sector buyers and to both managed-care plans and institutions in the fee-for-service sector about what is going on in the private market as well as about what we are doing. I think there is a considerable amount of convergence, in that while it is true that in some ways we are a little bit behind some of the private sector buyers in the monitoring of managed care performance, on the other hand, we have certain advantages in performing those functions that they do not.

Many of them expressed to us considerable frustration and concern about the availability of data, for example, for managed care plans. We have substantially more authority to collect the data than they do and a large enough piece of the action, in most instances, to have a statistically reliable look at certain things.

I think in several areas there is considerable convergence, certainly around some of the objective measures that tend to get talked about in terms of report cards. We are working with the National Committee on Quality Assurance and their HEDIS report card in both the Medicare and Medicaid setting and moving toward convergence in that regard.

In the development of indicators in preventive services, we work closely with the managed-care industry. In terms of patient satisfaction measures developed primarily through AHCPR, we are working very closely with the larger buyers. We are ahead of the private sector in terms of development of particular quality indicators and there, again, frankly, we are increasingly drawing on our experience and knowledge from the fee-for-service sector to develop indicators that we can then test and see if they are applicable and appropriate in managed care and I think the private sector is watching some of that activity with great interest.

Dr. LEE. All the agencies are now involved with managed-care health plans in one way or another; the Centers for Disease Control, for example, in prevention. We are holding a series of working meetings with representatives of managed-care plans and

the Office of Health Promotion and Disease Prevention is working with about 20 medical directors of HMOs to put prevention into practice.

In some cases, they use the HEDIS guidelines. In other cases, they take putting prevention into practice documents and apply those in different settings. There are multiple examples and we would be glad to provide for the record the collaborations that are now going on between managed-care plans and local health departments, for example, to improve the health of the populations in those areas, Milwaukee and Seattle, and a number of other areas, and we have cooperation with the AHCPR and the GHAA.

We have a research conference coming up. They are working with Kaiser Permanente on the implementation of guidelines.

Mrs. JOHNSON. I appreciate that. I hope that there is the same kind of intensive relationship with managed-care plans, because I think you are right, Mr. Vladeck, that the government does have a position that enables us to drive the data collection decisions of the entire public and private system. If we make the right decisions in terms of data collection, we will have a better system in the future for everybody, public and private.

If we make the wrong decision, then the private sector will go a different way and everybody will be stuck collecting two sets of data, which has been a common problem in the past decade.

I want to be sure as we move forward on this and I am pleased with your testimony. You are clearly doing what our experience in this area would lead us to do, that in the end we come out with pretty much a single data collection system. It is what has slowed down simplification in a lot of areas.

If you could get back to me on any work that you have done in the area of prescription drugs. Some years ago HCFA funded a study that discovered that a lot of senior hospitalizations were the direct result of too many medications and too many physicians involved and nobody minding this person's medication shop and we developed very good data about how to prevent hospitalization through better management of prescription drugs. To my knowledge, A, I can't find it, B, I don't know that anything ever came of it policy-wise.

Mr. VLADECK. We will get back to you with the information.

[The information was not received at the time of printing:]

Chairman THOMAS. Mr. Cardin.

Mr. CARDIN. Let me thank both of our witnesses for their testimony today and for their work in trying to improve the quality of health care that all of our people enjoy.

One of the difficulties that we have is that it is more difficult to come up with measures of judging the quality of a managed-care program versus traditional fee for service. Both of you, in your testimony, have pointed out the importance of consumer information, better information for the consumer to make a choice as to quality.

If the consumer is empowered, then I think the market will be of higher quality because of the ability of the consumer to make a choice of one of the higher quality providers. That becomes more difficult when you are trying to judge a plan versus fee-for-service providers and the lack of uniform information in managed care is

an obstacle we will have to overcome and you have talked about that in your testimony.

My comment or question is that if an individual is in a plan where they have no choice, if they are in an HMO that requires them to use the providers that are in that HMO, and they are basically in that plan because their employer provides subsidies and there is no opportunity for them to make a choice, should the Federal Government be concerned about that lack of choice by the consumer and should we be considering legislation that perhaps requires, at a minimum, that the consumer be offered a POS option so at least the consumer has some choice and therefore we have a better opportunity to make sure the market really works and the consumer helps in quality assurance?

Mr. VLADECK. We had some experience last year with suggesting some national rules about the operation of the private health insurance market. It was not an unmixed success so I do not know that—

Mr. CARDIN. This Committee also had some problems in that area.

Mr. VLADECK. I do think that increasingly you will find a perception on the part of folks from all parts of the political spectrum that there should be some basic national standards about consumer protection in health insurance broadly defined—indemnity as well as managed-care plans. Otherwise, we will encounter the phenomenon which we are already seeing of a whole variety of different sorts of State legislation which many of the plans will find less comfortable than some agreed-upon national set of standards and which will also exacerbate the problem of driving more and more employers out of the insurance market, per se, into self-insurance in order to avoid those sorts of things and further fragment and complicate the system.

I think there is increasing recognition of consumer protection issues and the fact that we will get a potpourri of State rules that are all over the place in the absence of some Federal activity in that regard.

Mr. CARDIN. Would you favor, in that national guideline, some protection to guarantee a choice to the consumer?

Mr. VLADECK. Personally, I would feel strongly both about internal mechanisms in all plans relative to grievances, to appeals of decisions about denial of care, the source of care, as well as some degree of choice.

Dr. LEE. To the extent that you can give the consumer the choice of the plan as opposed to the employer choosing the plan—Medicare gives the consumer that choice—that, to me, is the critical issue and then providing the information. Mrs. Johnson made a critical point, we have to have standard data so people can compare.

A report card from one plan may not be the same as one from another. In making those choices, information is critically important.

Mr. CARDIN. What I meant by choice was a choice of plan, as long as the consumer has the ability to get into a plan so there is some weighing of quality and not just the employer making the choice.

Mr. VLADECK. I think that is true. One of the things that all good systems do, whether public or private, is protect people who have made bad choices. The fact that someone has chosen a plan should not eliminate the need for some internal appeals and grievance process.

Mr. CARDIN. You will also need a way for consumers to be able to understand these plans.

Mr. VLADECK. Absolutely.

Chairman THOMAS. I will try to follow up on questions that you have answered so that we can explore it because one of my concerns is the HMO cookbook in terms of procedures. I am struck by the fact that, given the proliferation of the way in which people's health care is being delivered, it is more and more difficult to measure. Sometimes heavy front end on the preventive. It seems to me that in the private sector, to a certain extent, if you hit on something that seems to work, you are less likely to publish it in a book so everybody else can copy it.

It tends to be a proprietary thing and you understand how to manage and save money and you are relatively reluctant to share that with others. I think that is going to be one of the concerns as we move forward in terms of how structures open up and we are able to truly measure what it is that they are doing, because if they are doing a good job they will lose that edge.

Mr. VLADECK. If I may suggest, Mr. Chairman, I think that is also an argument for public support of the development of outcome standards and consensus guidelines about norms of effective service.

Dr. LEE. If we can focus on quality and if the competition is on the basis of quality rather than just price, and that is what I think—it is not a settled issue yet. There is too much emphasis, on instead of managed care, managed cost, and that is a critical issue because you can underserve populations whether fee-for-service or capitation and only by having adequate quality measures and comparing on the basis of quality will we protect the consumer in the end.

Chairman THOMAS. On your bell curves, as you indicated, clearly we are moving away from what you should not do to what you should do and I do not think we should focus on the front end of that curve either. You concentrated in the center of the bell and then moved the bell to the right.

Sometimes we get carried away with the extremes and that becomes our anecdotal chemicals. My concern is that when you are dealing with quality versus cost information it is extremely important. Sometimes too much information becomes chaos in that when you are providing a very long checklist, you begin to look at choosing a health care provider like an IRS form. We have to watch that as well.

Sometimes an agency, probably of the government, that has a degree of trust could have a Good Housekeeping seal of approval approach so that you know that you have met the minimum standards and then leave it more up to the person using choices that are not necessarily objective, but feel good to them. That is our basic goal rather than the front end of that bell curve.

There was a discussion on the 50/50 which protects beneficiaries. There is nothing sacrosanct about a 50/50 is there, especially as we look more into managed care?

Mr. VLADECK. I do not believe there is magic to the 50/50 rule. We have a somewhat analogous standard in the Medicaid Program which is 75/25. Once you get below 25, our experience in Medicaid suggests you really are talking about segregated plans, but somewhere between 25 and 50 does not seem to be a lot of difference.

Chairman THOMAS. I agree on the diminished end of it, but sometimes we pick a number and lock into it and sometimes we lose the possibility of gaining additional information if we are not wedded quite so much to that number.

The gentleman from California talked about the movie theater quality—I agree, and the quality, do your feet stick to the floor, yes or no? My other concern has to do with feet in terms of letting people get in and out of programs.

Clearly, the ability to leave a choice is a good measure of whether or not they liked it, but if it is too frequent, for example, if it is on a monthly basis that you can get in and out, how can you run a managed program where if a secretary offended someone they can walk. If you talk about a reasonable timeframe like a year or so or you provide a period of reflection to determine whether or not they want to revoke the decision they made, kind of like what we have now with folks for an election period, that kind of a structure, for example, a year with possible period of revocation would be preferable to a monthly in and out.

Any reaction?

Mr. VLADECK. I understand and agree conceptually. I have to tell you, however, and I would suggest that both today with subsequent witnesses and in other discussions, I was, at first, surprised and now I am accustomed to it to hear the almost unanimous opinion of the managed-care plans that they would rather have an unhappy customer leave than have a customer locked in. I frankly, think for policy purposes at this point in the evolution of all these systems, my instinct is to defer to the judgment of the folks who are operating these programs on the front line.

There is always the actuarial concern that they will use that essentially disenrollment at will to get rid of people as they become expensive—we do not find evidence of that. I would suggest that you ask that same question to folks running the plans because I do not fully understand their feeling, but it is a strongly held one.

Chairman THOMAS. It would seem to me that you would have some kind of a comparable checklist as reasons for leaving so there is an exit interview or something which provides us with some data that we can then utilize. What we get into is statistics about x number of people leaving and OK, they left, and x the number of people that came in. I am concerned that we do not gather information that will provide us with some tool that we can move forward on.

Mr. STARK. Mr. Chairman, could I ask along the line of getting the necessary information for the nontheater type of research? We are going to hear from a witness later today, and I just wanted to check this. Medicare does not have access to uniform patient-encounter data of services provided to its risk populations. They

are available in the fee-for-service sector and used to profile and analyze patient care, but you do not, as this witness will suggest, have available to you the encounter data in managed care in HMOs. Is that correct?

Mr. VLADECK. That is correct.

Mr. STARK. Do you need legislation or do you just need encouragement? It would seem to me that if you don't have that data, you can't compare managed care with fee-for-service. Is this something that would need legislation—

Mr. VLADECK. It is not clear to me that we would require legislation in order to do that. We are addressing the issue by trying to develop a reasonably high degree of consensus of what the data are that ought to be required and we think we can do that under existing authorities. Certainly any expression of interest or guidance from the Committees of jurisdiction and from the Members helps to prod us along.

Mr. STARK. If we think that there is some benefit to managed care plans, but we want quality data and report cards—if you guys cannot get, in effect, the medical records, you can get them from the fee-for-service side but not from the managed-care side, I do not see how you can inform us accurately. I would like to encourage you and if there is anything we could do, it seems to me that data should be available to you, please let us know.

[The information was not received at the time of printing.]

Chairman THOMAS. I want to thank both of you very much. Good luck on your trip out to the coast.

The next panel will be a panel of doctors, Robert H. Brook, professor of medicine and health services, University of California at Los Angeles Center for the Health Sciences, and director of the health sciences program, RAND Corp.; R. Heather Palmer, director, the center for quality of care research and education, Harvard School of Public Health; and Don E. Detmer, professor of surgery and health policy, vice president and provost for health sciences at the University of Virginia.

I want to thank each of you for coming, and would indicate that for purposes of the record, any written testimony will be made a part of the record, and you may proceed in any way you see fit to inform this Subcommittee.

I guess the easiest way is just to start left to right and move across the panel.

Ms. Palmer.

STATEMENT OF R. HEATHER PALMER, M.B., B.Ch., S.M., DIRECTOR, CENTER FOR QUALITY OF CARE RESEARCH AND EDUCATION, HARVARD SCHOOL OF PUBLIC HEALTH

Ms. PALMER. Good morning, Mr. Chairman and Members of the Subcommittee, and thank you for giving me this opportunity. I am a physician, a U.S. citizen, for over 25 years and director for the center for quality of care research and education at the Harvard School of Public Health.

Chairman THOMAS. These microphones do not pick up very well. You need to have it directly in front of you, and speak into it.

Thank you very much.

Ms. PALMER. I recently led a team of researchers in a 3-year demonstration of quality measurement and improvement in Medicare fee-for-service physician office care in three states, and led a panel of HMO physicians and quality of care experts in the Delmarva project to make recommendations for Medicare managed care review by PROs. In a future where Medicare will increasingly offer beneficiaries choices between competing managed care plans, I have four recommendations for the Subcommittee.

First, major threats to quality of care for Medicare beneficiaries relate to the difficulty providers have in keeping up with rapid changes in clinical science. Clinical practice guidelines help providers keep up with advances. To help providers to follow guidelines, they should use guideline-related performance measures to track their progress.

For example, high blood pressure is the most frequent diagnosis for office visits for patients 65 years or more. Treatment is important because reducing blood pressure by a small amount reduces the risk of having a stroke by 42 percent and of heart attack by 25 percent. Prevention of strokes and heart attacks not only saves beneficiaries from death and disability, but it yields large dollar savings on health care. Clinical practice guidelines for treatment of high blood pressure change with new scientific evidence about which drugs in which combinations to use for which patient circumstances. Clinicians or health care plans that use the same drugs year after year soon fall behind in providing best quality at least cost.

The Agency for Health Care Policy Research conducts outcomes research and uses the results to provide clinical practice guidelines that help health care providers to keep up with scientific advances. Most of these guidelines are directly relevant to the care of Medicare beneficiaries. The Agency for Health Care Policy Research will soon publish a handbook describing a method for measuring guideline-related performance as a form of quality measurement. By this means, HCPR, which owes its existence in large part to the leadership of then-Congressman Gradison, is a vital resource for improving quality in the Medicare Program.

Second, beneficiaries should receive consumer reports comparing performance related to clinical practice guidelines to assist in their choices between managed care plans. These reports need to include explanations of guidelines and of related performance measures. The content of the reports should rotate over time over the range of health care needs of Medicare beneficiaries. Consumer reports should be based on national performance measurement sets to assist beneficiaries who receive care, plans who provide care, and businesses who buy care in multiple states.

NCQA, the HCFA, and the AHCPR are already leading in the development of such measure sets.

Third, cooperative quality improvement programs are needed to protect the interests of beneficiaries who cannot make informed choices among managed care plans. Consider a man whose wife of many years died recently of cancer. He is too depressed to read Consumer Reports. Or, a woman who chooses her plan because of its excellent care for high blood pressure but does not consider the plan's neurosurgery services because she does not know that next

year she will develop a brain tumor. Or, a man whose failing eyesight or hearing make him too confused to consider changing plans.

In quality improvement programs, PROs coordinate cycles for health care plans and organizations, feeding back comparisons of performance to each provider. They reveal benchmarks that encourage plans and organizations to strive for the best level of performance shown to be achievable.

The FAA, Federal Aviation Administration, provides a precedent for this. It doesn't simply publish information on crashes and near misses, leaving consumer choice to weed out unsafe airlines. Instead, airlines share information through the FAA on better ways to promote safety so that information on safer flight is not treated as a trade secret. The same approach should apply with regard to safety and health care.

HCFA has already committed the PROs to quality improvement programs, which should expand to include private purchasers in each state.

Fourth, accreditation that monitors internal quality improvement programs within plans should provide the threshhold for plans and organizations to praticipate in Medicare. Consumer reports for performance related to clinical guidelines are needed in addition to accreditation to make visible to beneficiaries the differences among plans that accreditation does not eliminate.

Cooperative quality improvement programs are needed in addition, and should be at the State level, because health care is shaped by State regulation and politics, local health care markets, and the local cultural and business environment.

Accreditation organizations at the national level are not well situated to conduct such State-level programs. Also, there is a conflict of interest between accepting fees for accreditation and accepting fees to provide individualized technical assistance that might improve an organization's chance of being accredited.

In summary, a mix of quality improvement strategies is essential to protect Medicare beneficiaries, programs of internal quality improvement, consumer report cards, and State-level cooperative quality improvement programs. All of these need to relate to clinical practice guidelines, together with accreditation as a condition of participation in Medicare.

The AHCPR is essential to this agenda. I am grateful to the Subcommittee for this opportunity to present my recommendations on these issues which greatly affect the lives of the 36 million Medicare beneficiaries.

Chairman THOMAS. Thank you very much, Dr. Palmer.

[The prepared statement follows:]

TESTIMONY OF R. HEATHER PALMER, M.B., B.Ch. S.M.
CENTER FOR QUALITY OF CARE RESEARCH AND EDUCATION
HARVARD SCHOOL OF PUBLIC HEALTH

Good morning, Mr. Chairman and members of the Subcommittee, and thank you for giving me this opportunity to discuss with you how quality of care can be obtained for Medicare beneficiaries.

Area of Expertise

I am a physician. I have been a U.S.citizen for over 25 years. For 20 years I have conducted research and education concerning measurement and improvement of quality of health care at the Harvard School of Public Health, where I am Director of the Center for Quality of Care Research and Education. I previously served as a Board member of the National Committee for Quality Assurance (NCQA) and of the American Medical Peer Review Association (AMPRA), which represents the Peer Review Organizations (PROs). I am immediate past chair of the American Medical Review Research Center (AMRRC), a research and educational affiliate of AMPRA. I have provided consultation to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In my testimony before this Subcommittee, however, I do not represent any of these organizations.

Let me briefly summarize three projects in which I led a team of research in work that is directly relevant to the issues before this Subcommittee.

Medicare Fee-for-Service Physician Office Care: the DEMPAQ Project[1]

The project to Develop and Evaluate Methods to Promote Ambulatory Care Quality was a partnership between the Delmarva Foundation for Medical Care (Delmarva), the PRO for Maryland and the District of Columbia, together with the PROs for Alabama and Iowa, and our research team. We established liaisons with the medical societies and medical specialty societies in the three states, and worked with them to develop and evaluate clinical performance measures for six chronic conditions with related clinical services, and for preventive care for Medicare beneficiaries.

Each performance measure is applied to patients with a given condition and relates to a specific aspect of care for that condition. For instance, a measure concerns the percentage of patients with a condition who receive a service that is indicated for that condition. One hundred eleven performance measures were tested on claims data files for approximately 40,000 beneficiaries in each state, and 263 measures were tested on approximately 4600 patient records from approximately 240 physician offices within the three states. The final report of this three-year project was released in July, 1994.

The PROs in these three states are now working with the Health Care Financing Administration on the Ambulatory Care Quality Improvement Project, in partnership with many of the same liaison physicians who collaborated in the DEMPAQ project.

Medicare HMO External Performance Review: the Delmarva Project[2]

The Delmarva Foundation for Medical Care again formed a partnership with our research team to conduct this project between September, 1993, and March, 1995. In the first phase of this project, we worked with a ten-person expert panel comprised of HMO physicians and quality-of-care experts. The panel included NCQA's project director for the Health Plan Employer Data Information Set (HEDIS) project and several physician members of the HEDIS workgroup. In a series of panel meetings and mailings, panel members used a modified Delphi technique to review 23 existing sets of measures including, 268 individual measures, in order to select a set recommended for PRO review of HMOs. Draft reports of this work were sent for widespread review and comment by HMOs, PROs, and consumer advocacy groups.

The report of this first phase, issued in August, 1994, included recommendations for:

- a core set of measures for all enrollees, and two diagnosis-related measure sets (one for diabetes and one for high blood pressure and heart disease);

- a phase-in of data requirements for Medicare HMOs for the data needed to construct these types of measures;

- future interactions between PROs and Medicare HMOs to take the form of HCFA's other cooperative quality improvement projects; and,

• procedures for data transactions between PROs and HMOs to ensure the accuracy of comparisons for performance measures.

Subsequently, we worked with clinical panels of diabetologists, cardiologists, and generalist physicians to develop detailed specifications of performance measure sets recommended for possible pilot testing by HMOs and PROs.

Typology of Measure Sets and Measures[3]

AHCPR contracted with the Center for Health Policy Studies (CHPS) of Columbia, Maryland, who in turn contracted with our research team to develop a typology of clinical performance measures. With CHPS, we collected and analyzed examples of the range of clinical performance measures currently in use. Overall, we collected 1287 measures from 40 different measure sets. We then classified the measures along several different dimensions and created a set of linked databases to store, sort, and retrieve measures. The goal was to assemble information that could assist potential users of quality performance measures.

Summary of Recommendations

In a future where Medicare will increasingly offer beneficiaries choices between competing managed care plans, I recommend that this Subcommittee consider five points.

First, major threats to quality of care for Medicare beneficiaries relate to the difficulty providers experience in keeping up with rapid changes in clinical science. As clinical practice guidelines help providers to keep up with scientific advances, providers should use measurement of performance related to clinical practice guidelines to track their progress toward improvement in quality of care.

Second, comparison of performance measurements related to clinical practice guidelines should be available to assist beneficiaries in choosing between managed care plans. This information should be in the form of "consumer reports" rather than "report cards." These reports should include detailed explanations of guideline recommendations and of the related measures. Content of the reports should rotate over time to cover the range of health-care needs and chronic illnesses experienced by Medicare beneficiaries.

Consumer reports should be based on national performance measurement sets in order to provide comparable information on health care plans and organizations in different states to assist beneficiaries who receive care, and plans who provide care, in multiple states. A national set of performance measure sets is also valued by businesses who buy care for their employees in multiple states. Accrediting organizations are already leading in the development of such measure sets.

Third, cooperative quality improvement programs are needed to protect the interests of those beneficiaries who, because of frailty, the unpredictability of illness, or limited mental faculties, cannot make informed choices among managed-care plans.

HCFA has already committed PROs to this type of program. Cooperative quality improvement programs should expand, however, to involve providers, consumers, purchasers, and quality-of-care experts in each state.

Fourth, accreditation should provide the threshold for plans and organizations to participate in Medicare.

Fifth, the focus of performance measurement must shift toward ambulatory care because it is the type of care experienced by most beneficiaries, and because small investments in prevention and early treatment of disease can spare patients from suffering more advanced disease, and can avert the greater costs of diagnosing and treating more advanced disease. Providing managed ambulatory care is a major objective and an area of special expertise for health maintenance organizations (HMOs).

Keeping Up with Advances in Clinical Science

Quality health care is care that best maintains and improves the health and satisfaction of patients. Quality can be achieved by choosing tests and treatments that best suit each patient's individual

needs, and by managing care so that tests and treatments are provided safely, efficiently, and humanely.

Since the knowledge base and technology of clinical science change often, care must constantly be improved in order to maintain quality. Such change occurs rapidly as a result of research and development funded both by the public and private sectors. Like Alice and the Red Queen in "Through the Looking Glass," providers of health care have to run fast just to stay in place.

In the 1990s we have diagnostic and therapeutic technologies that can save lives, limit disability, and prevent the occurrence and progression of disease. New technologies emerge continuously at a dizzying pace. These technologies may be more effective but are often also dangerous. A provider who doesn't use these new technologies denies patients chances to improve health and well-being. A provider who uses these new technologies inappropriately harms patients. Providers have trouble knowing what are the right things to do, how to do them, and what outcome to expect. All health-care professionals have to struggle constantly to update their skills and their knowledge to keep up with advances in clinical science.

As technologies emerge that can achieve more for patients, health care becomes more complex. With many persons involved doing potentially dangerous things to patients, the possibilities for miscommunications and errors in implementation multiply. Hospital and ambulatory care managers and staffs must continually adapt to change by planning and implementing the use of new technologies. This creates difficulties for safe and timely provision of care.

The continuing avalanche of new diagnostic tests, new drugs, and new procedures requires competent management in order to improve quality of care at an affordable cost. When resources are limited, providers cannot repeatedly add new technologies; they must strive to improve quality by using more wisely the dollars that are available. Differences in competence in management of health care will lead to differences in quality of health care.

With increasing technical and managerial complexity, also, it is easy to lose sight of the caring, trusting relationship that patients seek from their clinicians. Yet satisfying patients depends upon respecting their concerns, and involving them in their own care. Both health care professionals and managers must struggle to preserve a time and place in complex health-care systems for clear communication between patients and those who care for them.

Implications for Medicare

Many Medicare beneficiaries experience multiple chronic diseases. Major threats to the quality of care for Medicare beneficiaries relate to the difficulty that providers experience in keeping up with rapid changes in clinical science for many different diseases.

Let us take just one disease as an example: high blood pressure is the most frequent diagnosis for office visits of patients of 65 years or more.[4] In the Delmarva study, we found that 37% of the elderly patients randomly sampled for record review had high blood pressure. Treatment is important because reducing blood pressure by the small amount of 5-6 millimeters of mercury is estimated, using empirical data from large studies, to reduce a patient's risk of having a stroke by 42%.[5]

Every four years, recommendations have changed in response to new scientific evidence concerning which of nine different classes of drugs, in which combinations, should be used to treat high blood pressure, for which patient circumstances.[5,6,7] Clinicians, or health care plans that continue to recommend the same drugs year after year without regard to new scientific evidence, soon become seriously out of date.

Clinical Practice Guidelines, Performance Measurement, and Quality Improvement

It is difficult for practicing physicians to determine, for every disease experienced by Medicare beneficiaries, and for every new piece of clinical science, whether the evidence is sufficient to require changing the care they give to their patients. For instance, in the DEMPAQ data for 1989-1991, we found that 30% of Medicare beneficiaries with high blood pressure were treated with calcium channel blocker drugs. In that time period, these drugs were still recommended as one option for initial treatment of high blood pressure. Just last week you probably saw the news reports about the possibility of increased risk of heart attacks for patients taking these drugs.

Obviously, physicians should not change patient treatments on the basis of news reports or even of incompletely digested scientific publications. That is why clinical practice guidelines are needed. When experts weigh the accumulated evidence from clinical trials and from outcomes-effectiveness research about what works and what is safe, they can issue recommendations that help providers keep up to date with scientific advances.

Guidelines for care of high blood pressure are issued by the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure.[5,6,7] AHCPR has issued many other guidelines directly relevant to the care of Medicare beneficiaries, as have many medical specialty societies.

As providers use guidelines in deciding what is the right thing to do for patients, they should measure their performance related to clinical practice guidelines as a way to monitor the quality of care. It is important to understand that performance measurements concern what is done on average, for many patients. We should not expect that guidelines will be followed slavishly in every case because they cannot apply to every patient's circumstance. Indeed, some patients may decline to accept a service recommended by a guideline. Yet, over time, if the percentage of eligible patients experiencing care that conforms to a guideline is increasing, this is an indication that care is improving.

Leading managed-care organizations already internalize practice guidelines, re-design their delivery systems to facilitate following guidelines, and then track progress toward quality improvement by measuring guideline conformance in repeated cycles over time.

The DEMPAQ project demonstrated a similar model that works in fee-for-service office practice by measuring average performance related to clinical practice guidelines for randomly selected volunteer physicians within a state. State medical societies and medical specialty societies worked with their state PRO, the DEMPAQ team and AMRRC to design and conduct physician workshops for quality improvement. The workshops focused on quality of care in those clinical areas where the DEMPAQ performance measurements suggested that improvements were indicated.

The Health Plan Employer Data Information Set (HEDIS),[8] developed by the National Committee on Quality Assurance (NCQA), is an example of guideline-related performance measurement. Other examples are those specified in the two diagnosis-related measure sets for diabetes and for ischemic heart disease/hypertension that were developed in the Delmarva Project for possible testing in HCFA's pilot project in Medicare managed care.

AHCPR will soon publish a handbook describing a method for developing and evaluating guideline-related performance measures. With other research colleagues, I co-wrote this book. We were guided by an AHCPR workgroup of experienced health-care professionals who critiqued successive drafts of the book so as to ensure that it would be practical and useful to a wide variety of users.

I cite these examples to underline for the Subcommittee that guideline-related performance measurement for the purpose of quality improvement is already available as an "off-the shelf" technology, ready for large-scale use.

Guiding Beneficiary Choices: Not Report Cards, but Consumer Reports

Are clinical performance measures also useful for "Report Cards" for consumers? I believe that consumers will find clinical performance measures of great interest if they are presented in an understandable format. Many of the "Report Cards" used to date are too black and white, contain too few measures, too little clinical information, and fail to address different consumer needs and preferences. Consumers need something more like "Consumer Reports." "Consumer Reports" on automobiles give detailed accounts about different types of vehicles that may meet the needs of different groups of consumers, e.g., family vans, light trucks, luxury sedans, and small town cars. For each type of vehicle, desired attributes are displayed in tables or diagrams, e.g., safety, speed, reliability, interior space, comfort, and appearance. The accompanying text educates the consumer about the potential importance of each feature and how it is measured.

Similarly, performance measure sets need to cover clinical conditions of interest to different beneficiary groups. Reports on clinical performance should include text educating beneficiaries about the care that is recommended for each condition. Performance measures covering the

different aspects of care recommended by clinical practice guidelines should be displayed graphically, accompanied by text explaining how this aspect is measured, and any limitations of the measurement. Measures should be grouped in diagnostically related measure sets (DRMS) as recommended to HCFA in the Delmarva Report.[2]

In addition to measures concerning appropriate use of tests and treatments, consumers will likely value measures that describe timely and hassle-free delivery of care, and clear communication from clinicians. Such measures, based on patient survey information, are also readily available - such as the measures developed by the Picker/Commonwealth Program for Patient-Centered Care, and the PROSPER measures referred to by Dr. Lee in his testimony.

Isn't Accreditation of Health Care Plans and Organizations Sufficient?

Are consumer reports really needed? Isn't accreditation of plans and organizations sufficient? The accreditation offered by both the National Committee on Quality Assurance (NCQA) for HMOs, and by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) for hospitals and health care networks, require the organization being accredited to operate an internal quality improvement program. Accreditation visits then provide oversight of the effectiveness of these programs. However, differences in quality that may matter to beneficiaries exist even among accredited organizations.

Accreditation can set a threshold level of quality but does not eliminate differences in clinical performance among plans and providers. In health care markets, competition cannot favor those who perform clinical care better unless these differences are made visible to beneficiaries. This reasoning supports the use of consumer reports for clinical performance measurements.

Consumer reports on clinical performance add value beyond that provided by accreditation specifically if they include multiple diagnosis-related measure sets. Presumably, a Medicare beneficiary will seek a plan that serves elderly persons well and will not be interested in the plan's performance on child care or prenatal care. If this beneficiary has high blood pressure, she will be interested in how well the clinicians in a plan treat high blood pressure, how well they monitor for adverse effects of this therapy, whether they explain to enrollees how to take these medications and how well the plan promotes lifestyle changes that help to control blood pressure. If she does not have diabetes and has no family history of diabetes, she may feel that a plan's performance on diabetes care is not relevant to her choices.

In fact, of course, the leading accreditation agencies, both the JCAHO and NCQA, are leaders in developing and testing sets of performance measures that can be used to compare health care plans and organizations. A feature of both these sets of measures is that they are developed for use nationwide. This is important because both Medicare and many corporations purchase health care in multiple states. Many health-care plans also cross state boundaries. Having national measure sets avoids the burden of collecting and interpreting measurement data that differs from state to state. Also, many Medicare beneficiaries receive health care across state boundaries, because they live in cities that cross these boundaries or because they spend winter months in warmer parts of the U.S. — for them also having national quality measurements is an advantage.

Are Report Cards Enough? The Case for Cooperative Quality Improvement Programs

For competition based on informed consumer choice to ensure quality of care, consumers must be able to understand and act upon consumer reports of clinical performance. There are many reasons why such market mechanisms will be inadequate to protect quality of care for all Medicare beneficiaries.

For instance, consider a man whose wife of many years died recently of cancer; although she died in part because of the poor care that she received, he is too depressed to read consumer reports or to choose to leave his health plan.

Or recall the woman we considered above who chooses her health plan because of its excellent care for high blood pressure; she doesn't consider the poor quality of the plan's neurosurgery services, because she does not know that next year she will develop a brain tumor.

Or consider a man whose failing eyesight and hearing, untreated by his current health-care plan, contributes to his tendency to become confused. The lack of care itself hinders him from using consumer reports to make informed choices.

These examples illustrate why some mechanism in addition to consumer choice is needed to protect the interests of those beneficiaries who, because of frailty, the unpredictability of illness, or deteriorating mental faculties, cannot make informed choices among health-care plans. Cooperative quality improvement programs, like those that HCFA has initiated through the PRO program, are designed to provide this needed protection for Medicare beneficiaries.

There is already a federal government program that provides a model for cooperative quality improvement in health care, namely, the Federal Aviation Administration (FAA). The FAA does provide consumer reports. However, for reports of airplane crashes and near misses, the FAA does not simply publish the information and leave it to consumer choice to weed out unsafe airlines. Instead, the FAA works with all airlines together to devise the best means to protect passenger and crew safety. In other words, airlines do not compete on safety but only on the "amenities" of air travel. Airlines share information through the FAA on better ways to promote safety so that information on safer flight is not treated as a trade secret. The same approach should apply with regard to safety in health care

How Do Cooperative Quality Improvement Programs Work?

In cooperative quality improvement programs, external quality improvement agencies coordinate cycles of performance measurement for health care plans and organizations, feeding back comparisons of performance to each provider. The comparisons reveal "benchmarks" that encourage plans and organizations to strive for the best level of performance shown to be achievable. Alternatively, the external agencies may encourage all providers to improve beyond existing levels of performance, if all are performing below levels that are achievable with use of effective health care.

Each plan or organization then prioritizes areas for quality improvement and may conduct related, but more detailed, performance measurements to direct quality improvements. The original measures can subsequently be re-used within the plan or organization to evaluate the impact of any changes that were made.

HCFA has already committed PROs to this type of program. Cooperative quality improvement programs were also recommended in the Delmarva report as an appropriate mode of interaction between Medicare HMOs and PROs. The report recommended these activities for PROs:

- act as advocate on behalf of HCFA and Medicare beneficiaries, communicating quality-of-care requirements to plans in the form of performance measures and target levels of achievement;

- act as a catalyst for and facilitator of internal continuous quality improvement (CQI) activities in plans by focusing attention on "cooperative projects" that would involve all plans in a state, by providing benchmark performance data, and by providing technical assistance to plans with limited CQI capabilities;

- act as a manager of data collection and analysis services by auditing the accuracy of sampling, administrative data analysis, and medical records abstracting, and providing broad based technical assistance.

There are two reasons why the accrediting agencies, as presently constructed, cannot readily perform these roles. Firstly, there is a conflict of interest between accepting fees to provide accreditation services and accepting fees to provide individualized technical assistance that might improve an organization's chances of being accredited. Secondly, accreditation agencies, at least at present, are national level organizations, and cooperative improvement programs should be conducted at the state level because health-care delivery is shaped by state regulation and politics, local health-care markets, and the local cultural and business environment. This endorsement of state level cooperative improvement programs does not weaken my earlier support for the national performance measurement sets created by the accrediting agencies. National measurement sets should be used in state-level quality improvement programs.

Given the importance of the local environment, and the need to avoid duplicative efforts, cooperative quality improvement programs should involve providers, consumers, purchasers, and quality-of-care experts in each state.

Accurate Comparisons of Clinical Performance

If performance comparisons are to guide beneficiary choices, it is critical that the comparisons should be accurate. The only thing worse than no comparisons is misleading comparisons. Information that misleads consumers not only wastes resources but may provide perverse incentives that actually distort markets. Ensuring a level playing field for comparison imposes the stringent conditions discussed next. The General Accounting Office (GAO) reports that these conditions have not been altogether met in several large scale private sector quality measurement initiatives.[9] [10]

Data Availability and Accuracy

Clinical performance measurement requires accurate data about the care experienced by patients; this data must contain considerable clinical detail about the services provided and the patient's health state at different points in time.

In the fee-for-service sector, Medicare's National Claims History File provides an overview of services provided to all beneficiaries, in all settings of care and in all geographic locations. This database does not contain information on care provided within inpatient institutions, nor of services that Medicare does not cover, such as prescription drugs. Nevertheless, we were able to use this data in the DEMPAQ project to create several informative measures of care. Similar measures could only be created for managed care settings if HCFA were to phase in some minimal data requirements for Medicare HMOs comparable to those already in use in the fee-for-service sector. Such a phase-in of data requirements was, in fact, recommended in the Delmarva project report. Pharmacy databases, unavailable in fee-for-service Medicare, are quite widely available in Medicare HMOs and are useful for clinical performance measurements.

In the DEMPAQ project, we were able to create many clinically meaningful measures of performance by abstracting data from physicians' office records for patients and physicians sampled from the Medicare claims data. There is a widespread opinion that record-based measure sets are "too expensive"; this opinion appears to be founded on the unjustified assumption that large numbers of records must be abstracted. In the DEMPAQ project, each patient record obtained was tested against 263 possible performance measures, with an average of 22 applying to any record. Reliable estimates for average physician performance in a state could be obtained with samples of as few as 300–500 records. A cost analysis showed the average cost of applying the 263 measures to a record to be approximately $44. Allowing for costs of sampling cases, we estimate that the cost of obtaining a set of measures of average performance for a state (or by inference, for a large health-care plan) at $50 per record, would be up to $25,000 per measurement cycle.

In the Delmarva Project Report on External Performance Review for Medicare HMOs,[2] two diagnosis-related measure sets were recommended to HCFA, one for diabetes and one for high blood pressure and heart disease. Some measures in each set derived from administrative data, but more derived from patient records data.

The Delmarva report also recommended a rich selection of performance measures based upon patient surveys for consideration for external performance measurement of Medicare HMOs.[2] The report notes that surveys could not currently be conducted by HCFA because of restrictive regulations. Since surveys that obtain adequate response rates have relatively high costs per survey, the report recommended that surveys should also be sent only to samples of patients selected using administrative databases. Administrative databases would, therefore, be needed to sample beneficiaries to create both patient records-based or patient survey-based performance measures.

Verification of Measures

In a competitive market, some neutral party is needed to verify the accuracy of performance measures reported by each health-care plan or organization. Ensuring comparability of data and comparable computation of measures from different health-care organizations requires considerable technical expertise in conducting data audits. The Delmarva report recommended that PROs could provide this service.

Allowing for Patient Differences

When comparing performance measurements among health-care plans and organizations, it is important to account for differences in the patient populations that they serve. For instance, since it is more difficult and costly to give care to sicker patients, it is unfair to make comparisons without

allowing for differences among plans in the severity of illness of their enrollees. Failure to allow for these differences provides perverse incentives that would encourage plans to avoid accepting such enrollees or to avoid providing necessary services to them.

Patient differences that must be accounted for relate to personal characteristics such as age, gender, and patient preferences concerning risk-taking, clinical characteristics such as diagnoses and severity of illness, as well as characteristics related to health care use such as length of time enrolled in an HMO, and whether hospitalized, in a nursing home, or on home care. The Delmarva report recommended special studies of enrollees who disenroll, because disenrollment may reflect dissatisfaction with the care provided.

Difficulties in Using Patient Health State to Infer Quality of Care

Comparisons among organizations and health-care plans are problematic when patients' state of health after receiving care is used to infer whether the care given was of good quality. Such measures are only interpretable for diseases with relatively high rates of death, complications, or severe impairment. In addition, death, complication or impairment must occur close in time to the care given, large numbers of patients must receive care for this condition, and adequate measures of severity of illness for this condition must be available. Given the present state of the art, this restricts performance measurements based on patient health states to a few relatively acute and severe conditions that generally require hospital care.

For the large volume of ambulatory services that make up the bulk of managed care, it is currently more meaningful to use guideline-related performance measurement. The fact that the guideline recommendations themselves are based on clinical trials and outcomes-effectiveness research is sufficient to ensure that improved conformance to guideline will yield improved patient health.

It is particularly difficult to infer quality of care for many conditions using patients' own assessments of their health state. For instance, patients' reports of their health state give misleading impressions about quality of care for preventive care. Patients receiving immunizations and screening tests do not experience symptoms of the condition that care is intended to prevent; therefore, patient reports of their health state cannot be used to detect any difference in the short term between health-care plans that give adequate preventive care and health-care plans that give none.

For another illustration of this difficult but important point, let us think again about the example of high blood pressure. Patients may not experience symptoms from high blood pressure even when the blood pressure is high enough to increase the risk of stroke and heart attack manyfold. Paradoxically, treatments that reduce blood pressure and reduce the risk of stroke and heart attack may make patients feel worse because of side effects of the medications.[11] In this example, a health plan that treats patients better in terms of reducing long-term risks of death and disability would appear worse on performance measures based on patients' reports of their health.

A better measure of performance for high blood pressure would be to measure the percentage of patients receiving guideline-recommended therapies. As an alternative, the average level of blood pressure among enrollees being treated for high blood pressure could be used if adequate allowance can be made for patient differences in severity of their untreated high blood pressure, or if the average level of blood pressure is compared to the average intensity of treatment. For example, we first measure the average blood pressure level for enrollees under treatment for high blood pressure in a plan; if this level is high relative to other plans, we are concerned. However, if a plan with a worse average blood pressure level is performing better on average in the aggressiveness of therapy, we can infer that this plan's enrollees suffer disproportionately from a form of high blood pressure that is more difficult to treat. We conclude that this plan is a high-level performer despite the fact that it serves a sicker population.

Focusing on Ambulatory Care to Improve Health and Avert Costs

Performance measurement must include ambulatory care because it is the type of care experienced by most Americans. In 1990, approximately 78% of Americans contacted a physician in an ambulatory setting, while only 8% experienced a hospital admission.[12] The average Medicare beneficiary has five ambulatory care visits in a year.[4]

Ambulatory care is also vital because small investments in prevention and early treatment of disease can spare patients from suffering more advanced disease, and can avert the greater costs of diagnosing and treating more advanced disease. For instance, HCFA's Cooperative Cardiovascular

Project is an innovative approach to an important problem - improving hospital care for Medicare beneficiaries who experience heart attacks; but improved prevention of heart attacks is also important. For patients with high blood pressure, the risk of a heart attack can be reduced over time by 25% by a small reduction in blood pressure of 5-6 millimeters of mercury, according to an estimate based on large studies.[5] Projects that improve care for high blood pressure in the ambulatory care setting are needed, therefore, in order to prevent heart attacks from occurring at all.

Lastly, the focus of performance measurement should shift toward ambulatory care because managing ambulatory care is a major objective of and an area of special expertise for health maintenance organizations (HMOs).

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Chairman THOMAS. Dr. Brook.

STATEMENT OF ROBERT H. BROOK, M.D., PROFESSOR OF MEDICINE AND HEALTH SERVICES, UNIVERSITY OF CALIFORNIA AT LOS ANGELES' CENTER FOR THE HEALTH SCIENCES, AND DIRECTOR, HEALTH SCIENCES PROGRAM, RAND CORPORATION

Dr. BROOK. I would like to thank the Chairman for inviting me to come.

I would like to begin from two perspectives. First, I am a physician, a geriatrician—I take care of elderly patients, and I actually deal with these issues of cost and quality on a day-to-day. Second, I have spent the last 20 years of my life developing measures of quality of care and health status.

When I, as a physician, go to see my physician, and I am sitting in the room with all my clothes off, wearing a robe that does not cover all of my body, I am not exactly in a powerful position. I do not have the information the specialist might have about my disease. It does not matter who you are, the bottom line for all of us when we go to see our physicians, and all of us will get sick, is that we want a quality product. We want value for our money and we want the quality of care to be excellent.

The real question facing us as we change the medical system through competition, through market forces, or through any other mechanism, is whether quality will someday be as important to the agenda as cost. There is no question that cost and price will remain a concern, but in order for us all to get a product that increases in value, quality must remain on the agenda.

My second perspective on quality of care comes from the research I have done in this area. We have made a lot of progress through both the Agency for Health Care Policy and Research and its predecessor, the National Center for Health Services Research and Development. Today, we are able to measure mental, physical, and social health and the quality of health care provided to patients.

We have measured the appropriateness of care—that is, whether patients need the procedures they receive and whether they are not receiving procedures they do need—by measuring whether the health risks exceed the health benefits. We can also measure how well a procedure is performed, that is, I can tell you whether or not it is done in a technically competent manner.

We can also measure consumer satisfaction with care.

All of these aspects of health care are measurable. The question at the moment is whether we want to make a commitment to measuring them and, when we reform the marketplace through competition, whether the institutions and organizations that produce more value for money or better quality of care will be the ones that survive.

Now, in this marketplace, what should the Federal role be—or should there be any Federal role in this marketplace? I have spent the last 10 years trying to get managed care organizations, business, and the government together to try to form coalitions to develop tools to measure quality of care.

I can tell you that the private sector is not willing to spend the money to develop the tools that are needed. Part of their reason for

not doing so is that the tools for measuring quality are a public good. If one group spends money to develop tools and puts them in the public domain to be used by everyone else, other groups that did not pay for the tools benefit substantially? No business in this country operates this way. Thus, it is essential that the Federal Government assume a leading role. In developing the tools by which quality of care can be measured, whether those tools are practical guidelines, performed standards, or even just data collection methods to measure the performance of health plans.

Given the science we already have available, what is reasonable to expect with regard to our ability to develop those tools and apply them to real policy questions over the next several years? First of all, we need an additional $100 million a year to support tool development. This enables us to develop a system whereby we could measure managed health care plans on the dimensions of consumer satisfaction, appropriateness of care, and technical excellence within a 3- to 4-year timeframe. However, it is essential that the private sector and the public sector work closely together if we are to accomplish this goal.

The second area of the science that must be advanced is the behavioral one. We need to develop better information about how to change the behavior of doctors and organizations to make them function better. We know so little about what mechanisms might make doctors and organizations perform better, give us more value for our money.

We know that about a quarter of the services delivered could be eliminated without harming anybody. Why don't we just get rid of them? At the sametime, we know a lot of people do not get services they need and die. Why can't we make these available. We have some indication that, among patients admitted to hospitals in the bottom 20 percent of hospitals, in terms of quality, the death rate is an additional 6 deaths per 100 people admitted.

We need more information about the science of changing behavior and that also requires an additional substantial investment of funds through organizations such as the Agency for Health Care Policy and Research.

We also need to answer the questions that you asked us today. Is managed care better than fee-for-service? If so, what form of managed care is better than fee-for-service? How does market reform work in one part of the country as opposed to another? We can provide accurate answers to these questions in a timely manner. But, again, additional money is needed.

Finally, we need to have an information system that allows people to have better information about the quality of their health care plan, their hospital, and their doctor. Our best guess is that this would require about $10 per American per year—an insignificant amount of money relative to the vast sum of money we spend on health care each year, but essential if we are to develop information systems and methods for analyzing and presenting data that would provide Americans the information they need to help choose wisely among plans, doctors, and hospitals.

Thank you for allowing me to testify.

Chairman THOMAS. Thank you very much. I think you will generate some questions.

[The prepared statement follows:]

TESTIMONY OF ROBERT H. BROOK, M.D.
RAND CORPORATION

I am Robert Brook. I am Professor of Medicine and Health Services at UCLA and Director of the RAND Health Sciences Program. I thank the Committee for inviting me to testify today on quality assessment and improvement in the context of the Medicare program. We are proud of having the most advanced health care system in the world, but we also are paying more than any other country to get that care. Market forces have played a major role in raising both cost and quality. However, the medical marketplace is much better informed about cost than quality, and consequently we get less value from our expenditures than we should.

My purpose is to provide some general comments with regard to maintaining quality of care in the Medicare population as well as in the private sector. Most of my comments are based on research we have done at RAND and UCLA over the last quarter century. I hope that our findings provide some insight into the importance of measuring quality, as well as ensuring that changes in the health care system -- whether through competition, regulation, or cost containment -- are accompanied by a determination to maintain and even improve quality of care.

It is critically important that we understand how changes in the way we deliver care affect the quality of care and the health status obtained by the American people. This testimony will describe the role the federal government should play to assure that the quality of the American health care system is at least as sound in the next century as it has been in this one, and to make individual patients better able to evaluate the quality of care they are receiving. In order to accomplish this, the federal government must provide funds to *first*, to improve the science of measuring and improving quality, *second*, to support evaluations of how changes in government policies and programs affect quality, *third*, to support efforts to make information about the level of quality in managed care plans and other organizational structures available to the public, and *fourth*, to foster quality-enhancing behavioral changes by both the providers and purchasers of care.

Quality of Care Varies Widely

The absolute need for the federal government to participate in the preservation and improvement of quality of care has been underscored by the research findings generated over the last 25 years in the quality of care field. Two of our most relevant findings are concerned with geographic variation in the use of medical procedures and whether or not a given procedure, when it is performed, is appropriate. For example, our research has demonstrated that where you live determines to a large degree whether or not you receive a medical procedure.[1] Our research shows that the use of common therapeutic and diagnostic procedures such as hemorrhoid removal, coronary angiography, endoscopy, or even coronary artery bypass surgery varies as much as 300 percent, depending on the area of the country in which you live. This variation in use cannot be explained by differences in health status or clinical need. Rather, it reflects differences in physician style, and these differences in style have profound implications for both cost and quality of care.[2]

Variation in use, then, leads naturally into the second issue, the appropriateness of procedures. Although we would expect that high-use geographic areas have more inappropriate care than low-use areas, our data do not support this hypothesis. Instead, the proportion of patients receiving a procedure for less-than-appropriate reasons does not vary much among geographic areas. Thus, simply reducing the number of procedures by changing economic incentives (for example, the proportion of the bill the patient pays or the fee collected by the physician) will not reduce the proportion of inappropriate procedures. [3, 4] The RAND Health Insurance Experiment, in which we randomly assigned families to different health insurance plans that varied in the amount of out-of-pocket medical expenses people had to pay, supports this conclusion. [5,6,7] In this study, we found that if care was free, people used more of it, sometimes as much as 50 percent more than people who had to pay half of the cost, up to a preset amount related to their family income. We also found

that some of the additional care in the free plan was beneficial and some was not. In fact, at the end of the study, we found that people who were enrolled in the cost-sharing plans had levels of health status similar to those who were enrolled in fee-for-service plans. On the other hand, increasing the amount that a person had to pay for care resulted in an indiscriminate decline in care. Some people did not receive care that was beneficial and thus suffered health consequences; others avoided receiving unnecessary care that would have been more harmful than helpful and thus improved their health status.

In sum, our research shows that if we are going to contain the growth of health care costs in the United States, as most people insist we must, mechanisms that rely solely on economic and administrative principles will result in the indiscriminate elimination of care that is both beneficial and not beneficial to the patient. We must therefore develop mechanisms and policies that eliminate care that is not needed (or even harmful) to patients while maintaining care that has been demonstrated to be clearly beneficial. In other words, we must work toward ensuring that quality, not just cost and access, is considered when the structure of the health system is altered by forces such as managed care and competition. [8,9,10,11,12] We are relying heavily on market forces to give us more for our health care dollar. However, no market -- health care or other -- functions well if it is ill-informed about quality. The federal government must play a central role in improving the science of quality measurement, in using that information to improve the programs it supports, and in fostering the availability of quality information in the private marketplace.

Providing the resources necessary to maintain a quality health care system will not be inexpensive. Our estimates show a need of two hundred and fifty million dollars a year in new money to improve the science of measuring care, to evaluate the impact of policy changes and market forces on quality, and to improve the science of how we change clinical and organizational behavior to promote better quality of care. In addition, large sums of new operational money -- between $5 and $10 a person -- are needed to facilitate the American people's choice of health care plans and providers in a competitive marketplace. However, compared to the trillion dollars a year this country will be spending on health care, it is a bargain if this money can help ensure that quality of care is maintained in the next century. If this money is not forthcoming, I can almost assuredly promise you that the quality and efficiency of the health care system in America will suffer.

Quality of Care Has Measurable Components

What exactly is quality of care and how can it be measured? Our research has shown that there are three components of quality. The first is appropriateness. By appropriateness I mean that when a person receives a procedure, its health benefit exceeds its health risk. An inappropriate procedure is one for which the benefit to the patient is less than the risk. And finally, if the benefit is about equal to risk, we define the care as equivocal. Clearly, the most desirable care is that for which the benefit to the patient is greater than the risk. Certainly, it would be preferable to discontinue procedures for which care is not beneficial. Some might even be willing to give up paying for care in the public sector if the cost of the care is very large in relationship to the benefit. At any rate, research has concluded that for many procedures, up to one quarter of those being performed could be eliminated without affecting the health status of the American people.[11-17] On the other hand, it is equally true that many people, including those enrolled in the Medicare program, do not receive procedures that would improve their health. [18,19]

The second important component in measuring quality is the technical excellence with which it is delivered. For instance, we want to be sure that when coronary artery bypass surgery is performed the mortality rate is low, there are few complications, and the inserted arteries and veins stay open for a long time. We want to be sure that if an X ray or mammogram is taken, it is of sufficient quality that important lesions can be detected. In essence, it is not enough for a procedure to be appropriate, it must also be performed well.

The third component of quality of care is patient satisfaction. All of us, when we visit a physician or health care facility, would like to be treated humanely and with dignity.

Satisfaction is the component of care that is often most obvious and most easily measured. It simply involves asking patients about their experiences with care. However, it can also be the least valid measure of quality, because without better information about appropriateness and technical quality, patients can be fooled. They can be satisfied with the manner in which they are treated, but they actually may be receiving "care" that is inappropriate or technically very poor, and this may produce undue suffering and even death.

All three of these components of quality can be measured using tools developed over the past 25 years. However, the science of medical care does not stand still. If quality is to remain on the agenda while the health care system is radically changed by competition, cost containment, and regulation, the tools to measure quality must be continuously improved and must be made available in the public domain. As the information base of medicine changes, so must the tools to measure the quality of that care.

Federal Government Can Help Preserve Quality of Care in Four Ways

1) Support the Development of Better Quality Measurement

What roles can the federal government play to make sure quality is maintained or even improved into the next century? The first priority of the federal government must be to ensure that the science of measuring quality is maintained at the highest possible level and that the resources necessary to do this are provided. Public sector funds must be available to improve and develop the tools for measuring quality. And, these tools must be made available to all who have a stake in maintaining quality health care, whether they be managed care organizations, businesses, labor unions, physicians, nurses, consumer groups, or individuals. Unless these tools are available to the public, it is likely that price considerations, not quality, will be shaping the health care system five or ten years from now. And as our research has demonstrated, this will result in the dismissal of a large percentage of care that is necessary and will encourage a flight toward mediocrity.

The government's role in developing tools to measure quality of care has been demonstrated at RAND on numerous occasions. For example, a large federally funded grant from the Health Care Financing Administration enabled us to evaluate how the introduction of the Prospective Payment System affected quality of hospital care for Medicare patients.[20-22] This new hospital reimbursement system was established in 1983 to help control rapidly increasing Medicare costs. Before 1983, Medicare reimbursed hospitals on a cost-plus basis for each component of inpatient care, but under the new system, Medicare now pays a single lump sum for each admission, based upon the patient's diagnosis. To date, the RAND evaluation is the only national clinical evaluation of this program. In our study, we developed tools to measure the process of care, that is, what health care providers did to patients with one of six common medical conditions — heart attack, heart failure, stroke, pneumonia, hip fracture, and depression. We also developed tools to measure how sick the patient was at the time of hospitalization and what happened to patients after the hospitalization was concluded. Our evaluation of the impact of the Prospective Payment System on these dimensions of quality indicated that, by and large, the reimbursement of hospitals prospectively did not result in an overall decline in patient outcomes or in what physicians did to patients while they were hospitalized. We did, however, find one disturbing result: Patients were discharged from the hospital more quickly and in a clinically more unstable condition than before, and a significant number of these patients died unnecessarily. We concluded that if Medicare is going to change how it reimburses hospitals, it is incumbent upon the federal government to ensure that this policy decision does not harm patients. An ongoing evaluation of the impact of the Prospective Payment System on quality is needed, and other studies such as the one I've described should be undertaken, especially if policies to further contain the cost of the Medicare program are implemented.

The tools we developed in this project enabled us to reach another important conclusion. We found that there are wide variations in the quality of care delivered in U.S.

hospitals. A patient admitted with a heart attack to one of the hospitals rated in the top 25 percent of hospitals in terms of quality of care was much more likely to survive than was a patient admitted to one of the worst 25 percent of hospitals. After controlling for severity of illness at admission, we found that an additional six out of 100 patients admitted to a hospital in the bottom twenty-fifth percentile died. This increased mortality rate was due to a lower level of both physician and nursing quality as well as to a lack of available technology such as intensive care units. This research, when coupled with other studies, suggests that perhaps as many as one-quarter of hospital deaths for some common medical conditions, such as heart attack or pneumonia, could be prevented. [23]

The development of methods and tools for measuring and promoting quality of care has just begun to pay off. We are making new breakthroughs every day, and it is absolutely imperative that the federal government provide substantial new monies to the federal agencies supporting this research. I'm thinking in particular of the Agency for Health Care Policy and Research (AHCPR), which bears the primary responsibility for ensuring that quality of care is maintained throughout the American health care system. The research community needs 100 million dollars of new money a year to continue its research on the measurement of quality of care. I contend that the price is well worth the benefits we and our children will reap.

2) Monitor the Effects of Changes in Policy and Markets

The second role of the federal government, as partially illustrated by the above study, is to monitor continuously not only how changes in policy at both the state and national level, but also how developments in the health care marketplace, affect quality of care. In order to eliminate policies and programs that are harming people, or to improve upon policies that do work, we must know not only their effect on cost but also on quality, as assessed at a clinical level. The federal government is the only entity that can provide funding to answer many important questions. For example: Are market forces increasing or decreasing quality? Do African Americans receive lower quality of care than Caucasians? Is the likelihood of surviving a heart attack the same in rural America as it is in urban America? Are we implementing policies that are decreasing the level of quality, or increasing variations in quality, across regions of the country or across ethnic or racial groups? And finally, how do we stack up internationally? Is quality of care better in the United States or Switzerland? In what country would you have a greater likelihood of surviving a heart attack and why?[24] To answer these questions, the research community needs funding support in the amount of $50 million a year.

3) Develop an Information System

The third role for the federal government is to help stimulate in the private sector, or to develop in the public sector, an information system that will provide to the entire U.S. population information about how their choice of a health care plans, and perhaps even their choice of a hospital or doctor, affects the quality of care they receive. Provision of this information must involve the private sector through a private-public partnership. However, its success is critically dependent upon improving the science of measuring quality and making the measurement tools available in the public domain, as described above. The cost for such a system will be 5 to 10 dollars per person per year. Again, research has demonstrated the need for such an activity. Although not relevant to the Medicare population, work we have done with managed care organizations has shown that the quality of prenatal care varies remarkably depending upon which organization one goes to.[25] Similarly, the likelihood that a woman receives an unnecessary hysterectomy varies by the managed care plan she chooses.[26] Finally, research in New York and Pennsylvania has shown that the likelihood of surviving a coronary artery bypass surgery depends not only on the hospital where the surgery is done, but also on the physician one chooses and that higher cost does not guarantee higher quality. [27,28] If such information were available to help people choose in which plan they should enroll, reform based on market forces would consider both quality and cost, and hopefully the better organizations, not necessarily just

the cheaper ones, would survive as cost containment or reduction in the growth of the health care industry occurs.

4) Help Implement Behavioral Change

The final role for the federal government is to increase the fundamental scientific knowledge about how one helps organizations, physicians, or hospitals to change so that they can deliver better care and more cost-effective care. Research by sociologists, economists, clinicians, and psychologists is needed in this area to answer many important questions. For example: How can the productivity of a physician visit be measured? What behavioral techniques work best to produce cost-effective care? What incentives are effective in changing physician and nurse behavior ? Do different organizational structures result in different levels of quality? Answers to these questions will help the health industry produce a better product. An investment of a 100 million dollars a year is needed to improve science in this area. alone would not be too much.

Conclusion

The science of measuring quality of care has come a long way in the past quarter century. This scientific progress owes a lot to the Agency for Health Care Policy Research (AHCPR) and its predecessors. Health Care Financing Administration (HCFA) has sharpened the application of this science through its efforts to improve quality in Medicare and Medicaid, for example, through the PRO program.

It is feasible that within a few years, if our efforts in this area are expanded, the four goals of federal policy envisioned above could be achieved. However, to accomplish this the research community needs at least $250 million a year in new money to improve the science of quality measurement, to evaluate policy and program changes, and to make quality of care information available in the private marketplace. The natural home for these new monies should be the agency which has the mission to perform such tasks, namely the Agency for Health Care Policy and Research.

We *can* develop and implement policies to improve the efficiency and effectiveness and quality of our health care system. We must make a concerted effort to keep quality on the agenda and to make sure that quality and price receive equal consideration. In the absence of information on quality, it is cost that will drive decisions about changes in the health care system. If this is the sole engine by which we alter the health care environment, one thing is certain -- mediocre organizations, mediocre physicians, and mediocre hospitals will be the ones that survive, rather than the organizations, physicians, and hospitals that can make the American health care system the best in the world and the ones to which, when we become sick, we would like to go. We can measure quality of care, we can evaluate how federal and state policies affect quality, and we can help to ensure that the best organizations are the ones that survive in a competitive marketplace, as opposed to those that merely contain costs and restrict the level of technical quality they provide to a level that may harm patients. We can do better, and the government has a vital role in ensuring that we do so.

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Chairman THOMAS. Dr. Detmer.

STATEMENT OF DON E. DETMER, M.D., PROFESSOR OF SURGERY AND HEALTH POLICY, AND VICE PRESIDENT AND PROVOST FOR HEALTH SCIENCES, UNIVERSITY OF VIRGINIA

Dr. DETMER. Thank you. I am pleased to be here. Thank you for this opportunity. I also am a physician and maintain an active practice in peripheral vascular surgery. In addition, I chair the Board of Health Care Services at the Institute of Medicine. I also chaired the IOM Committee on Improving the Patient Record.

I particularly want to respond to your question about ways to best assure quality of care as well as provide to beneficiaries the information they need to make good health care decisions. What should the Federal Government do now to allow us ultimately to secure these ends? First and foremost, the government should make a comprehensive commitment to the computer-based patient record.

Today health care is undergoing a ground shift of seismic proportions. At its best, our health care system delivers professional quality of care. Our Nation is now making a rapid transition to managed care, integrated health care systems, and this change has many positive features, and the country clearly had to do something about our way of organizing and financing care.

It is also true that every American has a lot at stake in these changes, and there is a real potential for strip-mining our health care system. Political leadership will be required to assure that managed care is implemented on a level playingfield with respect to quality; that there be competition on value rather than price alone; and that there be valid public report cards on performance.

One cannot assure the value of anything without reliable and valued data. In looking forward in time, we will not have all the data we need without robust computer-based records and computer-based record systems. Professional quality care is measurable, but its measurement is subtle and complex, including patient satisfaction, cost, and the severity of illness being treated.

If professional care is to be assured in the future, it will spring from continued Federal support and enhanced support of health services research as administered through HCFA, the AHCPR, and a few other agencies. Continued funding of health services research and computer-based records by ACPR and HCFA will be critical.

Computer-based patient records will allow us to monitor care continuously, automatically issue appropriate reminders, provide access to clinical practice guidelines relevant to the case at hand, and take actions to assure better outcomes. With such an approach, our medical knowledge will become progressively more evidence-based and less opinion-based.

Person-specific relevant medical data on a right-to-know and need-to-know basis must be available across the Nation. If a Californian is visiting Monticello and soon thereafter arrives comatose at our emergency room at the University of Virginia Hospital, the outcome of care may well depend on our gaining prompt access to relevant information in her medical record. Similarly, a resident in Washington should be able to access the record of his

own vascular illness to assure its accuracy and participate intelligently in his care.

When the Federal Government commits fully to the CPR concept, we will have a law mandating a policy on confidentiality, privacy, and data accuracy.

Standards would be established for data elements, vocabulary, transport of patient data, and security to protect patient privacy and confidentiality as well as data integrity. Market forces alone will be inadequate to drive standards developments far enough and fast enough. Federal support would accelerate progress to the benefit of all, particularly the marketplace. The government would create discrete identifiers for each individual, health professional, and health institution.

These are key recommendations of the 1994 Institute of Medicine Report on Health Care Data Systems and has, again, surprisingly wide agreement.

Our Nation will have an information superhighway. We must assure that health information crucial to professional quality of care can ride on it. Without prompt action at the Federal level, our State laws and policies will be inconsistent and very tough to straighten out later.

But most importantly, why should some patients suffer unnecessarily when the information exists but we cannot get to it in times of legitimate need?

At times, personal, State, and national answers can only be researched through policies set at the Federal level. Many of us share a vision of comprehensive delivery systems which provide a continuum of high quality services in a cost-effective manner. However, integrated delivery systems without integrated information systems are a misnomer.

Unless and until we develop the medical data systems that provide timely, accurate, consistent, complete and successful data to meet legitimate needs, we will never achieve the level of clinical knowledge that is possible, we will never be cost effective in our care, we will never assure quality of care, nor will we achieve the level of health that the American people deserve.

Thank you for this opportunity to share my views. I will be happy to respond to questions as I can.

[The prepared statement and attachment follow:]

STATEMENT OF DON E. DETMER, M.D.
BEFORE THE SUBCOMMITTEE ON HEALTH

Committee on Ways and Means
U.S. House of Representatives

March 21, 1995
Chairman Thomas and other members of the Committee:

Thank you. My name is Don E. Detmer. I am University Professor ofSurgery and Health Policy, and Vice President and Provost for HealthSciences at the University of Virginia in Charlottesville. I maintain anactive practice of peripheral vascular surgery. In addition, I currentlychair the Board on Health Care Services of the Institute of Medicine. From 1989 to 1991 I chaired the IOM Committee on Improving the Patient Record .

Four years ago, I spoke to this subcommittee about the critical role of computer-based patient records (CPRs) in improving the quality and controlling the costs of health care. I am pleased to be here today to respond to Chairman Thomas' request to hear about "ways to best assure professional, quality care as well as provide to the beneficiaries the information they need to make good health care decisions." I will focus more on the former than on the latter but both are obviously important.

What should the federal government do now? First and foremost, the government should make a comprehensive commitment to the Computer-Based Patient Record. Parts of the government are heavily committed but others are not. The entire government needs to commit to the computer-based patient record by addressing the performance criteria presented in the 1991 IOM CPR Report. {1}

Today, health care is undergoing a ground shift of seismic proportions. The partial list of changes underway are identified on the last page of my testimony. At its best, the U.S. health care system delivers professional, quality care. Our nation is now making a rapid transition to managed care and this change has many positive features. The country clearly had to do something about our way of organizing and financing care.

It is also true that every American has a lot at stake in the outcome of this change, and it is in our collective interest to take all reasonable steps to assure professional, quality care in the future. The coming changes do hold a real potential for strip-mining American health care. The Institute of Medicine recently created a special initiative to keep an eye on what happens to quality in the months and years ahead. Political leadership will be required to assure that managed care is implemented on a level playing-field with respect to severity-of-illness adjustment, appropriate cost-containment, public report cards on performance, and quality through competition on value rather than price alone.

One cannot assure the value of anything without reliable and valid data, and we will not have such data without robust CPRs and CPR systems. Our nation's quality measurement efforts have been based over the years within the Health Care Financing Administration (first through the PSROs and, more recently, the PROs), NCHSR, and more recently, in the Agency for Health Care Policy and Research (AHCPR). These agencies have done yeoman's work developing the methods needed to track our progress and improve medical practice. Health services research is now coming of age and its potential to improve the cost-effectiveness and productivity of health care is beginning to be felt. Most recently, AHCPR has been funding very important work, particularly those projects which link quality measurement to medical informatics (the use of computers to address medical needs of various types).

Continued funding of health services research by HCFA and AHCPR is crucial, especially when one considers the size of the federal government's health care investment. One cannot assume that this work will be done by the private sector. Rather, as one looks forward to managed care, the private sector will more likely become less willing to share data which have substantial proprietary value.

My second observation is that professional, quality care is measurable, but its measurement is subtle and complex, involving a number of relevant dimensions including the process and outcomes of care, patient satisfaction, costs, and the severity of illness being treated. If professional care is to be assured in the future, it will spring from information derived from computer-based patient records and as a result of federal support of biomedical research through the National Institutes of Health and of health services research and development through AHCPR, HCFA, and other agencies.

Third, professional, quality care typically requires an initial investment in order to save money over the long term. For example, if you don't pay the costs needed to sterilize surgical instruments properly, you will pay more later to care for the postoperative infections. The same is true for immunizations and other preventive measures which avoid morbidity.

Fourth, only computer-based patient record systems will allow us to monitor care continuously, automatically issue appropriate reminders, provide rapid access to clinical practice guidelines relevant to the case at hand, and take actions to assure better outcomes. Person-specific relevant medical data on a right- and need-to-know basis must be able to cross the nation. Let me bring this closer to home. If a Californian visiting Monticello arrives comatose at our emergency room at the University of Virginia Hospital, her life may depend on our gaining prompt access to the information in her medical record. Less dramatic but nonetheless important, a resident of Bethesda seen in consultation in my vascular clinic should be able to access his own record to assure its accuracy and to participate intelligently in his care.

Recent studies have shown that when beneficiaries enter information about their own health into a computer-based patient record, the data are more complete and accurate. One recent study documented that, in 81percent of the cases in an outpatient clinic, physicians using current paper-based systems could not find all the patient information they desired during a patient's visit (Tang, Fafchamps, and Shortliffe). The results of missing information are delays in care, repeated diagnostic tests, added patient discomfort or work, and/or decisions made without the full range of needed data. Quality is compromised and costs go up.

It is fairly straightforward to describe how patient data should flow to enhance quality of care. We should be able to (1) capture data as a natural by-product of providing care or at least through one-time data entry by health care professionals; (2) store the data in a retrievable format; (3) transfer data among the various sites of care that serve patients; (4) aggregate the data and provide access to health services researchers for public health and policy purposes; and (5) bring up-to-date research results to the clinicians at the point of care. With such an approach our medical knowledge will become progressively more evidence-based and less opinion-based. I do not intend to imply that any of these steps are easily achieved. Although such an information flow makes eminent sense for health care, it will take a number of policy and technical steps to accomplish this vision.

When the federal government commits fully to the CPR concept, much more will happen in Washington and also across the country. We would see a law mandating a comprehensive preemptive federal policy on confidentiality, privacy, and data accuracy. It would be tough and would result in encryption efforts and substantial penalties for putting one's digital nose in the wrong place. This is a key recommendation of a 1994 IOM report on health data systems, and experts have a surprising degree of agreement on this issue. Such legislation deserves to be a very high priority.

Second, a variety of standards should be established to cover a set of patient data elements, for vocabulary to ensure consistent meaning of patient data, for messaging to allow transport of patient data within and among institutions, and for security to protect patient privacy and confidentiality as well as the integrity of the data. The government would create discrete identifiers for each individual, health professional, and health care institution. Whether the personal identifier is the Social Security Number plus an additional private personal identification number, or PIN,or a totally new number, I don't know. I do know we need discrete identifiers.

Although a lot of time and effort has been devoted to standards, much more remains to be

accomplished. In the U.S., standards development has relied largely on volunteers who fund their own efforts. It is not at all clear that market forces alone will be adequate to drive standards development far enough and fast enough. Federal support through funding, incentives, or even mandates would go a long way toward accelerating this process.

Our nation will have a information superhighway. We must assure that health information crucial to professional, quality care can ride on it. Some of these issues were addressed in several bills introduced during the 103rd session of Congress -- S1757/HR 3600 and S 1494/HR 3137. Without prompt action at the federal level we shall inherit a patchwork of state laws and policies which will be inconsistent and which will be a nightmare to straighten out later. Keep in mind that approximately half of the nation's people receive care across state lines. States have major roles to play in health care but data must be able to move and must be understandable from one state to another. Personal, state and national interests at times can only be served through policy set at the federal level.

Finally, partnerships with the private sector should increase, with the government paying costs at fair market prices to buy needed health care information from health care organizations, including insurers. Further, government should continue substantial investments in research and development as well as informatics education. The other needed standards would allow legitimate work to move forward with resultant improvements in personal health care.

As reliable, accurate data from the point of care are generated, secondary data sets drawn from this information can generate the intelligence needed to wisely inform individuals and the public in general with what they need to make personal choices. The Professional Review Organizations and other national public health agencies such as the AHCPR, the Center for Disease Control, and the Food and Drug Administration will then have the reliable and valid data they need to address their mandates. The results of these efforts will be reinfused into professional activity through the National Library of Medicine and other units of the National Institutes of Health.

And last and only if needed, federal cost-sharing with the private sector should be considered if it is needed to diffuse computer-based patient records across the country at the end of the decade. This might particularly be needed in more isolated parts of the nation if we are to bring professional, quality care by effectively using telemedicine.

Many of us share a vision of comprehensive integrated managed health care delivery systems which provide a continuum of high quality services in a cost-effective manner . Integrated delivery systems without integrated information systems are a misnomer. Unless and until we develop the medical data systems that provide timely, accurate, consistent, complete, and accessible data to health professionals and, the public as appropriate, we will never achieve the level of clinical knowledge that is possible, we will never be cost-effective in our care, we will never assure quality care, nor we will ever achieve the level of health that the American people deserve.

Thank you for giving me this opportunity to share my views with you. I will be pleased to respond to any questions or comments.

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FOOTNOTES**********

{1} According to the IOM committee, comprehensive CPRs and CPR systems should: (1) contain a problem list; (2) support systematic measurement of health status and functional level; (3) document the clinical rationale for patient care decisions; (4) link to other clinical records across settings and across time to provide a longitudinal record; (5) provide comprehensive confidentiality safeguards; (6) offer easy access to authorized users; (7) allow selective retrieval and formatting of information; (8) link to local and remote knowledge, literature, bibliographic, or administrative data bases and systems; (9) assist in the clinical problem solving process; (10) support structured data collection and store data using a defined vocabulary as well as support direct data entry by practitioners; (11) aid in the management and evaluation of quality and costs of care; and, (12) be flexible and expandable.

Basic Transformations in U.S. Health Care

Yesterday	Tomorrow
medical care	*health* care
acute, episodic care	longitudinal, chronic care
inpatient	outpatient
illness	illness/wellness
individuals	individuals and populations
"non-system" health care system	comprehensive, integrated health care system
fee-for-service	capitation
credentials; technology	price, then value
traditional authority	scientific evidence
paper-based	computer-based
MD dominance	multidisciplinary team approach
3° specialist	1°,2°,3° generalist/specialist
basic biomedical research	basic, applied, and health services research
white male leadership	diverse leadership
paternalistic behavior model	collaborative model of behavior

Don E. Detmer, M.D. (10.94)

Chairman THOMAS. Thank you very much, Dr. Detmer. I thank the entire panel. The gentlewoman from Connecticut, Mrs. Johnson, will inquire.

Mrs. JOHNSON. Thank you, Mr. Chairman. I thank the panel for your testimony. You have raised so many questions, it is hard in 5 minutes to know where to start.

First of all, I am absolutely fascinated by your optimism. As an optimist, that is a surprising statement. Two little questions. Does all of this research include VA hospitals as well as for-profit and nonprofit hospitals? And also, can you measure the impact of preventive actions as well as you can measure the impact of illness-related or incident-specific actions?

Anybody who wants to comment on those things.

Dr. BROOK. The answer to the question is that we can measure the effect of preventive care on both cost and health outcomes. We have just published a paper, which we will be happy to send you, on the diagnosis, management, and treatment of early breast cancer. We did various cost-benefit analyses related to mammography screening and we presented the results in a way that provides managed care organizations with information about strategies for managing women that have breast cancer.

Chairman THOMAS. We would very much like to have a copy of that.

[The information follows:]

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Benefits and Costs of Screening and Treatment for Early Breast Cancer

Development of a Basic Benefit Package

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Special Communication

Benefits and Costs of Screening and Treatment for Early Breast Cancer

Development of a Basic Benefit Package

Herman Kattlove, MD, MPH; Alessandro Liberati, MD; Emmett Keeler, PhD; Robert H. Brook, MD, ScD

Objective.—To develop a basic benefit package for detection and treatment of early breast cancer by evaluating the effectiveness and costs for screening mammography, primary surgery, adjuvant therapy, and follow-up care.

Data Sources.—Published articles were retrieved through MEDLINE; additional articles were obtained through searches of their bibliographies. Cancer statistics were taken from Surveillance, Epidemiology, and End Results (SEER) Program data, population statistics were taken from US Census data, and charges from 1993 Southern California Medicare fees were used to represent costs.

Study Selection.—Studies were selected on the basis of their design. Preference, in decreasing order, was given to meta-analyses of randomized trials, individual randomized clinical trials, prospective cohort studies, retrospective cohort studies, and case series.

Data Extraction.—Studies were examined for the effect of the intervention on overall survival, disease-free survival, and health-related quality of life. We evaluated effects on survival in terms of number of lives saved at 10 years and average years of life saved. Costs were related to the benefits observed and modeled onto a hypothetical health care organization of 500 000 lives.

Results.—Based on this analysis, we recommend a basic benefit plan for the detection and treatment of early breast cancer that would include the following: (1) screening mammography only for women aged 50 to 69 years; (2) choice of mastectomy or breast-conserving surgery with radiation therapy for all women with early breast cancer; (3) adjuvant therapy for all women at risk of recurrence; and (4) only clinical follow-up without routine testing for metastatic disease.

Conclusions.—By choosing which services they provide to specific groups of patients, providers can substantially reduce their expenses and still provide quality health benefits.

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ONE OF THE recurrent questions in the health care system reform debate is how to define the benefits that should be provided equally to all citizens. Developing such a basic benefit package is difficult. Evidence about health outcomes, patient preferences, and costs is required. Regrettably, it is easier to estimate the expense of medical care than to project the benefit. Assessing patient preferences is equally difficult.

See also p 149.

Bearing in mind all of these problems, we have used an explicit approach to estimate benefits of and expenses for services that are offered to women to detect and treat early breast cancer (found in the breast or axilla only). Breast cancer occurred in 182 000 women in the United States in 1993,[1] consumed more health care dollars ($6.5 billion in 1990) than any other cancer,[2] and has been well studied.

We discuss four main decision points in the diagnosis and treatment of early breast cancer: screening mammography, primary surgery, adjuvant therapy, and follow-up care. We have applied data on the expense and benefits of these four services to a hypothetical health care organization of 500 000 lives in which 360 new breast cancer cases would occur yearly.

METHODS AND ASSUMPTIONS

Literature Review and Assessment of Evidence

We searched MEDLINE for each of the four topics (screening mammography, surgery, adjuvant therapy, and follow-up care) from 1980 to 1993 and added references from other articles and reviews (Appendix Table 1; appendix tables are available from the National Auxiliary Publication Service [NAPS]). For each of these topics, based on a modification of the scheme of the Canadian Task Force on Periodic Health Examination (Appendix Table 2),[3] we developed summary judgments of the strength of the evidence concerning benefits. We assessed the published studies according to a hierarchy that weighted meta-analyses and randomized clinical trials over prospective cohort studies, retrospective cohort studies, and case-control studies or case series.

Costs and Benefits

The costs of services could not be easily defined. As a proxy, we used charges,

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Table 1.—Charges and Benefits of Screening Mammography*

Age, y	Deaths per 1000 Women		Potential Lives Saved per 1000 Screened at 10 y	No. to Screen to Save One Potential Life at 10 y	Charges to Save One Potential Life at 10 y, $†	Potential Extra Days of Life per Person Screened	Charges for Extra Year of Life, $†
	Control	Screened					
40-49‡	1.84	1.98 (1.60)	0 (0.24)	(4181)	(1 480 000)	0 (2.5)	(51 700)
50-59	3.94	2.49	1.45	690	183 000	11.7	8280
60-69	4.83	3.02	1.81	553	146 000	9.8	9880
70-74	5.35	5.35	0	...	...	1.8 §	35 900

*Data taken from Tabar et al, Table 6.[10]
†Charges for mammography and workup of positives (1.5%)=$88.50 ($77 for mammography and $11.50 extra for biopsies), based on "package" of four screens over 7 years for ages 40-49, three screens over 6 years for ages 50 to 69, and two screens over 3 years for ages 70 to 74.
‡Swedish overview[8] found mortality ratio of screened/control=0.87 (95% confidence interval, 0.63-1.2). Numbers in parentheses reflect sensitivity analysis if 0.87 is correct, and 1.84 per 1000 would die without screening.
§Survival of the screened group is better for the first several years, but at 10 years the survival curves of the screened and control groups meet.

namely, Transamerica Occidental Life Southern California 1993 Medicare rates. The benefits for various services are presented for every year (or fraction of a year) of extra lifespan or per life saved. Our use of "the cost of saving a life" is presented strictly for comparison purposes; we do not intend to place a monetary value on a human life.

The extra life span was calculated from the DEALE formula[4]:

$$\text{Gain}=(L/[1+d_t L])-(L/[1+d_c L])$$

where L is the life expectancy at the midpoint of the described interval; d_t, the hazard for treated patients; and d_c, the hazard for untreated patients. This formula was used where the hazards for both groups are known, as is the case for adjuvant therapy. For screening mammography, we estimated extra lives saved at 10 years and extra lifespan from survival curves for the 10 years following screening. Survival curves were derived by using the actuarial estimate given in Miller.[5] When hazards were not known, the extra life span was calculated from the following formula:

$$\text{Gain}=(SG\times NS)+(LS_{10}\times LE_{mp+10})$$

where SG is the sum of the survival gains per person in the 10 years following initial screening; NS, the number screened; LS_{10}, the lives saved at 10 years; and LE_{mp+10}, the life expectancy of average US women whose age is 10 years more than the midpoint of the age range screened. We also used the concept "number needed to treat" of Laupacis et al[6] to determine the cost of saving a life. For example, if a treatment saved one life for every 10 treated, then the cost to save one life would be the cost of treating 10 patients.

Screening Mammography

The only benefit we considered for screening mammography was survival; we did not consider health-related quality of life because such data were not systematically collected in the screening trials. Studies[7-16] of screening mammography found a 30% reduction in mortality for 50- to 69-year-old women who were screened, but no statistically significant benefit for those older than 70 years or younger than 50 years (Appendix Table 3).

To estimate the benefits of screening mammography and the costs of these benefits, we used data from Tabar et al[10] who presented mortality figures by year for women in each of the four age groups in two Swedish counties. Results from the two counties were not significantly different so the data were pooled in a survival analysis (Table 1). We estimated the charge for mammography at $88.50 per person screened. This includes both the charge per mammography ($77) and the charge ($11.50) for evaluating positive mammograms. Data from the United Kingdom study[17] on the specificity of screening was used to calculate this charge. Although the literature does not support a statistically significant benefit of screening on mortality for woman aged 40 to 49 years, we performed a sensitivity analysis based on the 13% nonsignificant survival benefit contained in the overview of the Swedish studies.[8]

Primary Surgery

None of the studies[18-32] demonstrated a survival advantage for a more extensive procedure (eg, mastectomy over breast-conserving surgery), although breast-conserving surgery was associated with a higher incidence of local recurrence (Appendix Table 4). This conclusion is not affected by the recent reanalysis of the National Surgical Adjuvant Breast and Bowel Project B-06 trial available from CancerNet through the Internet.[33] We reviewed four dimensions of postsurgical health-related quality of life[34-54] (fear of recurrence, psychological adjustment, body image, and sexuality) and found that, in most studies, patients undergoing breast-conserving surgery had a better body image than those undergoing the more extensive procedure. None of the other dimensions (particularly fear of recurrence) was affected by the type of surgery (Appendix Table 5).

Medicare allows $4166 (for the surgeon, anesthesiologist, and hospital) for the more extensive procedure and a total of $10 918 for breast-conserving therapy and radiation therapy ($3511 for breast-conserving surgery and $7407 for radiation therapy). Thus, the need for radiation therapy to prevent local recurrence increases the cost of breast-conserving surgery by $6752 over that of the more extensive procedure.

Adjuvant Therapy

We derived our conclusions about adjuvant therapy from the meta-analysis of the Early Breast Cancer Trialists' Collaborative Group,[55] which considered overall survival; insufficient data are available on the impact of this treatment on health-related quality of life. This meta-analysis concluded that adjuvant polychemotherapy for patients younger than 50 years reduced relative mortality by 25%; adjuvant polychemotherapy for those aged 50 years or more reduced relative mortality 12%, while tamoxifen for 2 years reduced relative mortality 20%; the two modalities combined reduced relative mortality 30% (Appendix Table 6).

To calculate expenses, we used the standard cyclophosphamide, methotrexate, and fluorouracil (CMF) regimen for chemotherapy. The charges for the nine treatments ($2523) include chemotherapy drugs, antiemetics, administration of these, supplies, blood cell counts, and physician visits. For women older than 50 years, we considered tamoxifen for 2 or 5 years or tamoxifen for 2 years with the addition of CMF polychemotherapy (Table 2). We did not add an extra charge for surveillance for endometrial cancer because that surveillance would be part of routine follow-up for all women who have a uterus.

Follow-up

To assess the effectiveness of routine follow-up testing for women with early disease, we used the recently completed Italian randomized clinical trials that compared intensive with routine surveillance[56,57] and other, less rigorous studies.[58-61] These studies have indicated that most recurrences, when detected, were symptomatic, and that routine follow-up testing did not improve survival

Table 2.—Charges and Benefits of Adjuvant Therapy for Women With Early Breast Cancer at Different Risks of Dying

Therapy	Compared With	Predicted Risk of Dying at 10 y, %*		
		20	40	60
	Women Younger Than 50 y			
CMF†				
Lives saved at 10 y/100 women treated	No treatment	5‡	10	15
No. to treat to save one life at 10 y		20	10	6.67
Charge to save one life at 10 y, $		50 460	25 230	16 828
	Women Aged 50 y or More			
Tamoxifen for 2 y				
Lives saved at 10 y/100 women treated	No treatment	4‡	8	12
No. to treat to save one life		25	12.5	8.33
Charge to save one life, $		50 000	25 000	16 667
Tamoxifen for 5 y§				
Additional lives saved at 10 y/100 women treated	Tamoxifen for 2 y	1	2	3
Additional No. to treat to save one life		100	50	33.3
Additional charge to save one life, $		300 000	150 000	100 000
CMF and tamoxifen				
Additional lives saved at 10 y/100 women treated	Tamoxifen for 2 y	2	4	6
Additional No. to treat to save one life at 10 y		50	25	16.67
Additional charge to save one life, $		126 150	63 075	42 058

*Node-negative risks range from 10% to 40%; node-positive risks range from 30% to 60%.
†Cost for nine treatments, including drugs (cyclophosphamide, methotrexate, and fluorouracil [CMF]), antiemetics, supplies, blood counts, and office visits is $2523.
‡Average life prolongation for 45-year-old, 1.4 y ($1802/y of life); for 55-year-old, 1.08 y ($1852/y); for 65-year-old, 0.79 y ($2877/y); and for 75-year-old, 0.55 y ($3636/y).
§Assumed 5% increase in benefit over tamoxifen for 2 y.

Table 3.—Charges and Benefits of Screening Mammography in a Hypothetical Health Care Organization of 500 000*

Age, y	No. of Women† (Package, Screens/y)	Annual Charges for Screen Package, $1000	Annual Benefit, No. of Lives Saved ‡	Charges per Life Saved at 10 y for Package of Screens, $	Annual Charge if Mammography Performed, $1000	
					Annually	Biennially
40-49	33 017 (4/7)	1670	0 (1.1)	(1480 000)	2922	1461
50-59	22 607 (3/6)	1000	5.5	182 000	2001	1000
60-69	22 128 (3/6)	979	6.7	146 000	1958	979
70-74	9323 (2/3)	550	0		825	413
75-79	7513 (2/3)	443	No data	Not evaluable	665	332
80-84	5202 (2/3)	307	No data	Not evaluable	460	230
Total	**99 790**	**4949**	**12.2 (13)**	**406 000 (381 000)**	**8831**	**4415**

*Represents a cross-section of US population.
†Proportion in age group, 1991 US Census estimate.
‡Numbers in parentheses reflect sensitivity analysis if mammography reduced mortality 13%.[7]

nor did it seem to influence health-related quality of life (Appendix Table 7).

Routine surveillance, which includes office visits ($35) four times per year and screening mammography yearly, would incur charges of around $228 per year. Charges for a more intensive approach that would add an annual bone scan ($263), liver echogram ($94), chest radiograph ($38), and routine blood tests ($17) would be at least $640 per year. We have not included additional charges for evaluating false-positive results because recent data to estimate them are not available.

Model Health Care Organization

Benefits and charges for detecting and treating early breast cancer in a hypothetical health care organization with an enrolled population of 500 000 are presented. In this population, which represents a cross section of the US population, 360 new cases of breast cancer would be expected each year. Of these, approximately 83.5% or 300 would be stage I or II infiltrating carcinoma.[82]

RESULTS

Decision 1—Who Should Be Screened?

If we use the concept of a package of several screens as detailed by Tabar et al,[10] we estimate it would cost the health plan $11.9 million over 6 years to screen 50- to 69-year-old women (three screens each over 6 years); this screening would save 73 lives at 10 years (Table 3). Screening all women between ages 40 to 49 years (four screens over 7 years) would add an additional expense of $11.7 million over 7 years. The literature indicates that in this younger group, no lives would be saved; however, our sensitivity analysis, based on the Swedish overview[8] finding of a nonsignificant 13% reduction in mortality, indicates that eight additional lives might be saved over 7 years. Screening women aged between 70 and 74 years might add 1.8 days of life to each woman screened at an extra cost of $1.6 million over 3 years, but does not increase their survival at 10 years. No benefit data exist for women older than 74 years, but the rapid drop-off in benefit after 70 years of age suggests this group would benefit little from screening mammography.

Unfortunately, we cannot accurately apply the benefits found by the mammography screening trials to the present practice of continued annual or biennial screening because the trials were limited to a few years. However, we can conservatively estimate that continued biennial screening would provide no greater benefit for the equivalent number of screens than the benefit provided by the studies. The annual cost of repeated screening in the health care organization would be $8.8 million to screen all women older than 40 years annually and $4.4 million to screen them biennially. This cost would be reduced to $2

Table 4.—Charges and Benefits of Adjuvant Therapy of Early Breast Cancer in Women Younger Than 50 Years in a Hypothetical Health Care Organization of 500 000*

	Node-Negative Women (n=50)	Node-Positive Women (n=25)
Expected 10-y mortality, % (No. of deaths)	10-40 (5-20)	30-60 (7.5-15)
Treatment†	CMF	CMF
Benefit, %‡	25	25
Lives saved at 10 y, No. (mean§)	1-4 (2.5)	2-3.5 (2.75)
Charges to treat all patients, $	126 150	63 075
Charge to save one life at 10 y, $	50 000	23 000

*Of the 300 patients with local or regional disease (see Table 3), 25% (or 75) will be younger than 50 years of age (American Cancer Society National Cancer Database). Data from the Surveillance, Epidemiology, and End-Results (SEER) Program of the National Cancer Institute[85] show twice as many of these women will have local (node-negative) vs regional (node-positive) breast cancer.

†CMF indicates cyclophosphamide, methotrexate, and fluorouracil.

‡Proportional reduction in mortality.

§Mean of lives saved, calculated to estimate charge to save one life at 10 y.

million by screening women aged 50 to 69 years (the group that benefits most) biennially (the frequency in most of the studies).

Decision 2—What Kind of Primary Surgery?

The more extensive procedure and breast-conserving surgery followed by radiation therapy provide equal survival, but breast-conserving surgery would cost the health plan an additional $2.03 million because of the radiation therapy ($300 people at $6752 per person; this extra cost assumes that reconstruction therapy is not part of the basic benefit plan). No increased mortality has been found with breast-conserving surgery without radiation therapy, but the health care organization could not consider withholding radiation therapy until studies have been performed on the effect of the increased local recurrence on health-related quality of life.

This latter point applies to women of all ages. In the several studies that have tried to treat women older than 70 years with tamoxifen alone, local progression mandated surgery in a large proportion of these women (Appendix Table 4). Two editorials have criticized this practice[83,84] and argued that elderly women should be treated the same as their younger counterparts.

Decision 3—Who Gets What Type of Adjuvant Therapy?

For most women younger than 50 years, polychemotherapy is the standard treatment because it reduces mortality by 25% (Table 4). Its benefit is greatest in those with the greatest risk of dying (patients with positive lymph nodes). Although there are data to determine the approximate number of women with local (node-negative) vs regional (node-positive) breast cancer,[85] data to determine which node-negative women, who generally have a lower risk of dying from breast cancer, will benefit from therapy are not available.[86] The health care plan's cost of treating all women younger than 50 years with node-negative breast cancer is $126 150; the cost for treating all node-positive women younger than 50 years is $63 075.

For women aged 50 years or more, treatment options are more complex (Table 5). The meta-analysis of adjuvant therapy showed benefit both for CMF polychemotherapy and for tamoxifen and consistently indicated that more is better. Five years of tamoxifen appeared slightly better than 2 years, and adding CMF polychemotherapy to tamoxifen further reduced mortality. For the 75 node-positive women, this translated into costs ranging from $150 000 for the simplest therapy to $564 000 for the most extensive. Because there are twice as many node-negative patients, these charges are doubled for these women. An added cost in tamoxifen-treated patients would be that of treating any endometrial cancers that would arise at a rate of 1.7 per 1000 treated patients. On the other hand, tamoxifen therapy in the United States will become cheaper once its patent expires.

Decision 4—How to Follow-up Patients After Treatment? (Appendix Table 8)

Routine follow-up testing incurs significant excess costs for the health care plan over clinical follow-up ($961 000 vs $343 000 over 5 years) and provides no benefit in survival or health-related quality of life.

Summary Decision Table and Basic Benefit Plan

Table 6 summarizes the possible options for treating breast cancer in this hypothetical health care organization. The basic plan for early breast cancer would include the following: (1) screening mammography only for women aged 50 to 69 years, (2) choice of surgery with radiation therapy provided for those undergoing breast-conserving surgery, (3) adjuvant therapy for all women at risk of recurrence, and (4) clinical follow-up without routine testing for metastatic disease. This would provide near maximum benefits for women to detect and treat this disease.

COMMENT

In this article, we have used cost-benefit analyses to design a basic benefit package to detect and treat early breast cancer for a health plan of 500 000 persons. One limitation was our inability to measure costs, but we feel that Medicare charges are a reasonable approximation. We have been able to express these charges in terms of their health impact and have benefited by the high quality of clinical breast cancer studies.

Screening Mammography

Screening mammography has been shown to reduce mortality from breast cancer. Unfortunately, this benefit is expensive. This is particularly true for women younger or older than 50 to 69 years. Women older than 69 years do not benefit much because of competing causes of death. The question of whether women aged 40 to 49 years benefit from mammography is controversial. The Canadian study,[14] which has been highly criticized,[87] is the only study that specifically evaluated this age group and it found no benefit. The Swedish overview,[4] which excluded the Canadian study, found a small but not statistically significant benefit for screened women. Our sensitivity analysis determined that obtaining this possible benefit is expensive. Furthermore, the meta-analysis by Elwood et al,[7] which included the Canadian study, found no benefit for women aged 40 to 49 years, and the validity of the Canadian study has been vigorously defended by Baines.[84] The recent international workshop[89] upheld this viewpoint as did the most recent update from Nijmegen, the Netherlands[90] which also failed to demonstrate a benefit for younger women.

Therefore, if a plan were to adopt a cost-effective package, it would restrict mammography to biennial screens for women aged 50 to 69 years. This would save a health care organization of 500 000 approximately $2.4 million compared with screening this group annually and up to $6.8 million compared with screening other age groups. The national saving could be $1 to $3 billion, depending on compliance, for the same restrictions. If a plan adopted this strategy with regard to women aged 40 to 49 years, it would have the support of the National Cancer Institute, which has changed its screening recommendations and now recommends screening only women older than 50 years,[91] but not of the American Cancer Society, which still recom-

Table 5.—Charges and Benefits of Adjuvant Therapy for Women Older Than 50 Years With Early Breast Cancer in a Hypothetical Health Care Organization of 500 000*

	Treatment for Node-Negative Women (n=150)†				Treatment for Node-Positive Women (n=75)‡			
	Tamoxifen for 2 y		Tamoxifen for 5 y		Tamoxifen for 2 y		Tamoxifen for 5 y	
	And No CMF vs No Treatment	And CMF vs No CMF	And No CMF vs Tamoxifen for 2 y	And CMF vs No CMF	And No CMF vs No Treatment	And CMF vs No CMF	And No CMF vs Tamoxifen for 2 y	And CMF vs No CMF
Additional benefit, %§	20	10	5	10	20	10	5	10
Additional lives saved at 10 y, No. (mean)	3-12 (7.5)	1.5-6 (3.75)	1-3 (2)	1.5-6 (3.75)	4-9 (6.8)	2-5 (3.4)	1-3 (1.7)	2-5 (3.4)
Additional charges to treat all patients, $	300 000	378 450	450 000	378 450	150 000	189 225	225 000	189 225
Additional charge per life saved at 10 y, $	40 000	101 000	225 000	101 000	22 000	56 000	132 000	56 000

*Of the 300 patients with local or regional disease, 225 will be age 50 y or older and two thirds of those will be node-negative. Tamoxifen charges are at $1000/y. CMF indicates cyclophosphamide, methotrexate, and fluorouracil, and charges are at $2523.
†Expected 10-y mortality, 10% to 40% (15 to 60 deaths)
‡Expected 10-y mortality, 30% to 60% (22 to 45 deaths)
§Proportional reduction in mortality.

Table 6.—Summary of Charges and Benefits for Screening for and Treatment of Early Breast Cancer in a Hypothetical Health Care Organization of 500 000

Procedure	Annual Benefit, No. of Lives Saved (Mean)*	Annual Charge, $1000	Annual Charge per Life Saved at 10 y, $
Mammography screen			
50-69 y	11.9	3959/1979†	166 302+‡
40-49 y	0 [1.1]§	2922/1461†	[1 480 000]‡§
70-74 y	0	825/413†	...
Primary treatment			
Breast-conserving surgery and radiation therapy	Better body image	3284	Not applicable
More extensive procedure	Radiation therapy not needed	1250	Not applicable
Adjuvant therapy for women aged <50 y			
Node-positive, CMF‖ treatment	2-3.5 (2.75)	63	23 000
Node-negative, CMF treatment	1-4 (2.5)	126	50 000
Adjuvant therapy for women aged ≥50 y			
Node-positive			
Tamoxifen for 2 y	4-9 (6.8)	150	22 000
Tamoxifen for 2 y and CMF	2-5 (3.4)	189¶	56 000¶
Tamoxifen for 5 y	1-3 (1.7)	225#	132 000#
Tamoxifen for 5 y and CMF	2-5 (3.4)	189¶	56 000¶
Node-negative			
Tamoxifen for 2 y	3-12 (7.5)	300	40 000
Tamoxifen for 2 y and CMF	1.5-6 (3.75)	378¶	101 000¶
Tamoxifen for 5 y	1-3 (2)	450#	225 000#
Tamoxifen for 5 y and CMF	1.5-6 (3.75)	378¶	101 000¶
Follow-up over 5 y			
Clinical		69	Not applicable
Clinical and routine testing	None found vs clinical	192	Not applicable

*Variation due to differing mortality risks.
†Annual/biennial screening.
‡Based on charges for package divided by number of years needed to provide package.
§Numbers in brackets indicate sensitivity analysis of nonstatistically significant mortality reduction of 13%.[7]
‖CMF indicates cyclophosphamide, methotrexate, and fluorouracil polychemotherapy.
¶Additional charges compared with the procedure in the previous row and charges for lives saved are marginal charges compared with previous procedure (see Table 5).
#Additional charges compared with tamoxifen for 2 y. Charges for lives saved are marginal charges compared with tamoxifen for 2 y.

mends screening for all women older than 40 years.[32]

Primary Surgery

The type of surgery does not affect survival. Breast-conserving surgery is as effective as more extensive surgery. What is important is the ability to prevent local recurrence and satisfy the patient. While more extensive surgery will provide the lowest local recurrence rate and be the choice of some women, we have seen from the studies of health-related quality of life that others will suffer from loss of body image. Although it has been thought that the loss of body image with extensive surgery is compensated by a reduced fear of recurrence, our review of the studies in the literature reveals this presumption to be wrong.

Preventing the loss of body image costs more because breast-conserving surgery requires the addition of radiation therapy to prevent local recurrence. This would add an extra $2 million to our hypothetical health care organization's expenses annually and cost about $1 billion more nationally. However, it would be inappropriate to eliminate radiation therapy unless there were data on the effect of the certain increase in local recurrence on health-related quality of life. This is an area that needs further clinical research to identify which patients are at risk of recurrence and thus in need of radiation therapy.

Adjuvant Therapy

Adjuvant therapy benefits everyone who receives it. This benefit is directly proportional to the patient's risk of recurrence. Even treatment of low-risk patients benefits them, but this is relatively expensive in terms of the charges for saving or prolonging a life compared with treating high-risk patients. But the benefit-to-cost ratio of adjuvant therapy is greater than that for screening mammography. Likewise, the benefit of adding CMF polychemotherapy to tamoxifen in women older than 50 years adds expense, but again this expenditure achieves more value than screening mammography in this age group. The total expense for our hypothetical health care organization for treating all patients with the most aggressive adjuvant therapy would lead to charges of more than $2 million. Treating only node-positive patients with the least aggressive adjuvant therapy would incur charges of around $200 000.

Follow-up

Routine follow-up testing after primary treatment for early breast cancer

provides no known benefit in terms of survival or quality of life. Thus, our health plan should offer no more than clinical examinations, without testing, at intervals of 3 months to 1 year. Whether even this is required has not been evaluated, nor is it known whether specialists are needed for this follow-up.

Limitations

Our mammography analysis cannot measure the benefits of long-term mammography because all the studies were restricted to a few years. We also were unable to evaluate, with the exception of surgical treatment, the psychosocial outcomes of other therapeutic decisions. Even the toxicities and impairment of health-related quality of life during adjuvant therapy have not been well studied. For example, for women older than 50 years, CMF polychemotherapy added to 2 years of tamoxifen is more effective than 3 extra years of tamoxifen, yet one would need more information on the added toxicity of CMF polychemotherapy in this age group before recommending it routinely. Research is needed here to help physicians and patients make better decisions.

Our study also suffers because we cannot measure the true costs of treatment, both to the patient as well as to the health care organization. We have used Medicare charges in Southern California, which are useful for the purposes of internal comparison but are not necessarily generalizable to the rest of the United States or the world. Furthermore, we have not been able to estimate the patient cost in terms of toxicity from chemotherapy and time lost from work or from participating in one's major activity.

Finally, we also falter when it comes to measuring the benefit of treatment. Neither the concept of a life saved at 10 years nor the average prolongation of life can describe what truly occurs with treatment. The inexorable downward slope of the survival curves published in the adjuvant trials show that a life saved at 10 years may be lost at the 11th year. Likewise, the concept of average life prolongation does not take into account winners and losers in the fight against breast cancer. Furthermore, its estimation is subject to major variation in published reports.

Conclusion

We have discussed various decision points in the management of early breast cancer to illustrate a pragmatic approach to the initial definition of a basic benefit package. The advantage of the evidence-only approach is that it allows readers to judge the merits of our argument much more readily than they can judge the pronouncements of panels of experts or consensus conferences. This ability to evaluate our arguments becomes important because we have directed our study not only at individual physicians but at health care organizations who may be providing a benefit package for a large number of subscribers.

With the information we have presented, a health care provider can make choices. For example, providing aggressive adjuvant therapy, although less appealing, is a more cost-effective procedure than screening mammography. It is unclear whether any follow-up care other than routine primary care is needed after treatment of early breast cancer.

Finally, we would emphasize that this kind of analysis can be applied to many diseases and that this application may lead to the better choice of therapies for these diseases. We were fortunate in that breast cancer has been well studied with regard to outcomes such as survival and relatively well studied with regard to quality of life. Such is not the case with many other diseases. Perhaps analyses such as ours will encourage the performance of more and better clinical studies that will adequately measure these endpoints.

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RP-140 A Microcomputer Assessment System (MAS) for Administering Computer-Based Surveys: Preliminary Results from Administration to Clients to an Impaired-Driver Treatment Program. R. D. Hays, J. Gillogly, L. Hill, et al.

RP-147 Employment Effect of Mandated Health Benefits. J. A. Klerman.

RP-143 Changing Practice Patterns in the Management of Primary Breast Cancer: Consensus Development Program. J. Kosecoff, D. E. Kanouse, R. H. Brook.

RP-164 Insurance Coverage for Drug Abuse. J. A. Rogowski, D. E. Kanouse, R. H. Brook.

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Mrs. JOHNSON. What about the less specific prevention approaches? It is one thing for procedures in breast cancer and colon cancer and things like that. How about annual physicals and early physician visits or early nonphysician consultations? Some of the less specific approaches to prevention.

Ms. PALMER. In my view, when we are talking about proven health promotion strategies and health prevention strategies, that is, we have good scientific evidence that these strategies work to improve patients' health in the long run, to detect disease or prevent disease, the best approach actually is to ask patients themselves, that is, to use survey techniques, where we learn from the patients whether they were counseled, and whether they understood the counseling they received.

For instance, again, for smoking, about appropriate diet, about lifestyle, exercise, and about screening, they should receive. That is the most direct approach. Failing that, we can turn to data that come from medical records or from administrative data systems, and learn whether proven strategies for health promotion and disease prevention were being used by a managed care plan or a fee-for-service plan.

Mrs. JOHNSON. Have you been able to look at all at what the consequences are of integrated systems of care versus the self-referral system of the past? Have you been able to test and look at what is the impact on health and cost of a system that is capable of receiving early concerns, not necessarily a doctor's visit, and is able to manage concerns constructively through a more integrated system of care?

Dr. BROOK. I guess the bottom line to that question is that we have too little information that has compared fee-for-service systems with managed care. One challenge is that there are very different kinds of managed care organizations. We cannot compare a monolithic managed care concept versus a monolithic fee-for-service concept. There really needs to be more work done than what has been. Up to now what we have found—and a lot of our research has been done in the younger population—that on average, the quality of care delivered and the health status of the population is in the fee-for-service system compared to the managed care system is about the same. That is a very broad summary.

Now, we have very little information about the new forms of managed care that have sprung up over the last 10 years. Most of the information we have is about the group or staff models of managed care. They are the more traditional models and have been around for a longer period of time.

Dr. DETMER. I would say the pace with which change is occurring in the definition or redefinition of managed care is such that unless you have tools that can manage these things over time, you have got to be very cautious about generalized statements.

Mrs. JOHNSON. I thank you for your comments. I do think that as hard as it is right now to develop outcomes research and guidelines and all those things, this is the easy part, that because it is more procedure specific, it is more disease recovery specific, and that what we need to get to is systems impact information.

I thank you for your comments. My time has expired.

Chairman THOMAS. Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman.

I too have a lot of questions raised by this panel. Dr. Palmer, you mentioned the consumer type reports that allow consumers to make a better choice on their own. Granted when you are looking at large companies deciding what kind of health plan that they are going to choose, they may be able to have the experts to look through those consumer reports.

Do you really think that as complex as medicine is, it is not a question of looking at this like a safety record for an automobile that Consumer Reports may put out now, but with the complexities of medicine and choosing doctors, because there is a lot more bedside manner that goes into choosing doctors, if you are looking at how a consumer is going to make that choice, there are so many variables that go into that. Are these consumer reports going to be too complex so that people are not going to read them in the first place, because their is too much information?

Ms. PALMER. My guess is that consumer reports for health care will be like Consumer Reports for buying automobiles and expensive electronic goods and so on. There will be people who use them and people who are unable to use them.

I think that consumer reports in health care need to be a great deal more detailed than the kinds of report cards we have been seeing to date. That is, I could picture that if I have diabetes, I know that I have a risk for my family of breast cancer, I know that my husband is at risk for heart attack, when we go shopping for our health care plan, as we become Medicare beneficiaries, we would like to know how well do the plans take care of those conditions, and in addition, in relation to Congresswoman Johnson's concern, how well do they provide preventive care.

I think that there are many Medicare beneficiaries who would use that information and could benefit from it. But it is clearly not enough, as you point out. There are people who will not be able to understand or use that information—

Mr. ENSIGN. The reason I bring up the question is, there is a tiny percentage of the population that will use those reports, compared to the amount of money it is going to cost to compile those reports.

Dr. BROOK. The bottom line from economics and other fields is that, if only 10-percent of the population actually use them and made choices that were more rational, that would change the characteristics of the marketplace. We do not need 90-percent of the population to do that.

Mr. ENSIGN. I am not saying that we do, but will we even get 10-percent.

Dr. BROOK. I would love to be able to come back to you 5 years from now and answer that question for you with data instead of opinion.

Mr. ENSIGN. Dr. Brook, you tossed out $600 million for one figure and $10 per every American, about $2.6 billion. Where do you come up with those numbers?

Dr. BROOK. Basically we have looked at how much it costs to produce guidelines and standards. We have worked with managed care plans and businesses to develop a set of quality tools that would be used and continuously improved upon. Based on our experience, this is the range of money.

Mr. ENSIGN. Managed care does that now?

Dr. BROOK. No. For instance, in the guideline development area, someone asked, how do you pick a guideline? The classic way that doctors have put guidelines together is over lunch and tuna fish sandwiches, and basically you come up with a guideline at the end of it. Then you say, it is a guideline.

The way the agency and respectable public agencies are doing this is to put information together so that when I send it out to a doctor, it is based on science. That is a million dollar activity. I am sorry, but we have that much information and it takes that much time to do it. If you start doing it, that is the numbers you come up with.

Mr. ENSIGN. Did you get this through government estimates?

Dr. BROOK. No.

Mr. ENSIGN. These are private sector—

Dr. BROOK. Absolutely.

Mr. ENSIGN. When you are looking at government doing something for the same price that private sector is doing it, I haven't seen that.

Dr. BROOK. The government role so far in this field has been to give people like myself the money to do that, to give people that work in universities and not-for-profit organizations the funding to conduct research.

For the sake of argument, why give the money? Let's say that I am less efficient than a for-profit person. However, I put all my products out in the public domain, everything I do goes in the public domain; Let's say I am 25 percent less efficient than somebody in a for-profit firm. I do not believe that, but let's say I am. The bottom line is that everyone gets the benefit from what I do. As long as the people that are funded by these agencies actually put this material out for everybody to use—every managed care plan, every hospital, every doctor—and make it freely available, then I do not see how the for-profit center can produce, as economically, the standards and tools to measure quality or the kind of information we have talked about.

In terms of policy change, what is the incentive in the for-profit sector to actually produce and give you the kind of information and answers to the questions you asked us? Who is basically going to provide the answers to whether market reform is actually working? It is not in the interest of the industry to answer that question. It is in the interest of the Federal Government in a public role to answer that question. But, it does require funds to do so.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. At the very least, even if the information is not as efficient as a percentage dropoff, it is there for discussion. It is the center of discussion for criticism and praise, which creates an evolution onto another discussion.

Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. I also want to thank the panel, and especially Dr. Brook, for coming all the way from California and testifying here this morning.

I greatly appreciate your time and your in-depth knowledge of the issue. I have tried to review your written testimony as much and as quickly as I could. I probably would disagree with you on

most of your points, but I do want to throw it open for discussion and see if I can learn more on the issue.

The main question I have is, I have read through here and I see $250 million here and $2.5 billion here—where are we going to get this money from? Do you have any ideas for us from that point of view?

Dr. BROOK. Well, I am not in your chair, so, I cannot say where it should come from.

Mr. CHRISTENSEN. We have a real problem right now—

Dr. BROOK. Let me talk about the health system by itself. In my work on quality over the last 20 years, the marginal return in terms of health from investing the last dollar in the health system in this kind of work exceeds the marginal return in investing in actual service to a patient. We invest so little in our health system in dealing with these kinds of issues that there is more bang for the buck, so to speak, for investing in improving quality than there is in investing the last service we provide to people.

I am not here to tell you where to find the money, or to take it from Energy, or Defense, or somewhere else. The answer to your question is, you would get more in terms of health for the Medicare population by investing money in improving quality than in providing one more medical service to the population.

Mr. CHRISTENSEN. One of the things that we have been faced with on the Hill here is the fact that we are in a major budget crisis. Last week we fought tooth and nail to get a $17 billion cut. This week and next week we are going to be looking at $180 billion in various cuts to the growth of government.

I do not disagree with you that having the knowledge and the information before you is helpful. I guess I would be very questionable—I am one of those conservatives on the Hill that questions nearly everything government does and believes that maybe there is a better alternative and a better approach.

Do you believe that government could ensure quality by monitoring the hospitals and physicians on a case-by-case basis? Do you believe that the regulatory approach—

Dr. BROOK. Absolutely not. What I have tried to write in the paper, and I am sorry if it didn't come through, is that, I do believe in trying to make a competitive marketplace work, and that to function effectively every market needs to have information on quality and price. The role of the Federal Government is to actually stimulate the market to function well in terms of both quality and price.

That is what that investment would buy. If I was going to give you a number for regulating quality of care on a case-by-case basis, that number that I gave you would be many times higher.

I am not proposing a regulatory approach. I would just like the health care market to work well so that when you and I get older, maybe we will have a chance of going to doctors who produce better quality of care. That is, I feel there is a need to make the market fair. That is all I am asking, is for the Federal Government to make sure the market is fair i.e., that it competes in quality and price. Part of that is investment in science in this field.

Mr. CHRISTENSEN. What would be your opinion on how we could go about getting a sampling of some of this information through

the private sector? I realize what you are saying is that it is very tough for us to encourage the hospitals to work together and the various managed care organizations to give us this information on a voluntary basis so that we could assimilate some data without mandating that they do so.

There has got to be a way we can do this through the private sector. I know you have put a lot of time and effort into this. I would like to sit down and visit with you, because obviously you have a lot of knowledge in this area. I just don't know that the government approach is the best way to go about it.

Dr. BROOK. If I gave you the idea that institutions in the private sector will not cooperate, I didn't mean to say that. Managed care organizations and hospitals will help in this. One of your next speakers is Gail Warden and he has worked cooperatively with us in the past.

Once the tools are out there in the public domain, it may very well be that the for-profit secter is the best way of actually measuring and disseminating the information to the American public, and maybe the government doesn't need to play as great a role as it played in the past. The actual science, because of the whole marketplace problem, is probably a place where the government really needs to put a serious investment.

I am confident the private sector will come along if indeed the tools and the science were there to make it easy for them to come along.

Mr. CHRISTENSEN. Thank you, Dr. Brook.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Dr. Brook, you indicated in your opening comments you have been doing this for more than 20 years. My assumption is that things have begun to happen which allow you to do it better, more efficiently, better understanding.

Have we got some breakthroughs or has it been this slow accumulation and do we now have inertia moving us forward?

Dr. BROOK. There has not been a great deal of funding over the last 20 years, but there have been some breakthroughs. We can measure health. If I had to testify before you 20 years ago, I would not have had the foggiest idea what tools would be available to measure health. We have also done work to measure the appropriateness of care. I can come to you and tell you that a large part of Medicare dollars are wasted based on research; and I can tell you a large number of people do not get the care they need, based on tools developed by public funds provided to both HCFA and the AHCPR.

There have been major breakthroughs in the methods and the tools. It is now time to expand upon those, to develop practical, feasible tools and put them in place so that they can be used. It is time to go out of the R&D laboratory into an expanded science role so that these things can actually be used to help make the marketplace work better.

Chairman THOMAS. There is a local clothing retailer whose slogan is, "An educated consumer is our best customer." Dr. Detmer, your outline of what people need to know is, I think, something

that we can probably all agree upon, except the individual who is supposed to know it.

You have outlined a fairly heavy responsibility in terms of knowledge. It is a little bit like the American Association of Political Scientists who want to talk about the issues-oriented campaign versus the thing that really does motivate people to vote for a candidate, and they are always frustrated that people do not do that.

We have an ignorant consumer today in large part based upon the structures. Your model is obviously one we would like to strive for, but going back to the Consumer Reports example, they take quality and cost and wind up with a check rated best buy product. I think we are probably going to have to shoot for some structure, which I said to the earlier panel, that has either some legitimacy or respect, that does a lot of that internal evaluating along all those criteria, that we have to have, but comes out the other end with a recommended buy, a ranking, minimum approval structures.

I guess my question is, isn't this probably inevitably, unfortunately, a public agency rather than private? I tried to put as many adjectives as I could. Can you conceive of a private structure that could attain that kind of prestige for rating purposes?

Dr. DETMER. I guess where I come from, and I think Dr. Brook and I roughly feel the same on this, we need a scientific framework so that at least report cards have validity and are based on reliable information. Given that, I think the private sector can in fact score itself, but you probably do need to have somebody riding herd on that, although it is not as though we live in a society that does not look over each other's shoulder.

There clearly has to be a public role, without a doubt, to set some of the standards, and I think even the private sector is asking for that. But beyond that, I would have to really candidly say to you, I think we are still a little early in this. We have made a lot of progress in the measurement tools of the care itself in this business of how to transmit information to buyers in a way that can really help them make their decisions.

Some information needs may be specific to one's particular problem. If you need your hip replaced, you want a specific hip replacement data and not necessarily generic information. I do want to loop back to a comment, though, to Mr. Ensign. I think his question relates to the fact that if we do have public report cards, let's not forget that we are talking about a competitive marketplace where people, systems compete against one another. The systems also read those report cards a lot.

It is not as though the only check and balance in this is the user, the consumer, the beneficiary seeking it. The people out there in the market trying to deliver value pay a lot of attention to that themselves because they know they are also in competition with one another. Sometimes that can get lost sight of.

Chairman THOMAS. My concern is we move away from focusing on what we should not be doing to what we should be doing. We have a tendency with government agencies to make choices for people because you can make a better choice than they can. Cars were mentioned earlier, that people choose cars by color. That, to me, is an unbelievable method of choice, but a lot of people do that.

If you have that public agency, my fear is that you are going to get an unfortunate standardization, a lag time for making positive changes, because right now we are being saved in the health care sector by the private sector changing as rapidly as only the private sector can change and to the degree you do lock it into the government.

Now, my concern is, how do we, as we move forward—and you indicate perhaps the time line for getting these measurement tools is not as soon as we had hoped. To me, five, seven years is very disappointing, not coming up with something—

Dr. DETMER. I think there will be things coming sooner than that. I do not want to give the sense that we are not working on this and that it will not continue to evolve.

Chairman THOMAS. Easy things will come first and then the harder things.

Dr. DETMER. I do not think the government should be the only one prescribing these things. I do think it needs to set some compass points. We need to know when we say "government" what that means. We need to know where "south" is and "east" and "west". Unless we set those degree of standards, so we know what is A compared to B, do you really know that the report card is anything other than something in the wind?

Chairman THOMAS. I understand compass points. I understand relative relationships, "good" versus "better." I understand "best" less. What inevitably is going to happen is that people will use this and it will be converted into marketing tools. People will take these various standards and advertise, perhaps not using the ones that someone else on an objective hierarchal ranking would place as the most important, and that is part of my fear, of getting in and indicating that this particular choice is more important than another.

Going back once again to products in the marketplace, I know everybody who would look at it and test in all the magazines said the beta system was a far better way for video recording. VHS blew them out of the market, in part on pure price and availability.

It is not always the quality aspect. My concern is that you are going to slow down the process of change if we get into a government structure of picking what is, quote, unquote, best.

Dr. BROOK. Having come from southern California and having just studied most of the companies that provide managed care to about 4 million Californians now in individual group practices through all these new models, the innovation that has occurred in managed care is how to manage the price of care.

We have gatekeepers now. I, as a professor of medicine at UCLA, cannot refer my for-profit patients to a dermatologist without a Committee of my own doctors approving it. We have struggled very hard to make sure that costs can be contained. There has been much less innovation on the quality side.

Even though we are concerned that we may have iatrogenic and bad side effects from measuring quality, I am fearful that if we do not try to keep this market fair in both quality and price, the price is going to drive the issue.

Even though there are lots of good doctors and hospitals and managed care companies, if the lowest price drives the marketplace

and you cannot distinguish a better product from a worse product, we are going to be in a lot of trouble in the marketplace.

The Federal role has got to be to put the science out there and allow the marketplace to compete both on quality and price equally.

Chairman THOMAS. If there is a yardstick, people can compare if they have a desire to compare.

Dr. Palmer?

Ms. PALMER. Mr. Chairman, for all the reasons you have described, I don't think that consumer reports and consumer choice are sufficient means to protect the average citizen, including particularly the Medicare beneficiary, in terms of quality of care. That is why I believe that some kind of cooperative quality improvement program is needed, something that does the kind of brokering that the Federal Aviation Administration does on safety.

I think that is an essential component. There is too much that ordinary people will not be able to follow or have the interest to follow because they do not expect to get sick, just as one does not expect one's airplane to crash.

That is why some additional effort, which is brokered by a neutral party that is not in the market, namely some government structure, maybe is essential.

Chairman THOMAS. The only concern I would have is that one of the reasons everybody hangs together is that there are alternate forms of transportation, and that it is important to make sure that people feel comfortable about flying because they could take another route.

My concern is that we have only one route on health care, unlike the diversity structure.

Does the gentlewoman from Connecticut have another question?

Mrs. JOHNSON. Thank you, Mr. Chairman.

This is such an important area and so difficult to understand yet so important to our future that I just want to add a comment.

Dr. Detmer, in your testimony, you point to some things that I know from years ago, introducing legislation that would try to develop uniform data sets. I recognize a lot of what you are saying and trying to do, but at the same time you raise all the red flags.

You say, "Only computer-based patient record systems will allow us to monitor care continuously, automatically issue appropriate reminders, provide rapid access to clinical practice guidelines relevant to the case at hand, and take actions to assure better outcomes."

Now, to me, that is not our goal. I do not want a system where someone is monitoring care outside of that physician, on that moment-by-moment basis, and automatically issuing appropriate reminders that may be irrelevant to this specific patient. It may not show up in the data but it may show up in the communication between physician and patient, provide rapid access to clinical practice guidelines which are, by definition, average or general and not specific.

One of my fears in this area is that as we develop practice guidelines, we will come to believe in them, and as much as they are useful and as important as they are, they in the end are no

substitute for the judgment of the physician as to the care for a specific patient under specific circumstances.

I am interested, and I think Dr. Palmer to some extent has focused on this, what do we need now, what are the tools that we can best develop now serving consumer information as one of them, and what are the things we should be moving toward, which is the definition of certain common denominators or data that we want to develop in a uniform way to give us insight into both outcomes research in the sense of procedural specific or treatment specific information, quality information, and then systems specific information.

I think we have to be a little cautious about whether even if it is going to be desirable to develop automated patient records to the extent that you are recommending them, because one-time data entry by health care professionals, does that mean the doctor talks to someone who does the data entry, does that mean the doctor does the data entry? How do we get this accurately? How many miles can it go through and what kind of overhead are we going to put in there?

How much should be retrievable? How do we dump the right stuff into a national research effort on outcomes? And how do we not? If we dump information into a national research effort, how do we accommodate it with the fact that this hospital takes only very, very serious cases and, therefore, of course, has a higher complication rate?

I guess I am worried about the extent to which this panel wants to press us forward on the uniform systemic change matter. I am more interested in what are the three key things we should do right now to assure that as we move public programs into private sector alternatives, and States are doing this in Medicaid all the time now, there is a lot going on, what are the things we can do that will give us the best quality oversight of change.

Dr. DETMER. I probably would like to chat with you at another time, because I think actually you have highlighted almost every relevant downside. There are legitimate downside risks but there are also upside gains that I think could get a legitimate response. Obviously I will not do that at this point, but I would like to, because I think there are clear things to gain from them.

But to get to your specific question, I think that, as I mentioned, the bipartisan effort last year on the Health Information Modernization and Security Act is a needed piece of legislation, something quite like that. If I were to say one thing today, that would be where I would come down, because it is not as though we are not seeing these computer-based systems developing. I think that we do need to address that matter, because I am even more worried, candidly, about inheriting some of the downsides that you have spoken to in the absence of that kind of legislation than with it.

It doesn't quite get us immediately to more report card data, but it does secure some things we really need to attend to. I hope that is responsive.

Mrs. JOHNSON. That is helpful.

Dr. Palmer.

Ms. PALMER. If we have left you with the impression that there is nothing that can be done now, I think that is a big mistake.

Mrs. JOHNSON. You have not left me with that impression.

Ms. PALMER. I think there are some things that can happen that are happening immediately. Let me just mention one example. In the DEMPAQ project in which we studied care in three States for Medicare beneficiaries and fee-for-service office care, we were able to identify certain key aspects of diabetes care, including regular eye exams to detect early and prevent disease causing blindness, the use of tests which monitor much better control in diabetes. We know those things are not being received well enough by Medicare beneficiaries in fee-for-service care.

There is a similar measure in managed care plans. We know in some large managed care organizations that these things will also not be provided to Medicare beneficiaries. The answers to some of these problems lie, as you mentioned, in systems issues. The individual physician cannot turn around a system that makes it difficult to orchestrate the business of getting a proper eye exam done on a diabetic by a specialist and getting the patient back, or the monitoring of a diabetic over time.

Providing thrombolytic therapy promptly for a heart attack patient in the emergency room depends upon building a system of care which orchestrates how to do that. Just the physician making the decision isn't enough. We know these are areas in which already cooperative quality improvement programs are occurring in your own State of Connecticut. In the case of diabetes, you heard Dr. Vladeck testify earlier, that the measures of quality adapted from the DEMPAQ and HEDIS projects are soon going to be tested in managed care and already in fee-for-service care. The three PROs involved in the DEMPAQ study are beginning intervention campaigns, quality improvement programs in the three States, aimed at improving diabetes care.

We know how to start. We need to study how those efforts unfold, and what is the best way to do them. Over time, add in more disease modules, other conditions and preventive care, until we get a more complete program of how to maintain quality for Medicare beneficiaries.

Dr. BROOK. If I were to answer that question, I would come back to the statement, the world is changing extraordinarily rapidly out there in the private sector. Medicare is going to catch up. When that occurs, you want to make sure that that marketplace is functioning both on price and quality.

We can immediately begin both with improving the science and getting information out to everybody to make that happen, even if the first pass at it is not perfect. I am not worried that we are going to make mistakes in the information we release in the beginning. I believe 5 years from now it will be better than the information released next year. I believe we have to begin in a serious effort so the marketplace does not rely on price alone.

A lot of the people who are here after us are engaged in the private sector to produce great products or do great things. They need to have a marketplace out there to receive their goods. The role of the Federal Government has got to be to make sure that happens. That involves an investment in science, in getting information out.

That is where we have to start. If we are going to push to get places to have computerized medical systems or to want to do quality improvement, there has got to be external motivation to do it. People will buy better products and the better products will survive. The central role of the Federal Government must be to make information about quality available.

Chairman THOMAS. I want to thank this panel very much. Part of your problem in our anxiousness to find these tools to be able to utilize them is because, to a very great extent, we are dealing with art as well as science. The hierarchical culture of medicine in this country and the role of particular individuals within that culture have made it difficult in the past.

We are dealing with Medicare, which is kind of the last vestige of the old fee-for-service structure. We have got to convince people that they want to change. These kinds of measurements are critical for us in that process.

I want to thank the panel very much and look forward to the materials that you promised to send us.

Dr. DETMER. We are very grateful for your interest in this as well.

Chairman THOMAS. It is critical, and a tool that we need. We wanted to thank you once again for coming.

That was in part a transition to the next panel, which is Margaret E. O'Kane, president of the National Committee for Quality Assurance; Dennis S. O'Leary, president of the Joint Commission on Accreditation of Health Care Organizations; and David M. Bee, vice president of the American Medical Peer Review Association, to provide us with how rapidly the culture of medicine has changed.

We will start with Ms. O'Kane.

STATEMENT OF MARGARET E. O'KANE, PRESIDENT, NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Ms. O'KANE. Good morning, Mr. Chairman.

Chairman THOMAS. I would caution you, these microphones do not pick up. They need to be talked directly into so we can hear everything you have to say.

Thank you very much.

Ms. O'KANE. Thank you. My name is Margaret O'Kane. I am president of the National Committee for Quality Assurance. As this Subcommittee examines the private sector's efforts to reduce the costs for health care, we commend the Chairman for convening this hearing to explore the equally important subject of private sector quality improvement initiatives.

NCQA is an independent nonprofit organization which oversees two complementary approaches to health care evaluation; accreditation and performance measurements. NCQA accreditation examines a health plan's infrastructure while clinical and service performance is measured through NCQA's health plan employer data and information set, HEDIS 2.0 and 2.5, which I think you have heard a couple of the speakers refer to this morning.

NCQA is governed by a board of directors which includes large purchasers, health plan representatives, a consumer representative, a State legislator, a union representative, and AMA represent-

ative, and independent quality experts. By the end of this year, we will have accredited over half of the Nation's health maintenance organizations or HMOs.

This figure includes 80 health plans enrolling two-thirds of the Medicare beneficiaries in TEFRA risk contracts. Our accreditation standards are continuously evolving to reflect changes in health plan and market structure as well as purchaser and consumer concerns.

In our accreditation process, we look at six areas of plan performance; the quality management system of the health plan, the credentialing system for providers, the member rates and responsibility systems including complaints and grievances, member survey information and any other information that is provided to members, the utilization management system, preventive health services systems, and medical records systems.

Less than one-third of the health plans that we have reviewed against our standards have received full accreditation, and 12 percent have been denied accreditation.

Does that buzzer mean something?

Chairman THOMAS. It does, but ignore it, as we do.

Ms. O'KANE. The primary reason that so many health plans have undergone this rigorous process is the purchaser's interest in ensuring that their employees are only enrolled in quality organizations.

Large employers such as Xerox, GTE, Ameritech, IBM, Allied Signal, the States of New York and Ohio and many others have all required that the health plans with whom they contract seek NCQA accreditation. Last June, we began releasing the NCQA accreditation status list free of charge to any individual who phones or writes our offices.

In addition to this listing of all plans and their accreditation decisions, NCQA will begin providing summary reports of our accreditation reviews later this year so that purchasers and consumers will have even more information with which to evaluate health plans. In addition to accreditation, NCQA has developed a system for measuring health plan performance.

In 1993 we released the Health Plan Employer Data and Information Set 2.0, a set of 60 standardized measures of health plan performance in five areas. A recent survey by the Physician Payment Review Commission found that 84 percent of health plans were reviewing HEDIS to generate performance indicators or assess their ability to generate these measures in the future.

HEDIS covers five areas of health plans performance, quality, access and patient satisfaction, membership and utilization, finance, and health plan management and activities. This month NCQA released HEDIS 2.5, a comprehensive update of the specifications in 2.0 as part of our commitment to a continuously improving system of health plan performance measurement. Work on HEDIS 3.0 will begin later this year and we look forward to moving health plan performance to new levels.

While HEDIS was initially designed for commercial purchasers, it is important that health plans be held equally accountable for the quality of care that they deliver to all members regardless of who is paying for their services. With funding from the Packard

Foundation, NCQA is directing a project to create a set of comprehensive performance measures which address the unique issues of the Medicaid population. In the future we look forward to exploring how HEDIS might be enhanced for the Medicare population as well.

To better understand the challenges associated with producing, auditing and displaying health plan report card data, we conducted a year-long report card pilot project which just recently concluded. The project had 21 participating health plans covering over 9.6 million enrollees and used a subset of the HEDIS measures. This pilot project confirmed that external auditing is critical to any report card effort, particularly in light of the public's skepticism with provision of performance information.

We learned the degree to which health plan information systems vary, and we encourage investment to enhance clinical information systems within the overall managed-care industry to further quality measurement and data comparability goals. As a result of the project, we also look forward to developing new measures as part of the development for HEDIS 3.0.

Additional research is needed on the potential for developing and integrating risk adjustment into future report card efforts. While consumers are not generally accustomed to getting information on health plan quality, we are doing research which shows that they are excited by the potential of health plan report cards. With support from the Commonwealth Fund, NCQA has completed two parts of a three-part consumer information project to assess the consumer perspective on quality.

This includes an examination of what consumers want to know, what kinds of technical quality information they find compelling, how much information is enough, and how much is overwhelming and how the information should be presented. As a result of our research, we have found that consumers are not generally accustomed to getting information on quality of health plans. However, once introduced to the idea of report cards for health plans, consumers are very interested in the potential.

As you might imagine, consumers would prefer to see report cards that show clear differences among health plans. However, because the differences are sometimes subtle, we are researching consumer preferences on information format and presentation. When asked about issues specific to the health plan itself, most consumers identify physician choice as their first assessment of a health plan's quality.

We found that quality measures such as immunization rates and mammography do extend consumers' thinking about the role of their health plan. These quality measures give consumers a better understanding about what their health plan is responsible for providing.

While excited by these findings, we believe it is a mistake to define consumers' future information needs in terms of today. All health plans, regardless of their financing and delivery structure, should be held accountable for the quality of services and medical delivery. All health plans must be required to provide data on quality performance, or those more structured, that have invested in in-

formation and clinical management systems, could be put at a disadvantage in the marketplace.

Just as many States such as Pennsylvania, Florida and Kansas have coordinated their regulation of health plans with our accreditation program, so, too, could the Federal Government. NCQA will have accredited over half the Nation's HMOs by the end of this year, a figure which includes health plans responsible for 66 percent of the seniors that are currently in Medicare risk contracts. Because the plans assume the cost of the review, the Federal Government could receive a benefit at no additional cost.

While NCQA accreditation should not be a condition of participation in the Medicare Program, health plans which have achieved accreditation should not be subject to redundant HCFA certification processes. We recognize that reducing the rate of growth in the Medicare Program is a critical component of deficit reduction efforts and we believe there is real potential to reduce costs while improving quality through the use of managed care.

However, we urge the Subcommittee to build on the work of this hearing and ensure that efforts to reduce cost do not compromise quality in the process. Thank you for the opportunity to testify.

[The prepared statement follows:]

TESTIMONY OF MARGARET E. O'KANE
NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)

Good morning Mr. Chairman and members of the Subcommittee. I am Margaret E. O'Kane, President of the National Committee for Quality Assurance. We are pleased to have the opportunity to testify today before the Subcommittee on the important topic of private sector developments in quality measurement and improvement. As the Congress examines the private sector's efforts to reduce the rate of growth in health care costs, I commend the Chairman for convening this hearing to explore the equally important subject of private sector quality improvement initiatives.

The National Committee for Quality Assurance (NCQA) is an independent, non-profit organization which oversees two complementary approaches to health plan evaluation: accreditation and performance measurement. NCQA accreditation examines a health plan's infrastructure, while clinical and service performance is measured through NCQA's Health Plan Employer Data and Information Set (HEDIS 2.0 and 2.5). NCQA promotes improvements through the development and application of detailed standards for continuous quality improvement and measures of performance for health plans.

NCQA is governed by a Board of Directors which includes large purchasers (Federal Express, Xerox, CalPERS, and General Electric), health plan representatives, a consumer representative, a state legislator, a United Auto Workers representative, an American Medical Association representative, the NCQA President, and independent quality experts.

My testimony today will focus on four areas:

1. NCQA Accreditation
2. Measuring Health Plan Performance Through NCQA's HEDIS
3. Quality Information and Consumers
4. Future of Health Plan Quality Measurement and Improvement

NCQA Accreditation

By the end of this year, NCQA will have accredited over half of the nation's health maintenance organizations (HMOs). This figure includes eighty HMOs and CMPs enrolling two thirds of the Medicare beneficiaries in TEFRA risk contracts. Our Accreditation Standards are continuously evolving to reflect changes in health plan and market structure, as well as purchaser and consumer concerns. While a copy of the NCQA Standards was submitted to the Subcommittee, I will briefly summarize each of the six sections:

- *Quality Improvement:* What improvements in care and service can the Plan demonstrate? Does the plan full examine the quality of care given to its members? How well does the plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time?

- *Provider Credentials:* Does the Plan meet specific NCQA requirements for investigating the training and experience of all physicians in its network? Does the Plan keep track of all physicians' performance and use that information for their periodic evaluations? Does the Plan look for any history of malpractice or fraud? Has the Plan performed a quality assessment for health delivery organizations such as hospitals, home health agencies, nursing homes, and free-standing surgical centers?

- *Members' Rights and Responsibilities:* How clearly does the Plan inform members about how to access services, how to choose a physician or change physicians, and how to make a complaint? How responsive is the Plan to members' satisfaction ratings and complaints? Does the appeals process for grievances include a second review with different individuals?

- *Utilization Management:* Does the Plan use a reasonable and consistent process when deciding what health care services are appropriate for individuals needs? Are appropriateness criteria clearly documented and available to participating physicians? When the Plan denies payment for services, does it respond to member and physician appeals? Are physician consultants from the appropriate specialty areas of medicine and surgery utilized as needed?

- *Preventive Health Services:* Does the Plan encourage members to have preventive tests and immunizations? Does the Plan ensure that its physicians are encouraging and delivering preventive services?

- *Medical Records:* How consistently do medical records kept by the plan's physicians meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients' abnormal test findings?

A typical survey team for a 50,000 member HMO consists of three physicians and an administrative reviewer who spend three to four days at the health plan. For larger health plans, the number of physicians and length of time spent on-site is increased accordingly. Following an internal review by NCQA staff, the reports generated by the survey teams are forwarded to the all-physician Review Oversight Committee for a final decision.

The driving force behind NCQA Accreditation, and the primary reason that over half the nation's HMOs will be accredited by years' end, is the purchasers' interest in ensuring that their employees are only enrolled in a quality organization. Large employers such as Xerox, GTE, Bell Helicopter, Ameritech, IBM, Allied Signal, the States of New York and Ohio, Bristol Myers, General Electric, and many others have all required that the health plans with whom they contract seek NCQA accreditation. While large employers have accreditation mandates, accreditation results are in the public domain and thus shared amongst all employers and consumers.

In addition to purchasers, many states have coordinated their regulation of health plans with NCQA accreditation. Vermont has recently joined Pennsylvania, Florida, Kansas, and Oklahoma in either requiring that health plans undergo an external review by an independent organization or allowing accreditation to substitute for state reviews. Washington State has proposed similar regulations, and discussions are underway in many other states. We believe the federal government could similarly benefit by reducing duplicative oversight activities for those organizations that have achieved accreditation. While NCQA Accreditation should not be a condition of contracting for HMOs and CMPs, those plans which have achieved accreditation should not be subjected to redundant HCFA certification processes.

Last June, we began releasing a list of the accreditation status of every health plan reviewed by NCQA, as well as those scheduled for review. Updated monthly, the NCQA Accreditation Status List is available free of charge to any individual who phones or writes our offices. Since first releasing the list, NCQA has mailed out more than 2,500 copies to individuals and organizations across the country. Beginning this July, NCQA will provide summary reports of accreditation reviews, so that purchasers and consumers will have even more information with which to evaluate health plans. I will briefly outline the most recent accreditation statistics:

Full Accreditation (32 percent) is granted for a period of three years to those plans that have excellent programs for continuous quality improvement and meet NCQA's rigorous standards.

One Year Accreditation (40 percent) is granted to plans that have well-established quality improvement programs and meet most NCQA standards. NCQA provides the plans with a specific list of recommendations, and reviews the plans again after a year to determine if they have progressed enough to move up to Full Accreditation.

Provisional Accreditation (15 percent) is granted for one year to plans that have adequate quality improvement programs and meet some NCQA standards. These plans need to demonstrate progress before they can qualify for higher levels of accreditation.

Denial of Accreditation (12 percent) is given to those plans that do not qualify for any of the categories above.

Since NCQA began reviewing health plans, we have witnessed real improvements in the capability and sophistication of health plan quality improvement efforts. While these improvements are encouraging, our accreditation statistics are more reflective of a deliberate decision to set the NCQA Standards very high. The NCQA standards reflect the thinking of the most demanding corporate purchasers in the market, and should not be confused with entry-level requirements.

Measuring Health Plan Performance Through HEDIS

In November 1993 NCQA released the Health Plan Employer Data and Information Set HEDIS 2.0, a set of sixty standardized measures of health plan performance in five areas. While a copy of HEDIS 2.0 has been submitted to the Subcommittee, I will briefly summarize the five areas:

Quality - Measuring health plans' performance in the delivery of selected services in the areas of Preventive Medicine, Prenatal Care, Acute and Chronic Disease, and Mental Health.

Access and Patient Satisfaction - Measuring health plans' performance in providing members access to health care and in satisfying members.

Membership and Utilization - Measuring health plans' performance regarding membership stability and demographics as well as resource allocation within the plan.

Finance - Measuring health plans' performance in achieving financial stability by examining liquidity, efficiency, premium trend information, and compliance with statutory requirements.

Health Plan Management and Activities - Assessing health plans' management that can affect members' health, satisfaction, and use of services.

This month, NCQA released HEDIS 2.5, a comprehensive update of the specifications in HEDIS 2.0, as part of our commitment to a continuously improving standard for health plan performance measurement. Work on HEDIS 3.0 will begin later this year and we look forward to moving health plan performance measurement to new levels.

A recent survey by the Physician Payment Review Commission (Gold et al. 1995) found that 84 percent of health plans, including both HMOs and PPOs, were reviewing HEDIS to generate performance indicators or assess their ability to generate indicators in the future. Large employers and business groups from around the country have embraced HEDIS as the core set of measures to evaluate health plan performance.

While HEDIS was initially designed for commercial purchasers, it is important that health plans be held equally accountable for the quality of care they deliver to all members, regardless of the payor relationship. With funding from the David and Lucile Packard Foundation, NCQA is directing a project to create a set of comprehensive performance measures addressing the unique characteristics of the Medicaid population. On this project NCQA is working with HCFA, the State Medicaid Directors Group, and the states of Wisconsin, Minnesota, California, Oregon, New York, and Massachusetts. By building on the work of the private sector, the Medicaid HEDIS Project is a model for coordinating

public and private payor data demands. In the future, we look forward to exploring how HEDIS might be adapted for the Medicare population as well.

The twin goals of measuring health plan performance are to improve quality and assist individuals and organizations with their purchasing decisions. Given the complexities of risk adjustment and the wide variation in health plan data systems, however, HEDIS data is best used now for comparing one health plan's performance over time or against national goals where they exist. In the future, we fully expect that HEDIS data will be used as part of a "report card" for purchasers and consumers to compare the performance of one health plan against another and against national benchmarks.

To more fully explore the challenges associated with producing, auditing, and displaying health plan "report card" data, NCQA announced its Report Card Pilot Project in January 1994 with 21 participating health plans covering over 9.6 million enrollee. The Project concluded last month with a symposium here in Washington D.C. Thirty-eight of the HEDIS 2.0 measures were selected and refined for inclusion in the final report. While a copy of the Executive Summary and the Technical Report was submitted to the Subcommittee, I will briefly summarize the results in my testimony today:

External Auditing is Critical - The audit process is essential to the credible implementation of any report card effort. To ensure the validity and accuracy of the data in the Report Card Pilot Project, NCQA designed a two part audit. The first component was a self-reported baseline assessment of systems capabilities, which includes detailed diagrams of claims processing systems and supporting documentation from the participating plans. To validate the self-reported findings, we performed an on-site audit that placed special emphasis on those areas prone to data "fallout" and errors, as well as data acquisition and health plan characteristics that might influence data quality or completeness. For further verification of accuracy, the audit teams compared a subset of the actual administrative data against medical records or other source documents.

Health Plan Information Systems - Greater standardization of common data sets would enhance comparability and data integrity. Enhanced standardization would also reduce the audit burden, which is greatly increased by differences in the content, completeness, coding, and reliability of various data sets. NCQA encourages investment to enhance clinical information systems within the overall managed care industry to further quality measurement and data comparability goals.

Enhancement of Performance Measures - While the performance measures used in the Pilot Project were drawn from HEDIS 2.0, additional measures must be developed to ensure that report cards reflect the range of key clinical areas and meet the information needs of consumers. NCQA looks forward to developing these measures as part of the development process for HEDIS 3.0. Additional research is also needed on the potential for developing and integrating risk adjustment into future report card efforts.

Consumer Needs and Quality Information

Without information on quality and cost, consumers cannot judge value. While consumers are not generally accustomed to getting information on health plan quality, our research has shown they are excited by the potential of health plan report cards. Quality measures give consumers an appreciation of what a health plan is responsible for providing. When consumers learn that their health plan should be coordinating their care and providing a network of credentialed physicians, they become interested in the corresponding performance measures. Consumers also want more information on operational issues. Meeting these diverse needs for information with clear and compelling data is one of the greatest challenges in this field.

While helpful to consumers, public release of the Accreditation Status List and our future accreditation summary reports are only part of NCQA's outreach and research into consumer information needs. With support from the Commonwealth Fund, NCQA has completed two parts of a three-part Consumer Information Project to assess the consumer perspective on quality. This includes an examination of:

- What consumers want to know
- What kind of technical quality information they find compelling
- How much information is enough and how much is overwhelming
- How should the information should be presented

The first phase of the project consisted of in-depth consumer interviews and one focus group. The second phase included six consumer focus groups held in Seattle, Denver, and Philadelphia. The Agency for Health Care Policy and Research provided support for four of these six consumer focus groups. The third and final stage is planned as a demonstration and study of how consumers use report card information to make actual purchasing decisions in two metropolitan markets. We have also completed an HMO report card pilot project for the State of Maryland Health Care Access and Cost Commission which included consumer, provider, and employer focus groups.

As a result of this research we have found that consumers are not generally accustomed to getting information on health plan quality. However, once introduced to the idea of health plan report cards consumers become excited by the potential. As you might imagine, consumers would prefer to see report cards that show clear differences among health plans. However, because the differences among plans are often subtle, NCQA is researching consumer preferences on information format and presentation. While some consumers want overall health plan ratings and others more detailed reports, all consumers want to choose value.

When asked about issues specific to the health plan itself, most consumers identify physician choice ("Is my physician or a physician I choose on the list?") as their first assessment of a health plan's quality. Consumers also want more information on operational issues such as out-of-pocket costs and how the plan works. Consumers also identified accessibility and convenience, along with prevention and educational outreach activities as important concerns.

We found that quality measures (such as immunization and mammography rates) expand consumers' thinking about their health plan. Quality measures give consumers a better understanding of what their health plan is responsible for providing. When consumers learn that their health plan is responsible for coordinating their care and providing a network of credentialed physicians, they become interested in corresponding performance measures. National averages or industry standards are also helpful for consumers to make comparisons. While excited by these findings, we believe it a mistake to define or limit future consumers' information needs with today's expectations.

We have also become aware of a strong undercurrent of public skepticism relating to the provision of information. For example, there was a unanimous desire to know who was behind any rating efforts. Overall, it was felt that few organizations would publish the "bad" ratings. We are now entering an era when the release of spurious quality data could endanger the future of this field by validating the public's skepticism. As we go forward, we must continually emphasize the importance of a third party audit to ensure veracity. The challenge for policymakers is to both address and overcome the public's skepticism.

Future of Health Plan Quality Measurement and Improvement

I want to preface this section by noting that my remarks will pertain almost exclusively to quality measurement and improvement in HMOs. Preferred provider organizations (PPOs) and Physician hospital organizations (PHOs) are currently unregulated by the majority of states, and any discussion of health plan quality must begin with an acknowledgement of these gaps in the regulatory spectrum.

NCQA believes that all health plans, regardless of their financing and delivery structure, should be held accountable for the quality of services and medical delivery. Delivery systems such as managed indemnity and PPOs should at least be required to: credential their providers; monitor services and delivery complaints and grievances; implement standards for utilization management; and provide data about member satisfaction and clinical performance. All health plans must be required to provide data on quality performance, or those more structured plans that have invested in information and clinical management systems could be put at a disadvantage in the marketplace.

Competition in the health care marketplace is unique in the sense that innovations in quality improvement should often be shared in the interest of improving public health. Goals for HEDIS have been tied to important public health goals, such as those in Healthy People 2000. Through conferences and professional publications, NCQA is facilitating a national dialogue on quality improvement in managed care organizations. Having reviewed so many health plans from around the country we are in a unique position to identify best practices and facilitate a supportive learning atmosphere.

Just as many states have begun exploring the relationship between regulation and private sector accreditation, so to should the federal government. As mentioned earlier, NCQA will have accredited over half the nation's HMOs by the end of this year; a figure which includes health plans responsible for 66 percent of the seniors enrolled in TEFRA Medicare Risk Contracts. Because the health plans assume the cost of the review, the federal government receives a benefit at no additional cost. While NCQA Accreditation should not be a condition of participation in the Medicare program, health plans which have achieved accreditation should not be subjected to redundant HCFA certification processes.

NCQA recognizes that reducing the rate of growth in the Medicare program is a critical component of deficit reduction efforts. We believe there is real potential to reduce costs and improve quality through the use of managed care. However, we urge the Subcommittee to build on the work of this hearing and ensure that efforts to reduce costs do not compromise quality in the process.

Thank you again Mr. Chairman for holding this important hearing and providing the National Committee for Quality Assurance with the opportunity to testify.

Chairman THOMAS. Thank you. Dr. O'Leary.

STATEMENT OF DENNIS S. O'LEARY, M.D., PRESIDENT, JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS

Dr. O'LEARY. I am Dennis O'Leary, president of the Joint Commission on Accreditation of Health Care Organizations. We are most appreciative of the opportunity to testify before the Subcommittee.

Long before the enactment of the Medicare Program, the Joint Commission was established by the American College of Surgeons and other leadership organizations in the health care field that were and are committed to providing quality health care in this country. We remain the longest established health care accrediting body in the world, evaluating nearly 11,000 health care organizations, including managed care networks.

Today, I want to make two points to the Subcommittee. The first is that new and effective tools are available to measure quality of care in the complex and still evolving array of health plans across the country. These are important and necessary resources for evaluating the impacts of continuing change in health care.

The second is that Medicare should consider expanding its existing quality of care partnerships with the private sector as it plans for the significant future use of managed care by its beneficiaries. To do so will help ensure that we maintain and improve upon the best available health care in the world.

Let me begin by describing the Joint Commission's quality measurement framework for managed care systems. The Joint Commission's process for measuring quality has changed significantly during the last decade. We now have made a major and successful transition to a performance-based measurement system that is flexible, patient-focused and keyed to improving health outcomes.

These are critical elements to the design of a quality oversight program for managed care systems because they permit meaningful assessment of health plans regardless of their size, configuration or scope of services.

Our standards for managed care networks are built around the key functions that a health plan must carry out well in order to achieve good patient outcomes. This is a crucial focus, because a managed care network is more than the sum of its parts. It must integrate services across multiple and differing sites of care and assure that the needs of its enrollees are met at all points along the continuum of care. How well a network performs its functions has a large bearing on enrollee outcomes, the costs of care and the health status of the population served.

Moreover, setting standards in this manner as performance objectives around key functions is essential in a rapidly changing environment where care must be taken to avoid prescriptive requirements that could impede market entry for new types of delivery systems.

Examples of key functions addressed in our standards include the following; coordination of enrollee services along the service continuum, second, the management of information to ensure its timely availability at each site of care, third, the management of

human resources to ensure the appropriate number, type, and mix of qualified personnel to carry out the plan's obligations, fourth, the intranetwork education of and communication with enrollees and plan providers and practitioners, and finally, continuous measurement evaluation, and improvement of performance.

This last function, continuous quality improvement, is the cornerstone of the Joint Commission's new Integrated Network Accreditation Program. We see our job as sowing the seeds for internal quality improvement programs that their plans inculcate and operate as a sound business practice.

The second Joint Commission initiative is the establishment of a comprehensive database of performance indicators that address a range of quality issues such as access to services, enrollee satisfaction, health outcomes and functional status. Indicators address the results of care, and although inherently retrospective, often provide valuable insights as to internal systems changes that would improve future care.

Today, after extensive development and testing, the Joint Commission has a modern set of clinical indicators called the IMSystem that covers such areas as medication usage, cardiovascular care and trauma care. The Joint Commission is now expanding its inventory of indicators to include those developed by others. Nevertheless, establishing a comprehensive database of properly tested indicators is a daunting challenge and one that could certainly benefit from further public/private sector collaboration to standardize the measures.

The Joint Commission has had a long and productive partnership with the Federal Government in overseeing quality in the Nation's health care delivery organizations. This partnership provides a useful framework for meeting the challenges of quality evaluation as the country moves toward new models of health care delivery.

When the Medicare Program was enacted in the sixties the government looked to the Joint Commission's state-of-the-art standards to help craft its quality standards for hospitals. The Government also relied upon the Joint Commission's surveyors and its evaluation process for certifying hospitals.

This partnership has led to a consistent level of expectations for quality across the country. As new types of providers have been brought under Medicare, this partnership has been expanded to include home health, ambulatory surgery and laboratories. However, no such partnership arrangement exists for Medicare managed care organizations.

This is not the time to build a large government bureaucracy to oversee an evolving market nor is it the time to turn less than an acute ear to consumers reticent to choose managed care without the promise of quality protections. We need to join together drawing upon the Federal Government's leadership in funding outcomes research, clinical practice guidelines and other tools used in quality evaluation and for enforcement where necessary.

The private sector should be drawn upon for its expertise in actually developing state-of-the-art standards and performance measures, and for implementing large-scale quality oversight programs. Thank you.

[The prepared statement follows:]

TESTIMONY OF DENNIS S. O'LEARY, M.D.
ACCREDITATION OF HEALTH CARE ORGANIZATIONS

I am Dr. Dennis O'Leary, President of the Joint Commission on Accreditation of Healthcare Organizations. We appreciate your invitation to appear before the Subcommittee on this extremely important topic.

The demise of last year's national health care reform initiatives has not slowed, and in fact may have stimulated, the expansion of new models of health care delivery. This evolution is being driven by both the need and the opportunity to create more efficient mechanisms for providing a broad array of services. The new entities being formed have increasingly complex and sophisticated relationships, reflecting state-of-the-art thinking about approaches to health care delivery, but also create anxieties among the public as to whether due attention is being paid to the quality of the services and care being delivered.

This presents a major challenge to those in the private and public sectors involved with developing and implementing quality oversight systems. We must have measurement programs that are relevant to widely varied service arrangements and configurations. We must address ourselves to consumer concerns about disincentives for quality in a changing environment and to consumer demands for useful information to help them make important decisions about their care. An we must incorporate the evolving focus by purchasers and policymakers on population-based health, disease prevention, health promotion, outcomes, and consumer satisfaction.

The Medicare program must also face the fact that quality measurement in the 1990s is different and more complex than ever before. Medicare should anticipate and plan for significant future use of managed care by its beneficiaries, make sure that it has a construct for quality oversight that will satisfy the public, and take advantage of rapidly emerging, cutting-edge private sector initiatives. New types of delivery systems pose unique quality issues for all of us, but fortunately the government and the public can benefit from seminal work done over the past ten years in the private sector, and from a public/private partnership framework that has served the public well for the last thirty years.

The Partnership

The Joint Commission has had a long and productive partnership with the federal government overseeing quality in the nation's health care delivery organizations. This is a partnership that we value and one that continues to provide a useful framework for meeting the challenges of quality oversight as the country moves toward new models of health care delivery. This partnership marries market incentives to achieve formal recognition as a provider of quality evaluation services with the enforcement powers of the government where necessary.

When the Medicare program was enacted in the mid 1960s, the government recognized the important contributions that the private sector could make to the protection of the elderly. The Medicare insurance program was centered around hospital-based care. The government looked to the Joint Commission's state-of-the-art hospital standards to help craft Medicare's Conditions of Participation -- its quality standards for hospitals. Faced with the enormous task of determining the compliance of thousands of hospitals with those conditions, the government recognized that it could extend its limited dollar and human resources by relying upon the Joint Commission's cadre of experienced surveyors and its evaluation and decisionmaking processes for the purpose of certifying hospitals. At the same time, The federal Conditions of Participation would offer a public route of entry for those hospitals unable to comply with accreditation standards.

We believe that this partnership has worked well for all parties and has led to the continuous upgrading of care in the United States. And it has resulted in a consistent level of expectations for quality across the country. In fact, accreditation standards are reflected in most state licensure laws, and in legal decisions by the courts. However, the most notable benefits from the partnership have been incentives to providers for achieving optimal standards of care and assurances to the public that poor performers will lose their Medicare certification. Further, I believe that the give and take over the years regarding federal versus private sector performance expectations has served to improve each partner's contributions, while serving as a major stimulus for hospitals and other types of provider organizations to provide the best available care in the world.

As new types of providers and suppliers have been brought into the Medicare reimbursement system, this partnership has been expanded to nonhospital-based service organizations, such as home health, ambulatory surgery, and laboratories; and also to other national accrediting bodies specializing in specific areas. However, no formalized partnership arrangement exists for Medicare managed care organizations.

Quality Measurement Has Changed

The Joint Commission's process for measuring quality has evolved significantly since the mid 1980's when we began our Agenda for Change. The Agenda for Change has involved the creation of a performance-based measurement system that is flexible, patient-focused, and concerned with improving health outcomes. The advances in the state-of-the-art of quality measurement and evaluation have critical implications for quality oversight of managed care systems, because they permit contemporary and meaningful assessment of health plans regardless of their size, configuration, or scope of services.

I would like to describe three major components of the Joint Commission's new approach to quality evaluation and demonstrate how they are relevant to managed care plans.

The Recasting of Accreditation Standards

First, standards for all our accreditation programs have been rewritten around the key functions that an organization must carry out effectively in order to achieve good patient outcomes. This may appear simplistic, but it is a crucial principle in designing a quality and evaluation approach for complex entities like health plans. A managed care network is more than the simple sum of its parts; it is defined by its responsibility for integrating services across multiple and differing sites of care, and for assuring that the needs of its enrollees are met along the full continuum of care. How well a network performs its functions has a large bearing on enrollee outcomes, the cost of providing effective and appropriate services, and the eventual health status of the population served.

Moreover, setting standards in this manner -- as performance objectives around key functions -- is essential in a rapidly changing environment. Establishing prescriptive requirements would simply impede market entry as new delivery systems and products continue to evolve.

As has been our tradition, we drew upon the expertise of a broad array of stakeholders to develop the managed care network standards published by the Joint Commission last year. These standards constitute a comprehensive framework of performance objectives for the complex delivery systems of today and

tomorrow, regardless of their specific configurations. Some of the most important functions addressed in the standards are the coordination of enrollee services along the service continuum; the management of information to ensure its timely availability at each site of care; the management of human resources to ensure the appropriate number, type and mix of qualified personnel to carry out the plan's obligations; and intra-network education of and communication with both enrollees and plan providers. These dynamic functions require that the network's brain continuously address issues of coordination, integration, and communication while also setting network goals and assuring the appropriate allocation of resources, and continuously measuring, assessing and improving the network's performance.

That's why the Joint Commission's standards also emphasize the role of plan leadership in overseeing all of the network's key functions. Let me use "leadership" as an example of our new way of expressing performance expectations and how these apply to networks. Our old standards relied on each department in a hospital to provide leadership to its service. Consonant with our performance-based standards, that leadership responsibility has shifted to the hospital's management, clinical leadership and governance structures which are also required to determine the needs of the organization's community and plan for the provisions of appropriate hospital services. The comparable requirements for networks require the plan's central, identified leadership to be cognizant of the expectations of its enrollees; seek and listen to enrollee feedback, and actively work to address the identified needs.

The cornerstone standards in our new Network Accreditation program address the network's responsibility for continuously improving its performance. We emphasize these standards because quality is not achieved simply by the performance of periodic surveys. We see the Joint Commission's role as sowing the seeds for internal quality improvement programs that continuously measure, evaluate and improve performance. Instilling internal incentives for systems improvements at the local level is our primary objective, and it should, we believe, be the objective of all external review activities.

In recent years, we have seen great strides in the development of measurement tools to support quality improvement activities, such as reference databases, clinical practice guidelines, functional status and quality of life measures, and others. Moreover, many health care networks have begun to adopt some of the many approaches to CQI and TQM that have been popularized by American industry. Those of us who are onsite in these networks are in a unique position to provide technical assistance to providers and plans in establishing quality improvement programs. We can also determine whether their problem detection and solving processes are actually working, as we conduct interviews with patients and staff. This is a unique and invaluable aspect of the accreditation process.

The Development of Quality Indicators

A second initiative has been the development of a system of quality indicators that can be applied to accredited health care organizations on an ongoing basis and can be used both as early warning signs of potential problems and as continuous markers of quality improvement opportunities. Indicators address the results of care provided and, although inherently retrospective, often provide insights as to potential systems changes that would improve future care. Used in conjunction with accreditation standards, indicators make possible a comprehensive evaluation system that is both precise in the information that it gathers and predictive of future organization performance.

Today, after extensive development and testing activities, the Joint Commission has a modern performance measurement system and database called the IMSystem. The IMSystem encompasses a steadily expanding base of important clinical indicators that cover such areas as medication errors, infection control, trauma care and oncology services.

Let me give you an example of how a network indicator might differ from one used in a single site provider, like a hospital. If we were examining total hip replacement in a hospital, we might confine ourselves to measuring the appropriate use of the procedure, its technical performance, and the planning for the patient's transition to home. When looking at the same service in a network, we would go beyond those measures to address issues such as access to hip replacement surgery, coordination of follow-up care, and the patient's ability to function, including his or her ability to return to work. These added dimensions reflect enrollee expectations regarding the network's performance of its important functions.

We are now expanding our inventory of measures to include those developed by others. This will permit rapid expansion of the database to provide accredited organizations with to meet their varied needs and those of their enrollees.

Establishing an inventory of properly tested measures for use in managed care organizations is a daunting challenge and one that could certainly benefit from further private/public sector collaboration. The Joint Commission recently issued invitations to more than 250 organizations to solicit their involvement in a partnership of sharing performance indicators. We have had a very good response thus far. There is still a need, however, to standardize the measures in the inventory. If we are to have useful information, the performance data gathered from health plans must be comparable. Measures must also be valid, relevant to patient outcomes, and reliable. Otherwise we will waste a major investment in performance measurement and data collection activities.

Public Disclosure

A third initiative that came to fruition last year was the implementation of our new policy on disclosure of performance information about accredited organizations. We developed and began to make available to the public last December our first performance reports on accredited organizations. This, we believe, is part of our public trust. As the major gatherer and keeper of important performance information on 11,000 health care organizations, we have an obligation to share this information with today's increasingly knowledgeable and interested public.

Managed care plans are under increasing pressure to provide information to the consumer about their services, administrative policies, and key dimensions of quality. The challenge will be to produce reports that are truly helpful to those using the information to choose among plans. More clearly needs to be done to determine what consumers most want to know about plans, and how this information is best presented.

We believe that our new initiatives involving standards, indicators and public performance reports provide an important framework applicable to all types of service delivery and configurations. None of these parts can be taken in isolation. There are no data sytems, whether designed to capture routine outcomes or encounter data, that can substitute for onsite survey of a managed care network. There is no substitute for talking directly to patients and to practitioners; to visiting high risk and low risk sites of care; to observing first hand the underlying processes in action and what they are likely to produce. All the elements described in our testimony are essential to building and maintaining public confidence in the future health care delivery system in the United States.

Chairman THOMAS. Thank you very much. Dr. Bee.

STATEMENT OF DAVID M. BEE, M.D., VICE PRESIDENT, AMERICAN MEDICAL PEER REVIEW ASSOCIATION

Dr. BEE. Good afternoon, Mr. Chairman and Members of the Committee. My name is David Bee. I am a board-certified internist and have practiced in Glendale, CA, for about 20 years, 10 as a contracted IPA, independent practice associations, provider to 10 different HMO plans. I have also been a board member of the California PRO, CMRI.

I was one of the founders and also served a couple of years as the President of the California PRO. For the last year and a half I have been a full-time district medical director for FHP. I think I have seen a broad spectrum of health care as it has evolved over the last 20 years.

I am very pleased to represent AMPRA, the American Medical Peer Review Association. AMPRA is a national organization, membership association of quality improvement organizations, which includes all of the peer review organizations around the 50 States. I currently serve as AMPRA's vice president. AMPRA supports public and private efforts to protect and improve the quality of health care.

We want to do that through services involving active sponsorship of both internal and external quality management systems and we thank the Subcommittee for focusing attention today on this very important issue.

America's peer review organizations are private sector independent entities representing thousands of community-based physicians, nurses and other health care professionals, most of whom have had a very long commitment to continuous quality improvement of the health care system. PRO's collaborate with all community providers of health care, including employer groups, Medicare and Medicaid Programs, the AHCPR, State health departments, and consumers. We are seeking to impact the quality of health care and we are using the quality improvement tools of industry.

Mr. Chairman, 9 years ago this Subcommittee, with a laudable mission, drafted section 9313 of the Budget Act of 1986. This section commissioned the Institute of Medicine to design a strategy for quality review and assurance in Medicare. The Institute's 1990 report to Congress became the blueprint for reengineering Medicare's PRO program, which has evolved into the HCQIP described for you today. We strongly direct your attention to the fact that the HCQIP enjoys widespread support from numerous provider and Medicare beneficiary groups, as you will later hear.

Our written testimony before you describes several of the over 400 current projects already improving access, process, outcome and cost across the country. These projects have only been initiated for about the past 2 years and should be considered preliminary. However, the findings are quite encouraging.

I heard Dr. Vladeck say that he was not willing to put any cost saving numbers on the projects that are underway. A couple of our member PROs have been willing to project some cost savings.

In Arizona, using tools to stimulate the community to reduce inappropriate surgery for cancer of the prostate, the numbers gen-

erated their project into about $1.08 billion in savings if they are equally successful across the country. I must point out that the 1.7 number in your testimony was a typographical error.

Over 20 States, including my own State, are participating in stroke prevention projects and the Michigan PRO, using just 19 of its State hospitals projected a saving of over $1 million in prevented strokes if the guidelines were appropriately followed.

You have heard the story of New York in preventing unnecessary heart catheterizations which are projected to save about $7 million. Through AMPRA's facilitation, about 16 other PROs around the country are using these same projects to try to improve the care in their community in the same way.

AMPRA and its members are committed to using community-based, locally controlled, effective interventions in health care. We believe that community physicians using nationally developed guidelines in cooperation with their local medical societies, with local physician groups and especially societies, can develop the kinds of projects that will actually move to push Dr. Jenck's beautiful curves in the direction that we wish them to go. We believe that is the mission of the PRO, the mission of AMPRA, and we believe that using these tools together we can forge a high quality future for American consumers.

In conclusion, there have been tremendous advances in building the science of quality measurement. There is scant evidence, however, that we have been able to translate practice guidelines, outcomes research and performance measures into sustained changes in practice behavior. The PROs have demonstrated a unique competency in facilitating and integrating quality management concepts and tools at the local physician hospital health plan level through the health care quality improvement project.

Mr. Chairman, we appreciate the opportunity to testify and look forward to working with the Committee in designing strategies for improving the quality of health care for all Americans. Thank you.

[The prepared statement follows:]

TESTIMONY OF DAVID M. BEE, M.D.
AMERICAN MEDICAL PEER REVIEW ASSOCIATION

1. The American Medical Peer Review Association (AMPRA) representing federally designated Peer Review Organizations (PROs), support public and private efforts to protect and improve the quality of health care services, through active sponsorship of both internal and external quality management systems and programs.
2. PROs share a mission to serve as a primary agent in focusing local community energy to achieve significant and continuing improvement in the quality and effectiveness of health care. PROs engage health care practitioners, health plans, purchasers and consumers in collaborative efforts by: monitoring health care patterns to identify opportunities for improvement and tracking progress toward achievement of the highest quality of care; interpreting and sharing information about care processes, health outcomes, and current science; and actively encouraging all parties to make positive changes in behavior that would improve the status of individuals and populations.
3. The Ways and Means Committee is to be complimented for its role in setting a new course for Medicare quality assurance. Nine years ago, the Subcommittee drafted Section 9313 of the Omnibus Budget Reconciliation Act of 1986 commissioning the Institute of Medicine (IOM) "to design a strategy for quality review and assurance in Medicare." The IOM's subsequent report became the blueprint for Medicare's Health Care Quality Improvement Program.
4. Medicare's Health Care Quality Improvement Program is an exciting and dynamic new partnership between beneficiaries, providers, PROs, and the Health Care Financing Administration to improve the quality of care for Medicare beneficiaries. In the over 400 local improvement projects that PROs have implemented to date, there is clear evidence that patient outcomes can be improved, dollars can be saved, and beneficiaries can be educated and empowered to make informed health care choices. As the program matures and successful efforts are replicated across the country, there is even greater potential for accelerating the pace of improvement and cost savings. In one project area alone, an effort to reduce the incidence of radical prostatectomies, if the results in four states were mirrored across the country, the Medicare program would save over $1.7 billion.
5. The growth of Medicare managed care is an inevitable result of the managed care revolution sweeping the private sector. There are both risks and benefits to patient care associated with prepaid delivery systems that suggest the need to strike an appropriate balance between external monitoring and reliance on the unique internal quality assurance and improvement capabilities of integrated health plans. In this regard, AMPRA supports the resolve of the Health Care Financing Administration to redesign PRO oversight of Medicare managed care to fit the model of the Health Care Quality Improvement Program and recommends the inclusion of Medicare risk contract populations in the quality improvement projects already in progress. AMPRA supports the Medicare health maintenance organization (HMO) performance measurement project, led by the Delmarva PRO and Harvard University, and urges its immediate pilot testing prior to national implementation. Finally, AMPRA supports the development of a minimum patient encounter data set for Medicare risk contract plans to be used in support of both internal and external quality management efforts.

Written Statement
of the
American Medical Peer Review Association

Mr. Chairman and members of the House Committee on Ways and Means Subcommittee on Health, my name is David M. Bee, M.D., F.A.C.P. I am a board certified practicing internist with 20 years of bedside internal medicine and critical care practice. Last year I became a full-time medical administrator for FHP, a multi-state managed care company based in California. I am past president and current board member of California Medical Review, Inc., the Medicare peer review organization (PRO) in California. I have been associated with quality assurance activities since 1974.

I am here today representing the American Medical Peer Review Association (AMPRA), where I currently serve as vice president.

AMPRA is a national membership association of independent quality evaluation and improvement organizations, which includes the PROs. As an association dedicated to quality health care through independent and community-based quality evaluation and improvement programs, we appreciate the invitation to testify and thank you for bringing needed attention and focus to the issue of quality health care.

My remarks today will focus on the quality assurance and improvement services provided by the AMPRA membership for the Medicare program as part of its Health Care Quality Improvement Program (HCQIP). This work includes quality evaluation of both Medicare fee-for-service and Medicare risk contract plans.

The Quality Challenge

Regardless of one's political persuasion, protecting and improving the quality of health care services while working to ensure access to those services is a goal we all share. We must work together to design internal and external strategies to continuously improve health status and the delivery of health care services in our communities. At a time when health care delivery is being rapidly transformed by managed care and when budget pressures are expected to reduce expenditures for Medicare and Medicaid, Americans deserve a comprehensive system of quality accountability.

For over two decades, the AMPRA membership has been committed to serving as a catalyst in focusing community energy to achieve significant and continuing improvement in the quality and effectiveness of health care. As a national network of private sector, independent organizations, we have been called on by Medicare, Medicaid, and private purchasers to:

- monitor health care patterns to identify opportunities for improvement and to track progress toward achievement of the highest quality of care;
- interpret and share information about care processes, health outcomes and current science;
- actively encourage all parties to make positive changes in behavior that would improve the health status of individuals and populations.

Let me underscore that our work in local communities is not confined to the measurement of quality. While we begin with the application of quality indicators/performance measures to pinpoint opportunities for improvement, our real success is determined by out ability to catalyze sustained improvement through changes in practice behavior, health care processes and individual decision-making.

Our experience teaches us that any comprehensive quality initiative must incorporate three important functions: continuous quality improvement; consumer education; and quality protection.

Continuous quality improvement ensures that all practitioners involved in the delivery of care strive to reach the highest quality of care achievable based on current scientific and professional knowledge. Continuous quality improvement enhances health outcomes for individuals while reducing the costs of care.

Consumer education empowers the individual to make appropriate choices (lifestyle, medical treatment, provider, health plan, etc.) based on reliable and understandable information.

Quality protection ensures that individuals and populations escape harm from providers not meeting minimally accepted standards of care.

We urge the subcommittee to keep these key functions in mind when analyzing public and private sector quality initiatives.

THE HEALTH CARE QUALITY IMPROVEMENT PROGRAM -- A Model of Government Re-engineering

I would now like to turn my attention to HCQIP. Mr. Chairman, nine years ago the ways and means subcommittee on health authored Section 9313 of the Omnibus Budget Reconciliation Act of 1986 which commissioned the Institute of Medicine (IOM) "...to design a strategy for quality review and assurance in Medicare." In 1990, after review and study by a national panel of experts, the IOM issued its report.

This innovative study, *Medicare: A Strategy for Quality Assurance* -- embraced by Congress, the Bush and Clinton administrations, and all participants in Medicare's quality assurance activities -- became the blueprint for Medicare's HCQIP. As the program name implies, PROs form partnerships among government, providers, and beneficiaries for the purpose of improving the quality of care delivered to Medicare beneficiaries.

As you will hear today, HCQIP has become a model for government re-engineering and

privatization. The Health Care Financing Administration (HCFA), to its credit, has relaxed the reins of central control and regulatory authority and empowered local communities to seek their own opportunities for quality improvement. In its short history, HCQIP has demonstrated the potential to improve health outcomes for beneficiaries while reducing costs and expenditures for Medicare providers and the Medicare program.

The Evolution of Health Care Quality

Mr. Chairman, in describing HCQIP, it is important to be reminded that quality improvement has become one of the core tenants of health policy over the past decade, contributing to a healthier, more productive population which in turn results in significant health care savings. This shift to quality improvement reveals a fundamental change in the way health care is delivered, practiced, and purchased.

In 1993 Medicare followed this shift, transforming its oversight program from one of peer review -- singling out individual poor performers identified after the fact -- to one of quality improvement, promoting good practices and continually identifying opportunities for improvement within health care facilities.

As PROs, we now serve as active participants in health care quality improvement, adopting a seamless approach which unites us with physicians, fee-for-service and managed care providers, consumers, accreditors, federal and state agencies and local community representatives. Specific emphasis is placed on actively involving these groups in developing improvement agendas, programs and projects. With the PRO acting as the change agent, this approach encourages cooperation among all participants in the community's health care delivery system and promotes removal of competitive barriers.

As catalysts for community-wide quality improvement, we bring improvement methods and tools to providers and communicate with beneficiaries and providers to promote informed health choices. Information is now available to Medicare beneficiaries that will promote individual participation in health care decision-making. More specifically, efforts are underway to educate individual beneficiaries about preventive health care, provide information about treatment options, and to promote increased health awareness in the senior population.

As with other purchasers of health care services in the private sector and the insurance industry, Medicare has the right to sever contracts with providers found to provide poor care. This is accomplished through the quality protection authority, conferred by statute to the Medicare program's agents, the PROs.

Lastly Mr. Chairman, PROs have become central to improving not only the health of Medicare beneficiaries, but of other recipients of health care. As the quality improvement changes for Medicare beneficiaries become institutionalized, all populations -- not just Medicare beneficiaries -- will benefit from and utilize these improved health processes. Indeed, we invite the private sector to join our Medicare-sponsored improvement activities when topics are relevant to the under 65 population.

Local Quality Improvement in Health Care Facilities

In identifying opportunities for improvement, PROs profile patterns of care from representative samples of practices and services. These samples are compared to quality indicators, based on published practice guidelines, research, or widely accepted practice parameters. The data are analyzed and shared with providers (defined here as hospitals) who are invited to engage in improvement projects.

Participants in improvement projects range from one to several hundred providers. Facilities which collaborate with the PROs in an improvement project agree on a specified course of action to make the improvement, such as changes in protocols or treatment plans. Some facilities are able to make improvements on their own, but others may request that the PRO assist them with advice, tools, or technical expertise.

After improved processes have been adopted, PROs monitor improvements to determine the extent of the improvement. Since improvement is continuous, ongoing and periodic monitoring ensures that improvements are maintained.

Quality improvement projects in health care facilities typically involve disease processes, conditions, or procedures which are both prevalent and costly. Focusing on quality of care concerns -- reducing risk of complications in hospitals, preventing unnecessary procedures and promoting preventive care -- the health care facility improvement projects save money. The dollar savings are the incidental by-product of the improved care through quality improvement initiatives such as prevented admissions, reduced length of hospitalization, avoided surgical procedures and improved health status.

Quality Improvement Case Studies -- Improving Care and Saving Money

Given that the mission of HCQIP is to promote the quality, effectiveness, efficiency and economy of services to Medicare beneficiaries, the message is simple and compelling: **quality saves money**. Although HCQIP has been in existence for a relatively short period of time, the program shows great promise in documented improved quality of care and cost savings to beneficiaries, providers, and the Medicare program.

To illustrate the scope of HCQIP improvement efforts underway, many projects are not confined to individual states but are replicated in other locales, enhancing their impact across the nation. In addition, several PROs work together on multi-state projects, sharing methods and experiences, such as the twelve Rocky Mountain states which work to improve care for heart attack patients in 175 small rural facilities.

Following are a few case examples of improvement projects where providers have actively identified opportunities for improvement. At this early stage of the HCQIP program, we assume, Mr. Chairman, that participating hospitals will carry out and complete their self-generated action plans, leading to the desired benefits of quality improvement and cost savings. Currently, over 400 individual quality improvement projects are being implemented and are effecting real improvements in the community.

Case Study #1: Reducing Unnecessary Prostate Surgery. In the United States, prostate cancer affects about 30 percent of men over age 50. Since prostate cancer is slow to grow, most men die of other causes and the risk of the operation and its side effects -- impotence, incontinence, urethral stricture and death -- can outweigh the value of surgery itself. In fact, literature suggests that men over 70 experience little benefit from the procedure, that the option for surgery should be the exception rather than the rule, and that surgery is not justified at all in men older than 75.

Nevertheless, data show the procedure has grown rapidly among the Medicare population. Several PROs now are using guidelines produced by the Agency for Health Care Policy and Research (AHCPR) to educate patients and providers about viable alternatives to prostate surgery, including watchful waiting and radiation therapy. Preliminary data from one PRO study show a 75 percent reduction in radical prostatectomy for men in this age group after provider education was delivered. This drop in surgery has resulted in Medicare program savings of more than $1.3 million by the five collaborating hospitals and an increased quality of life for those patients. If all hospitals in the state were to become involved in this improvement opportunity, $2,621,160 per year could be saved.

Four additional PROs collaborating on a similar prostatectomy project estimate cost savings for 1993-1994 as ranging from $5.6 to $13.5 million, for a combined savings total of $36.8 million. If implemented by the entire nation, the projected Medicare savings could total over $1.7 billion. The movement has begun, as approximately 20 PROs are already implementing this project topic.

Case Study #2: Improving Blood Product Transfusion Practices. The nation's blood supply is at a dangerously low level and hospitals have been faced with the prospect of running out of blood products. Moreover, existing practices for reserving blood render it useless to other patients in an emergency. While this practice guarantees availability, usually only half of the reserved blood is actually used. By implementing minimal changes in the way blood is ordered and tested, one PRO helped hospitals to improve quality by maintaining a readily available blood supply and eliminating waste. The project has the potential to save as much as $700,000 annually if all hospitals in that state participate.

In addition to issues in securing blood, research has shown that across the nation blood components are being used in surgery even though patients may not need them. Unnecessary use of blood components increases the risk of allergic reactions and adverse events (such as transmission of infectious diseases like AIDS and hepatitis), results in a lack of precious blood resources, and leads to higher health care costs associated with complications. Reducing inappropriate blood use among 10 hospitals in one state could lead to an estimated savings of $256,065 to $4.1 million, according to that state's PRO.

Another PRO investigated the administration of platelets, a blood component, for Medicare patients in their state and discovered that the cost of platelet overutilization for six providers equaled $23,050 a year. The PRO educated physicians with regard to the College of American Pathologists' guidelines which recommend gauging platelet transfusion by patient weight. This improvement project reduces the waste of blood platelets and preserves inventory levels so other patients in need will have platelets available.

Improving the retention and administration of blood products will enhance quality of care for all patients by lowering the potential risk that comes with unnecessary transfusions and lessening the demand for a valuable resource. Currently, approximately 36 PROs are conducting blood conservation improvement projects.

Case Study #3: Promoting Appropriate Treatment of Heart Attacks. Using Medicare mortality data, several PROs are conducting projects on the appropriate use of thrombolytics (including aspirin) in patients admitted for heart attacks, one of the leading causes of death in the United States. Pattern analysis reveals that a significant number of patients are eligible for thrombolytic therapy but either do not receive thrombolytics at all, or if so, do not receive them in a timely fashion.

Guidelines published by the American College of Cardiology advocate the appropriate administration and timing of thrombolytic therapy. By promoting these guidelines, one PRO found that the cost for a heart attack episode dropped an average of $420 per patient stay and that the length of stay decreased by three days, all due to improved treatment as a result of their intervention. Another PRO estimates that nearly $2 million could be saved if improved management of thrombolytics were to prevent recurrent admissions by as little as 10 percent.

At present, approximately 21 PROs are pursuing projects on the appropriate use of thrombolytic therapy. These projects are one aspect of the larger cooperative cardiovascular program being implemented by the HCFA.

Case Study #4: Preventing Pressure Ulcers. Pressure ulcers are a serious national health problem that affect at least 1.7 million patients with an associated health care cost of more than $1.3 million. This condition can be difficult to treat and leads to unnecessary pain, increased risk of infection, intensified nursing care, extended hospital stays and higher patient care costs. Prompt and effective treatment, however, can minimize these effects and speed recovery.

Statistics reveal the costs of treating pressure ulcers as 2.5 times as much as prevention. Treating a single ulcer can range from $4,000 to $40,000. Pressure ulcers can be minimized by educating providers and promoting systematic adherence to preventive procedures, such as the guidelines published by AHCPR. Appropriate guideline implementation is estimated to reduce the cost of pressure ulcer treatment by as much as $40 million nationally. Expected savings from prevented pressure ulcer improvement projects in two small states equal $940,000. Currently, approximately 11 PROs are pursuing this project topic.

Case Study #5: Improving Heart Catheterization Practices. Heart catheterization, a procedure examining the arteries surrounding the heart, is a standard procedure in patients with coronary artery disease, the major underlying cause of death in the United States today. Although the procedure has historically been performed on both the right and left sides of the heart, the American College of Cardiology and the American Heart Association recently published guidelines stating that without specific indication, routine right heart catheterization is unnecessary. According to the guidelines, a cardiologist should neither provide nor seek compensation for catheterization services known to be unnecessary. Current review of Medicare data by several PROs shows that cardiac surgeons routinely examine both sides of the heart while preparing a patient for catheterizations, whether or not the suspected problem relates to both sides of the heart.

One large PRO found that many hospitals had no criteria for performing right heart catheterizations and that individual cardiologists appeared to make their own decisions. Indeed, many hospitals seemingly performed the procedure as training for their residents. After a series of provider meetings and intensive educational efforts, re-evaluation of data before and after the education found a sharp reduction in frequency of right heart catheterizations, resulting in less risk to patients and a savings of approximately $7.7 million per year. Approximately 16 PROs are now involved in this improvement opportunity.

Case Study #6: Preventing Strokes. Several PROs are examining the use of anticoagulants in patients hospitalized with a rapid irregular heart rate, also known as atrial fibrillation. Anticoagulants are recommended to prevent blood clots -- which in turn can result in strokes -- in patients with this condition, according to a consensus panel of the National Stroke Association, guidelines produced by the American Heart Association and others.

Improvement projects underway reveal that significant numbers of patients with chronic atrial fibrillation are not being given anticoagulants, however. Strokes impact quality of care by increasing the potential loss of life and the use of long term care facilities and pharmaceuticals; reducing quality of life, life expectancy, and family stability; and affecting the ability of the elderly to live independently. As a complication, strokes -- one of the leading

causes of death among the adult population -- can generate thousands of additional Medicare dollars per patient stay, not to mention the costs of rehabilitation, long term care and death.

Simply educating providers that anticoagulants should be considered in the absence of contraindications results in improvements in quality of life while diminishing the incidence of costly strokes. For one PRO, combined savings from two small state projects are estimated at over $1 million. At another, larger PRO, direct cost estimates as a result of reducing stroke admissions -- thanks to increased appropriate use of anticoagulants at only 19 hospitals -- ranged from $1.1 to $4.8 million in Medicare program savings. At present, approximately 20 PROs are implementing this improvement opportunity.

Case Study #7: Preventing Lower Extremity Surgery Complications. Pulmonary Embolus (PE), a blood clot in the lung associated with Deep Vein Thrombosis (DVT) -- a blood clot of the lower extremity -- is a frequent but largely preventable complication of any operation of the lower extremity, such as the knee or hip. In fact, PE is the single most common cause of preventable hospital-associated death.

Published guidelines show effective methods for preventing DVT/PE, and illustrate that patients who do not receive this care are unnecessarily exposed to the risk of serious complications. Pattern analysis by PROs uncovered significant numbers of lower extremity surgery where patients were not receiving appropriate monitoring and/or preventive therapy during admissions. Provider education emphasizes appropriate preventions, according to published guidelines, in patients undergoing these operations.

In one state, the average, annual Medicare charge for treating a patient for lower extremity complications was approximately $13,395. This figure strongly suggests that considerable cost savings will result as medically appropriate steps to prevent DVT/PE are implemented. Currently, approximately 11 PROs are conducting variations on this improvement project.

Beneficiary Education Initiatives

An important goal of HCQIP is for PROs to communicate with beneficiaries and providers to promote informed health choices. Recognizing the value of involving beneficiaries in the health care decision-making process, the Medicare program has made beneficiary education an integral component of its benefit structure. In this arena, PROs are making data available to providers and beneficiaries on health promotion, treatment options, and disease prevention.

Services which have proven potential for illness prevention (i.e., influenza and pneumonia vaccination) and early cancer detection (i.e., screening mammography) have been greatly underutilized by the Medicare population. Information about treatment options likewise targets two very common conditions in the Medicare population: breast cancer and prostate cancer.

Our approaches to disseminating information to Medicare beneficiaries vary. Several are being pilot-tested. They usually involve networking with consumer groups, the media, information hotlines, or organizations that share the PRO's interest in health promotion.

Beneficiary Education Case Studies

Case Study # 8: Influenza and Pneumonia Vaccination. Although many seniors are aware that the flu shot prevents illness, only about one third of all eligible persons obtain the shot. Both flu shots and pneumonia vaccinations are a covered Medicare benefit at no cost to the beneficiary. Individuals who are not vaccinated face increased risk of illness resulting in hospitalization and perhaps unnecessary cost to the system.

In one example of a medium sized state, Medicare billing data demonstrated that flu and pneumonia accounted for 7,761 hospitalizations in a one year period. The average length of stay was 9.2 days, with an average cost of $9,685 per stay. The total cost to treat these patients was in excess of $75 million. Individuals with heart and respiratory complications -- in addition to the flu or pneumonia -- cost more that $215 million to treat. In contrast, preventive measures such as the flu vaccine costs Medicare about $7 per shot, and the pneumonia vaccine (effective for approximately 6 years) costs approximately $20 per shot.

PROs mounted campaigns for the first time during the 1994 flu season and are prepared to do so again in anticipation of the 1995 flu season. PROs typically work with state health departments and provider and consumer groups to distribute information -- such as brochures -- in areas where seniors are known to congregate. Public service messages by the media enhance the outreach effort. Such pertinent information allows individuals to make well-informed health decisions.

Screening Mammography. Breast cancer is the most common cancer in women in the United States. Despite strong scientific evidence supporting the effectiveness of screening mammography and the universal recommendation that women 50 years and older undergo routine screening, studies have shown that only about one-third of older women comply. In fact, Mr. Chairman, in some states that rate is even lower. Since early detection of breast cancer can save lives and obviate the need for the disfiguring surgical procedures, the campaign to educate women of the benefit of screening mammography is compelling.

Treatment Alternatives. Breast cancer poses a serious threat to older women. Data has shown that women are not aware of their treatment options and are not taking advantage of breast conserving therapy, recommended in the early stage of the disease. We are in a unique position in the community to fill this informational void. Pilot programs are underway in several states to bring information about breast cancer treatment options to Medicare beneficiaries.

Involving patients in decisions about treatment options is a powerful tool in changing physician practice patterns. One PRO discovered this when it distributed an informational brochure about treatment options for prostate cancer. Letters from Medicare beneficiaries to the PRO make it clear that the information has helped many to ask informed questions of their physicians and to opt for the treatments that suit them best. Undoubtedly, the drop in radical surgery in that state was, in part, due to better informed individuals.

Quality Protection

Quality protection is integral to the PRO statute. Various mechanisms are in place through which we perform this obligation, the most prominent of which these are the beneficiaries' appeals, complaint rights, and the analysis of a random sample of medical records. In each case, the PRO determines whether services provided were medically necessary and appropriate; were furnished in the appropriate care setting; Medicare coverage policies were followed and correctly billed by the provider; and, whether the care conformed to acceptable standards of quality.

Beneficiary Complaints. Medicare beneficiaries or their families who are concerned or dissatisfied about the quality of care they received in a hospital or by a physician may request a PRO investigation. We will investigate the complaint and determine whether the care and services meet accepted standards of care.

In the event of a supposed quality of care problem, we will take corrective action. Actions may range from educational efforts with the facility or physician to a recommendation for sanctions submitted to the office of the inspector general in the event of gross and flagrant or substantial violations. This authority -- rarely exercised -- is used only if the hospital or physician is unwilling or unable to comply and when all other avenues have been exhausted.

Beneficiary Appeals. The beneficiary may appeal when the attending physician and the hospital want to discharge the patient and the patient does not agree. While many of these issues are easily resolved by the PRO in cooperation with the hospital and physician, there have been instances of potential harm or risk to the patient, warranting the PRO's intervention.

The beneficiary may also appeal any decision made by the PRO and if dissatisfied with the appeal, may present his case to an administrative law judge.

Random Sample Review: The PROs conduct a review of a random sample totalling approximately 1% of Medicare inpatient records and 3% of ambulatory surgery medical records. This allows for utilization and quality evaluations of physician and facility services. Random sample review reflects a minimum compliance monitoring of each Medicare provider, including prospective payment system (PPS) and non-PPS hospitals, and ambulatory surgery centers. A minimum of home health and long term care services is also included.

We scrutinize these cases to determine whether the services provided were appropriate and met Medicare payment guidelines and acceptable standards of care. In the event of a possible violation, the PRO may conduct further investigation of the provider to determine what action to take. Initial efforts stress an educational approach, but if the provider is either unable or unwilling to correct the problem, the PRO may recommend a sanction, including a civil monetary penalty or an exclusion from Medicare for a specified time. It should be noted that the sanction authority is only utilized as a last resort.

QUALITY IMPROVEMENT IN MANAGED CARE

Since the early 1980's, the Medicare program has encouraged HMOs to provide coverage to enrolled beneficiaries in return for fixed prepaid premiums (Mathematica). Under the aegis of the Tax Equity and Fiscal Responsibility Act (TEFRA), the Medicare program

initiated a Medicare risk program which allows HMOs to assume responsibility for providing all Medicare-covered services to beneficiaries in return for a capitated payment.

In addition to its primary goal of reducing costs, the risk program continues to embody two objectives: to provide more efficient health care *while maintaining or improving the quality of care*, and to give Medicare beneficiaries access to the same range of choices younger individuals enjoy.

Mr. Chairman, the growth of Medicare managed care is an inevitable result of the managed care revolution sweeping the private sector. There are both risks and benefits to patient care associated with prepaid delivery systems that suggest the need to strike an appropriate balance between external monitoring and reliance on the unique internal quality assurance and improvement capabilities of integrated health plans. In this regard, AMPRA supports the resolve of the Health Care Financing Administration to redesign PRO oversight of Medicare managed care to fit the model of the Health Care Quality Improvement Program.

Because PRO quality improvement projects rely on analysis of data which are readily available on the fee-for-service side -- *but lacking on the managed care side* -- a different method is called for in those care settings. The Medicare program has encouraged PROs to come forward with their recommendations for alternative methods. Pilot projects are underway in a number of states.

Quality Improvement in Managed Care Case Studies

Quality improvement efforts in managed care follow the same principle as in the fee-for-service environment, with the PRO and the plan jointly entering into quality improvement activities.

One case study involves a state in which 25 percent of the Medicare population receive health care through six "at risk" managed care plans. Less than a year ago, these plans formed a continuing quality relationship with the PRO. This relationship is based on two elements. First, there is continuing interaction between the plans and the PRO, both collectively and individually, on quality issues. Second, the PRO collects data from individual HMOs, compiles it, and then feeds it back to the plans, thereby enabling each plan to compare its own performance to that of all plans in the aggregate. Plans that choose to do so are free to share their data with other plans.

Case Study #1: Mammography Screening and Follow-up. A PRO recently focused on one plan's mammography process in an attempt to improve preventive care breast services in the state. Specifically, the project addressed:

- the degree of compliance with the HMO's mammography screening standard (one per enroll every two years);
- the timeliness in notifying the patient of the mammogram's result;
- the timeliness of follow-up treatment for an abnormal mammogram; and
- the relationship of certain selected patient and provider characteristics to screening compliance, and timeliness of notification and follow-up.

What makes this study unique from other initiatives in this area is that it addresses the critical issues of whether appropriate follow-up occurred after the mammogram (especially if the result was abnormal) and whether the follow-up was in a timely manner.

Since the HMO had no standards in place regarding the timeliness issue, the PRO, in partnership with the plan, agreed on two standards for timeliness: time between administration of the mammogram and patient notification of the results should occur within 14 days; and, follow-up between an abnormal mammogram and resulting biopsy should occur within 42 days after the patient has been informed of an abnormal result.

The study revealed that 40 percent of mammograms had no documented notification date in the medical record. Almost one third (n=120) of the mammograms without a documented notification result had an abnormal reading. Younger women with an abnormal reading were more likely to have no documented notification of results than were women at least 75 years old. Despite this lack of documentation, 69 percent of the 120 abnormal mammograms were followed by surgery.

This study demonstrates great variation in the documentation and timeliness of notification of abnormal mammography results. Even greater variability was encountered in the six independent practice associations (IPAs) (within this managed care plan), especially in timeliness to follow-up surgery. On average, surgery in the plans was performed one week later than the mean of 30 days. The study also revealed that 23 percent of the patients with abnormal mammograms did not have follow-up surgery.

The quality improvement plan resulting from the study included several mass educational efforts directed at providers and enrollees to increase mammography screening. The effectiveness of this effort is currently being evaluated. Other improvements targeted were documentation of patient notification and overall provider practice relative to breast cancer screening, notification and follow-up surgery.

Other ongoing activities PROs perform in conjunction with risk contracts include:

- quarterly monitoring of individual beneficiary complaint logs;
- performing reviews of unexpected deaths;
- serving as a catalyst in improving preventive care services (i.e. mammography);
- comparatively reviewing the management of major diseases (i.e. diabetes); and
- collaborating with plans and providers in four problem areas -- surgical replacement of hips and knees, incontinence, polypharmacy, and depression -- by encouraging adherence to guidelines on the management of care.

Case Study #2: Cataract Surgery. Medicare beneficiaries enrolled in HMOs in a state with a large Medicare population now have greater access to cataract surgery. Recently, the PRO began a statewide quality improvement project focused on cataract surgery.

A beneficiary had called to complain that his HMO denied him cataract surgery. When the PRO reviewed the health plan's pre-certification criteria, it found that it was radically different from criteria used in the fee-for-service sector and from the accepted AHCPR practice guidelines on cataract surgery.

Specifically, the HMO developed indications for cataract surgery based on a patient's visual acuity level were substantially different from the AHCPR guideline recommendation. The PRO notified the HMO of the discrepancy, and the HMO adopted the AHCPR guideline. Taking it a step further, the PRO requested cataract surgery criteria from all the Medicare HMOs in the state and discovered similar problems. To date, three HMOs covering over 250,000 Medicare beneficiaries have changed their criteria to conform to the accepted guidelines.

This study illustrates the benefits of PRO monitoring of beneficiary complaints. This helps the HMOs to develop improvement strategies. Improvements, in turn, generate satisfied beneficiaries preventing "plan hopping" which can result in savings for the Medicare program.

The HCFA Managed Care Pilot Project. As we have already heard this morning, the Delmarva Foundation for Medical Care (Delmarva) -- the PRO for Maryland and the District of Columbia -- together with Harvard University is developing a method for assessing the care of Medicare beneficiaries who receive their health care from HMOs and competitive medical plans (CMPs). Using performance measures developed in a previous Delmarva pilot project -- Developing and Evaluating Methods to Promote Ambulatory Care Quality (DEMPAQ) -- as well as HEDIS 2.0, Delmarva has outlined a set of three "core" measures and 17 measures in one diagnostic-specific module -- diabetes mellitus. A related project, the Ambulatory Quality Improvement Project (AQIP), is developing measures for fee-for-service ambulatory care that will use the same outcome indicators for diabetes. This will, in turn, allow HCFA to make meaningful comparisons between the outcomes of treatment for managed care and fee-for-service patients with diabetes. AMPRA supports immediate pilot testing of these measures prior to national implementation.

The Need for Encounter Data. As noted above, Medicare does not have access to uniform patient encounter data of services provided to its at risk populations. These data are available in the fee-for-service sector and are used to profile and analyze patient care data to identify opportunities for improvement. AMPRA supports HCFA's development of a minimum patient encounter data set that would allow the Medicare program to profile and analyze the care received by its HMO/CMP enrollees and facilitate the identification of improvement opportunities.

CONCLUSION

The HCQIP program is an exciting and dynamic new partnership among beneficiaries, providers, PROs and HCFA to improve the quality of care for Medicare beneficiaries. While still in an early stage of evolution, HCQIP has already demonstrated great potential. Past administrative burdens and regulatory controls have been significantly curtailed, reducing hassles and costs for Medicare providers and allowing resources to be concentrated on enhancing patient care.

Physicians hospitals, and health plans have -- with increased enthusiasm and commitment -- adopted established practice guidelines and protocols that will lead to improved

patient outcomes. Beneficiary education programs have been established to increase choices and the patient's involvement in treatment decisions. Finally, HCQIP has already documented that improved quality of care results in cost savings, for both the Medicare program and providers, from needless procedures averted, to resources better utilized and alternative treatments pursued.

In the last decade, there have been tremendous advances in building the science of quality measurement. There is scant evidence, however, that we have been able to translate practice guidelines, outcomes research, and performance measures into sustained changes in practice behaviors and health care processes. The PROs have demonstrated a unique competency in facilitating and integrating quality measurement concepts and tools at the local physician, hospital, and health plan level through HCQIP. This competency, in turn, has led to measurable change and improvement in health care practices. In addition, the PROs have successfully demonstrated the ability to transport these changes throughout an entire state, across state lines (via multi-state projects), and on a national level.

Mr. Chairman, we appreciate the opportunity to testify and look forward to working with the subcommittee on designing strategies for protecting and improving the quality of health care for all Americans. Thank you.

Chairman THOMAS. I thank the panel very much.

Mr. Ensign.

Mr. ENSIGN. Dr. O'Leary, if you had to structure a quality assurance program for the country, how would the private sector or the public sector fit in structure-wise? In simple terms, where would the funding come in?

Dr. O'LEARY. I think the basic expertise and infrastructure to do this lies in the private sector and I think that is where it belongs. We have a long track record to demonstrate that we do it well. There is also, though, the issue of the social contract between the Federal Government and the public and whether the Federal Government wants to play a role in providing assurances to the public that there is effective quality oversight.

That requires, in my view, at least a minimum of responsibility to assure that there is some agreement on what the standards and performance measures are going to be. I see that as more of a Bureau of Standards responsibility, as opposed to a Health Care Financing Administration regulatory responsibility. Somebody has to set the gold standard to establish comparability, and that, in my view, is something that we have seen work out more or less well in the past with other relationships and is something that is probably needed today.

Absent that, you will have competing evaluators out there; that is not horrible, but it does create some confusion among those who are being evaluated. I think that there is a potential partnership here that can capitalize on the resources and commitment of the private sector and assure accountability on the part of the Federal Government without any intrusive behaviors.

Dr. BEE. I think there are two components to quality evaluation and monitoring over a period of time. Dr. O'Leary and Ms. O'Kane represent the accreditation side, which sets the minimum standards for entry into the game. I think someone has to monitor how the game is being played and I think that that is best done by the private sector.

The PROs are private sector organizations that have contracts with Medicare, Medicaid and in many cases industry and insurers to do just that job. We do not believe that a regulatory approach is very helpful. Obviously, there are times when you have to say to a particular person do not do that anymore, but that is a very small part of the process of quality improvement.

The exciting thing is getting the data that so many of you mentioned this morning, an essential piece in our ability to find out what is going on. Until we find out what is going on, it is very hard to decide what needs to be changed. For us, quality means looking at what is going on, working with the people who are doing the activity, helping them decide what needs to be improved and then helping them monitor, assess, and do it all over again.

The quality improvement tools that have been so successful in industry are definitely applicable to health care and we think that we are doing a pretty good job of beginning the process of evolving the health care system as a whole and continuous quality improvement.

Mr. ENSIGN. You mention 1986 when a lot of this started. How long do you foresee this taking—another 9 years, 20 years, before we feel like we have a fairly decent system in place?

Dr. BEE. We are just beginning to find out how effective the system is. Those of us who get a chance to work with physicians and hospitals find them to be very excited about the prospect of actually having information about what they do. Most doctors have labored their whole professional lives with only a dim idea of what they did, how much of it they did and not a very good idea about the long-term outcomes of it. We are excited to get that information because we think it will help us do a much better job.

Dr. O'LEARY. I might comment that this is a building block activity. We feel pretty comfortable with the performance-based standards that we are using. I think that would be true for NCQA as well. The area of developing performance measures is a newer art form and one that we are engaged in building over time and learning how to integrate that into our basic accreditation process. Ultimately, we should be driving our evaluation systems on the basis of performance data which will tell us where to focus our evaluation activities.

Ms. O'KANE. I think cars are actually a good analogy. We see a system where issues affecting life and limb like the safety of cars and air pollution are regulated. There is available information for consumers on issues like comfort, ease of handling and durability that are not really life and limb issues.

I think that analogy holds in health care as well. There is a role for regulators to protect the consumer from harm and these regulatory processes have been working successfully, but they set a threshold that is very low.

The kind of processes that we have are aiming much higher. Our accreditation process has set standards that were derived from the most demanding purchasers in the private sector. We do not see our standards as appropriate for regulating market entry, but as doing something that might—especially when a plan meets our standards—replace parts of the regulatory process that are redundant. We have had a lot of successful public-private partnerships and we like the idea of working in partnership with the Federal Government as well.

Mr. ENSIGN. One last comment. I would caution everybody in the process that as we get into this data information process, the government sets something up sometimes once rules are in place, once standards are set, that can stop a whole new way of thinking. We can get into a paradigm. Once the Federal Government is involved, shifting that paradigm can be very difficult.

The instances you brought up with EPA and the Clean Air Act, suggesting that we could make some dramatic advances right now if they were not being halted because of certain paradigms that are being developed. This is the way we do it. We cannot do it any other way. I would make that note of caution. Thank you.

Chairman THOMAS. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Miss O'Kane, what percent of NCQA's budget is derived from the Federal Government?

Ms. O'KANE. It is a very minuscule percentage. I can get you the numbers. Most of our revenues come from our accreditation activi-

ties which the health plans pay for, and the rest from foundations. We had a small grant from the Medicaid Program to do a technical assistance document for Medicaid HMOs, about $25,000, so it is a minor—

Mr. CHRISTENSEN. Less than 5 percent, less than 1 percent?

Ms. O'KANE. Less than 1 percent.

Dr. O'LEARY. We are probably pretty much in that range. The contracts that we have are for mostly international service. We have a U.S. AID contract, Department of Treasury contract, a Peace Corps contract, but virtually all our revenues come from services we provide to health care organizations, which include Federal organizations like Federal hospitals. Less than 1 percent.

Dr. BEE. I cannot tell you with much precision because our members vary from those who do virtually no business except under their Medicare contract, to those for whom the Medicare business is less than half of their gross income. The PRO program was a congressionally mandated program to protect Medicare beneficiaries and it is performed under contract with HCFA, so that all of those dollars come out of the Medicare trust fund.

Mr. CHRISTENSEN. My reason for asking is, with all due respect, Dr. Brook requested another $100 million to study, in my opinion, what you are doing pretty much already; is that correct? I guess I want to ask Ms. O'Kane, it is my understanding that HMOs join your organization voluntarily; is that correct?

Ms. O'KANE. They do not join our organization. They pay to become accredited. It is a voluntary accreditation program. It is usually responding to a purchaser mandate, in some cases a State mandate.

Mr. CHRISTENSEN. Why would a company voluntarily submit to such a stringent standard that your organization runs them through as far as analyses, and is there a competitive advantage to having your accreditation versus say some others?

Ms. O'KANE. I think that we have managed to make a name for ourselves among the corporate purchasers who are trying to decide among various managed-care options. I think from the point of view of the health plans, they believe that this accreditation distinguishes them in the marketplace and gives them an edge. That is why they have really come forward.

Mr. CHRISTENSEN. Assuming we do not want a new Federal or State bureaucracy to develop these type of standards, should we try to keep it in the private sector? I know this is a loaded question, but in terms of—I just really have a real suspect of everything government gets their hands into.

Is there any rationale for the government to be doing this testing, to be looking for this information, to be becoming more informed in this area? Is there any rationale why we cannot keep this in the private sector?

I was impressed with Dr. Brook's rationale. But, I am trying to see if there is something in it that I am missing—

Ms. O'KANE. I think there is an important role of the Federal Government in terms of being a purchaser of services for the Medicare and the Medicaid population to be very demanding about the kinds of quality oversight processes that they are counting on to assure the quality of care that those beneficiaries receive. I

think that organizations in the private sector, like ours, need the help of purchasers and the government to keep us honest, by telling us the kind of information they want to have and making sure our processes are working the right way.

When we do reviews for States, sometimes State people come with us on the reviews so that they can have assurances that the process is working well. I think that is an important role. I do think that the government can work in partnership with us and that they need to be a presence, but that much of the work can actually be done very effectively in the private sector.

Mr. CHRISTENSEN. Mr. Chairman, could I have Dr. Bee and Dr. O'Leary also answer that question?

Dr. BEE. I will be happy to send you a 1-page comment by Dr. John Wennberg which explains why very large patient samples are necessary to learn meaningful information. A single HMO with only 1.5 million members such as mine, there are numerous health care questions that cannot be answered even with that large a patient sample. We do need to have some way of collecting very large samples, for example, the HCFA project called the CCP, Cooperative Cardialvascular Project, in which an enormous sample of patients over 65 with myocardial infarction will be studied and from that we will learn what works and what does not. I think that is one reason we need a Federal mandate in some areas.

The Federal Government is also the largest purchaser of health care services in this country. The purchasers of health care must have some responsibility for the payment for the quality monitoring. It is a part of the health care premiums and the government puts in the premiums. They should be a part of the cost of monitoring.

Dr. O'LEARY. I think a lot of this boils down to whether we want to have good information available for consumer choice. If you do, I have to tell you that the hopper is anything but full in terms of having good standardized measures and good risk adjustment systems to account for differences in patient populations. A lot of that work is coming out of AHCPR, the Agency for Health Care Policy and Research right now.

These are important roles—to help accelerate the process to develop good measurement systems and to establish some modicum of standardization. If we decide that we do not want report cards or consumer choice information, then those arguments, I think, in a sense disappear. The government is a major purchaser of care in this system and in that sense has some accountability in its social contract with the public. I would opt on the side of saying that, yes, there is a place for investment but not for any significant regulatory intrusion.

Mr. CHRISTENSEN. Thank you.

Chairman THOMAS. My friend is concerned that the government model will be the DOD in terms of standardization—I do share that concern. However, the other problem that we have is another common criticism of government and we ask do you have a product, when will you have a product? When can we use it? The private sector base is, we got something that is kind of OK.

I was looking at this article from Business and Health entitled, "HEDIS: Almost Ready for Prime Time." You have gone to 2, 2.5,

going to go to 3.0. I assume 5 years from now you will be at 7.5 or a completely rethought structure.

What we like about what you are doing is just do it. We will still be waiting for phase 1. So my questions read to how can you help us?

All of you were very cautionary about the size of the purchasing agent that we represent here in terms of health care, and we are going to play a major role, but I want to focus on the database which is obviously critical. Could Medicare play some kind of a helpful role in establishing criteria or uniformity for the collection of data? Or two, do we really need a complete national uniformity on the database or could we operate with a regional structure? Anyone?

Ms. O'KANE. Since you have mentioned HEDIS and 7.5, I want to jump in. There is an issue with people in the quality field. The issue is that the best is sometimes the enemy of the good and I think that we tie ourselves in knots sometimes to say, well, this isn't really the end point of where we need to be.

In doing that, we undermine the value of what we have done and I think that may be the case with HEDIS. I think HEDIS provides us with a lot of valuable information. We have a lot more information on health plan performance today than we did 3 or 4 years ago and I think we will move ahead. The information from our accreditation program also provides a lot of useful information.

Dr. O'LEARY. I would plead to not standardize the database, please. That is not a good government role. I think by contrast what would be helpful is some agreement on the criteria against which we will determine whether a measure is any good or not.

Another thing that would be useful is some agreement on good risk adjustment systems. These are resource kinds of issues that help the private sector come together more quickly in delivering the goods that everyone wants.

Chairman THOMAS. You are asking for decisions on the part of the government that is akin to making decisions on who gets the organ—whether or not—you are dealing with qualitative decisions in terms of what is good or not. One of the ways that we are going to have to be able to make a decision on what is good or not is to have a solid database from which to make those decisions. Are we going to rely on the private sector database or have confidence about the base to make the decisions about what is good?

Dr. BEE. One of the roles the government has is to arrange the world in such a way that we can do the things that need to be done without being regulated into them. We do not want uniform standards for data collection cast in stone because we are not sure which ones are useful. It needs to be a continuously improving process and government is not very good at that.

It is important as we talk about managed care that we realize that the vast majority of managed care in this country is not delivered in a nice Kaiser clinic somewhere. We have a million and a half members in our company and only 23 percent of them are cared for in a staff model clinic. The rest are seen in private doctor offices that have to contend with up to 23 other HMO contracts in Southern California, each of whom may want to pull a sample of

charts and evaluate the indication. When I was a practicing physician, that was kind of an aggravation.

One of the things the government needs to do is, to help do whatever it takes to make the game more efficient, so that we can collaborate, perhaps only one team has to come to my office to collect the information once a year for all health plans. These are areas of improvement that will reduce aggravation to practicing physicians and certainly the cost of doing business.

Chairman THOMAS. Hopefully, the Federal Government could be a coordinator and facilitator. That was rather frustrating in the 103d Congress. We did nothing in the area of uniform malpractice or insurance structure to assist the progress that was being made. At the very least, we hope we can play that sort of role.

Let me ask another question. Ms. O'Kane, since you are dealing with private sector folk, to what extent would it be helpful to focus on or emphasize on a more seamless approach to moving people from the workplace into a retirement health structure? Since the workplace is more and more becoming a managed-care world, we could create a seamless structure where employers who now pick up medigap on some retirees and others, they could be the basis for evaluation.

Do you have any program, thrust, interest, direction in looking at employers dealing with retired folk and what seems to be working?

Ms. O'KANE. Yes. This is an area of interest, but I do not have much light to shed in terms of our direct experience. I think Bruce Vladeck mentioned that we have been having discussions with HCFA about doing some Medicare HEDIS. Part of that, is to bring some of the employers in; employers who have large retiree populations would be key players.

On the issue of standardization, I sort of ducked on the second part of your question inadvertently. I think it is important to say that we have achieved a real degree of success with standardization of performance measures already because there is such a demand for it among the large corporate purchasers. They find that it is really impossible to make comparisons among plans in order to do value purchasing if they do not have standardized information. However, that does not mean that there should not be local ability to ask questions that might be relevant to the local population, and so forth.

Chairman THOMAS. My concern is that as we move more into the question of managed care for a senior population, that I want to make sure that we have an anchor to the real world and that it isn't just government bureaucracy setting up standards and structures to make decisions which attempt to capture reality in a bottle, which is one of the bigger problems I have right now with Medicare, and the real world is rapidly leaving us and we are not tied to it more and more. My concern is how we transition.

Ms. O'KANE. That is an area where we can point with pride at what we have done in terms of being able to broker discussions between the stakeholders in managed care organizations and the managed-care organizations. We are trying to come to a common definition of what do we mean by quality and measuring it in a very specific way.

Dr. O'LEARY. The Joint Commission has pretty extensive home care and long-term care accreditation programs, and those are stand-alone activities, but those are also component to our health care network accreditation program as well. So, there are mechanisms already in place to look at that population.

Dr. BEE. The Health Care Quality Improvement Program that Medicare has instituted for the PROs mandates that we look at care in all sites, including the home care, office care, and so forth, an expanding area. I know Mr. Christensen is concerned that we not throw good money after previously spent money in looking at these issues.

Medicare has invested a couple of billion dollars in review over the last 10 years and has built a structure of organizations that are capable of doing this kind of analysis, this feedback loop, the retraining of physicians hospitals and the community.

The PROs are extremely active in dealing with the beneficiary community to teach them how to use the system, how to prevent disease and most important, how to choose wisely between various treatment alternatives so that their true needs are met.

Chairman THOMAS. I thank the panel. I know you will continue to just do it—

Ms. O'KANE. Might I comment? I want to second Dr. O'Leary's plea for the idea that there really is a need for more development in the measurement area and that that is something that our organizations alone cannot fund. We think that there is an important role and that the government has played a very constructive role in that area in the past and we hope will continue to do so in the future.

Chairman THOMAS. To provide you resources to assist you in going forward over the next several years, hopefully you will provide us with an ability to not commit some of the mistakes you have made, and to not go off in directions that are not useful.

Thank you very much for the private sector going ahead and getting the job done. Thank you very much.

The last panel, Dr. John Nelson, a member of the board of trustees, American Medical Association; Gail Warden, president, chief executive officer, Henry Ford Health System on behalf of the American Hospital Association; William J. Osheroff, M.D., vice president, medical director, PacifiCare of California on behalf of the Group Health Association of America, and Beatrice Braun, board member, American Association of Retired Persons.

Your written statements will be made part of the record without objection. You may address the Subcommittee for 5 minutes.

Dr. Nelson.

STATEMENT OF JOHN C. NELSON, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. NELSON. Thank you, Mr. Chairman. I am John C. Nelson. I am a practicing obstetrician and gynecologist in Salt Lake City, Utah, where I also serve as deputy director of the Utah Department of Health. I was vice president of UPRO, the Utah's Peer Review Organization, for 5 1/2 years. Currently, I am on the board of trustees of the AMA, American Medical Association. On

behalf of the AMA, I would like to thank you for allowing us to testify.

The AMA applauds your leadership in examining Medicare and private sector health care quality assurance. My remarks today will focus on key aspects of these Medicare PRO programs.

In 1992, the Health Care Financing Administration unveiled the Health Care Quality Improvement Initiative and drafted the PRO Fourth Scope of Work. My own PRO in Utah and the AMA were instrumental in helping to conceptualize the Fourth Scope of Work to move away from a punitive approach and toward an educational approach. This scope of work fosters quality improvement.

Traditional quality assurance is punitive, guarantees the status quo and stifles innovation. However, quality improvement is educational, innovative and adds value to the health care which patients receive.

The AMA was pleased that significant improvements were made to the Fourth Scope of Work due to the input of practicing physicians. We were also pleased at HCFA's responsiveness to our recommendations. The Fourth Scope of Work has resulted in an increased level of collaberation among PROs, hospitals, and physicians on quality improvement efforts. In 1994, the initiative evolved into the current Health Care Quality Improvement Program.

HCFA announced last year that the data collection system that was under development to review the quality of hospital care provided to Medicare patients would be replaced with the MQIS, Medicare quality indicator system.

MQIS is a system of indicators used to measure the quality of care provided to Medicare patients.

The real concern of the AMA has always been the quality of care that our patients receive and the relationship between patients and the physicians who care for and about them.

We have appreciated the opportunity to work with HCFA to ensure quality improvement. The AMA has historically sought to play an active role in any public or private sector efforts to develop medical quality and performance standards. We have a critical interest in monitoring HCFA's refinement of the MQIS. It is essential that practicing physicians remain involved in the evaluation and implementation of these Medicare quality indicators.

Most efforts to review the quality of care that Medicare beneficiaries receive have been focused in the hospital setting. It should be noted that numerous, if not most, patient encounters occur in the physician's office and other ambulatory settings. Congress enacted legislation in 1986 requiring the program to develop methods for reviewing these ambulatory settings. To meet this requirement, HCFA developed the ACQIP, ambulatory care quality improvement project. ACQIP is a quality improvement approach to reviewing care provided in physicians' offices.

The two studies involved PROs in the States of Alabama, Iowa, and Maryland. The study is initially focusing on testing quality indicators for diabetes and volunteer physicians are being used to test the quality indicators developed. Inasmuch as this methodology is experimental, the AMA believes that any type of physician office review must be targeted or done on a pilot basis. It is crucial

that such review be nondisruptive to patients and allow for the smooth operation of office procedures. The AMA supports the cautious approach that HCFA has taken. We believe that projects such as ACQIP that focus on quality of care will prove to be useful. We caution, however, that benefits of ambulatory review as well as any review should be used to encourage and improve innovation and quality; not divert a physicians' ability to care for patients. HCFA currently is in the process of developing the PRO Fifth Scope of Work for the 3 years between 1996 and 1999. HCFA plans to continue to emphasize its educational and nonpunitive approach that was initiated under the Fourth Scope of Work.

The AMA is pleased that HCFA has actively sought the involvement of physicians in several national projects. However, concerns have arisen in several locations over the basis on which PROs select quality improvement projects. We encourage PROs to include State medical associations, specialty societies, and the local medical community to a greater extent.

We discussed our concerns with HCFA. We discussed our concerns with HCFA. We understand that a Fifth Scope of Work will require each PRO to choose many of its quality improvement projects from an array that has been selected by HCFA. We hope that such a provision will help to strike an appropriate balance between projects that have demonstrated validity and the need for PROs to have the flexibility to address the quality concerns that are locally based.

Mr. Chairman, it is important to note that some PROs have not historically had a history of positive relationships with physicians or other health care providers. Their traditional quality assurance, or a "bad apple" approach, has in the past created a tension between partnership with physicians and regulation.

Nevertheless, during the past 2 years physicians have reacted in a very positive fashion to refinement in the Medicare PRO program. A public-private partnership is key to developing and implementing a successful quality improvement initiative for our patients. The AMA intends to continue to monitor closely and actively participate in the future direction of this program.

As the Subcommittee continues its efforts to reform the Medicare Program and the current health system, we urge you to use the significant improvements that have been made in this program as an example of potential for positive change. The AMA looks forward to continuing its partnership with you, our patients, the Congress, and the administration to improve the quality of care further. At this point, I would be pleased to respond to any questions that you might have. Thank you very much.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives

RE: Medicare Peer Review Organization (PRO) Program

Presented by John C. Nelson, MD

March 21, 1995

Mr. Chairman and Members of the Subcommittee:

My name is John C. Nelson, MD. On behalf of the American Medical Association (AMA), I would like to thank you for the opportunity to testify before you this morning. I am a practicing obstetrician and gynecologist in Salt Lake City, Utah, and also serve on the Board of Trustees of the AMA. The AMA applauds your leadership in examining the important issues relating to Medicare and private sector health care quality measurement, assurance, and improvement. My remarks today will focus on several aspects of the Medicare Peer Review Organization (PRO) program.

PRO FOURTH SCOPE OF WORK

In 1992, the Health Care Financing Administration (HCFA) unveiled the Health Care Quality Improvement Initiative (HCQII) and drafted the PRO Fourth Scope of Work, which outlined the medical review requirements for PROs beginning April 1, 1993. Under this scope of work, PROs have responsibility for examining variations in the processes, outcomes, and quality of care, and for sharing relevant data gathered with hospitals and physicians. Pursuant to the Fourth Scope of Work, the PRO program experienced a fundamental and positive change in which PRO review was to be based on concepts of continuous quality improvement. The program was redirected away from a punitive approach that addressed individual clinical errors and toward an educational approach in which PROs analyze patterns of care and outcomes and, in turn, share this information with physicians and hospitals to identify potential means to achieve the best success rates in improving outcomes and quality of care. In placing a greater emphasis on physician and provider education, PROs are required to hire a physician to serve as a principal clinical coordinator. The coordinator works directly with local hospital staffs on national and local PRO-initiated cooperative projects.

The AMA worked closely with HCFA in drafting the Fourth Scope of Work. We were pleased that significant improvements were achieved due to the input of practicing physicians and HCFA's responsiveness to our recommendations during the development of the scope of work. For example, under the Fourth Scope of Work, HCFA:

- Eliminated the punitive and highly offensive Quality Intervention Plan point system, with a more educational review process to improve the quality of care to Medicare patients. The objectives of the new process were to identify quality concerns and deficiencies in rendered care; assess the causal relationship between the deficiencies and an adverse outcome; determine the source of quality concerns; and identify physicians, hospitals, and statewide problems on which to focus educational feedback efforts to improve the quality of care;
- Significantly decreased the volume of individual case review in favor of profiling and

pattern analysis;

- Required PROs to request and consider comments from state medical associations when formulating new review criteria, as well as to distribute any revised criteria to the medical community at least thirty days prior to implementation;

- Required that physician reviewers must be licensed in the state where the services under review are performed, have active staff privileges in at least one hospital in the PRO area, be active in practice at least 20 hours per week, and care for Medicare beneficiaries on a routine basis;

- Required that PROs must utilize consultants in active practice in relevant specialties when drafting new review criteria or changing existing criteria; and

- Required PROs -- for the first time -- to allow physicians to request a reconsideration of a final notice of a quality concern determination.

Physicians have had, in large part, a positive reaction to the PRO Fourth Scope of Work. It should be noted that there also has been an increased level of collaboration among PROs, hospitals, and physicians on quality improvement efforts. Hospital and physician complaints regarding PRO review have decreased significantly as well.

In 1994, HCQII evolved into the Health Care Quality Improvement Program (HCQIP). HCFA has stated that the program's mission is to promote the quality, effectiveness, efficiency, and economy of health care services provided to Medicare beneficiaries. In short, the program continues to move away from traditional inspection-based quality control and toward internal quality improvement using pattern analysis. The AMA continues to support the educational, non-punitive redirection of the Medicare PRO program as the program proceeds to evolve.

Medicare Quality Indicator System

The Uniform Clinical Data Set (UCDS) was a data collection and case finding system that had been under development by HCFA since 1988 to review the quality and necessity of hospital inpatient care provided to Medicare beneficiaries. HCFA had originally intended to implement UCDS during the period covered by the Fourth Scope of Work, which ends in 1996. Throughout its development, however, UCDS was plagued by a number of problems, including early results showing that UCDS had a much higher "false positive" quality referral rate than traditional nurse review, and concerns that UCDS and its 1600 data elements would be too costly and cumbersome to implement fully. Accordingly, in 1994, HCFA announced that UCDS would be replaced with the Medicare Quality Indicator System (MQIS), a system of indicators used to measure the quality of care provided to Medicare beneficiaries. The AMA believes that replacement of the UCDS with the MQIS is a positive development.

HCFA has stated that the MQIS will provide a basis from which to design improvement projects, track national trends, and possibly certify institutions for participation in Medicare. HCFA has indicated that projects evolving from MQIS should be able to combine statistical interpretation of Medicare data with effective feedback to the health care community to promote improvements in patient care and outcomes.

HCFA is attempting to develop its indicators based on existing practice parameters developed by the Agency for Health Care Policy and Research and the national medical specialty societies. Last summer, HCFA convened an expert panel to provide feedback on the strategy to establish and implement quality indicators. The AMA was invited to participate in the panel's deliberations, along with representatives from the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, the American Medical Peer Review Association, and the Agency for Health Care Policy and Research.

HCFA developed quality indicators for acute myocardial infarction as part of what has become known as the Cooperative Cardiovascular Project (CCP). Based primarily on practice parameters developed by the American College of Cardiology, these quality indicators were tested by PROs in Alabama, Connecticut, Iowa, and Wisconsin, and represent the first MQIS project that will be implemented at a national level by all PROs during 1995. The AMA coordinated periodic meetings of a CCP planning group to oversee the development of these quality indicators. The group included physician researchers, representatives of select national medical specialty societies, and representatives of the hospital, PRO, and beneficiary communities. The medical profession was involved in a consensus process to develop quality indicators based on practice parameters developed by physicians.

The AMA has always sought to play a significant and active role in any public or private sector efforts to develop national medical quality and performance standards. The AMA has a critical interest in monitoring HCFA's ongoing development and refinement of MQIS. It is essential that practicing physicians and physician organizations representing medicine remain involved in the evaluation and implementation of Medicare quality indicators. We will continue to urge national medical specialty societies and state medical associations to use their expertise and resources to help HCFA refine and strengthen these indicators.

Evaluation of PRO Program

HCFA has initiated a strategy for evaluating the effectiveness of the PRO program under the Fourth Scope of Work to provide guidance in the development of an evaluation strategy. HCFA created a workgroup in 1993, composed of representatives from HCFA, the AMA, the American Hospital Association, the American Association of Retired Persons, and the PRO industry. The Institute of Medicine was also asked to establish a committee of health care experts and business and consumer groups to conduct an independent review. The PRO program evaluation plan will attempt to: (1) build a community of individuals and groups committed to improving quality; (2) monitor quality of and access to care; (3) improve quality of and access to care; (4) communicate with beneficiaries and providers to promote informed health choices; (5) protect beneficiaries; and (6) develop an infrastructure conducive to HCFA's evaluation strategy. HCFA intends to complete and issue an evaluation report on the PRO program in September of 1995. The AMA is pleased to be a part of this evaluation process.

AMBULATORY CARE QUALITY IMPROVEMENT PROJECT

In 1986, Congress enacted legislation requiring the program to develop methods for, and to implement review in, ambulatory settings. To meet this requirement, HCFA developed the Ambulatory Care Quality Improvement Project (ACQIP). ACQIP is a multi-PRO cooperative project that began on July 1, 1994. It is the operational follow-up to the research-oriented project known as DEMPAQ, Development and Evaluation of Methods Promoting Ambulatory Care Quality. DEMPAQ focused on education and feedback to physicians based on two review methods -- medical records information and Medicare claims profiling to assess the quality of care provided to Medicare patients in physician offices. Performance measures for DEMPAQ were based on three key principles: quality review rather than utilization review; open development of performance measures versus a "black box" approach; and focus on practice patterns and corresponding feedback versus individual performance errors. Records-based performance measures were based on activities that physicians typically perform during an office visit, and claims performance measures were grouped into three types of profiles: condition-specific, office-practice, and preventive-care services.

ACQIP is a quality improvement approach to reviewing care provided in physician offices. The two year study involves PROs in the states of Alabama, Iowa, and Maryland and is initially focusing on testing quality indicators for diabetes mellitus. Volunteer physicians are being used to test the quality indicators developed. Physicians participating in the project will be provided with their profiles and aggregate data. The participating PROs will also provide education on appropriate care for diabetes to the Medicare beneficiaries in these states.

The AMA believes that any type of physician office review must be targeted and focused. It is crucial that such review be nondisruptive and allow for the smooth operation of office procedures. As a result, the AMA supports the cautious approach that HCFA has taken in attempting to develop an ambulatory review methodology, and the AMA believes that projects such as DEMPAQ and ACQIP that focus on quality of care issues will prove to be useful. While the AMA has been pleased with the improvements in implementation, we have had and continue to have major concerns regarding the benefits of ambulatory review measured against the significant regulatory burdens that would result.

PRO FIFTH SCOPE OF WORK

HCFA is currently in the process of developing the PRO Fifth Scope of Work that would encompass the three year period between 1996 and 1999. Under this scope of work, HCFA plans to continue to emphasize the educational, non-punitive approach that was initiated under the Fourth Scope of Work.

While the AMA is pleased that HCFA has actively sought the involvement of physicians in several national projects, concerns have arisen in several locations over the basis on which PROs select quality improvement projects and the degree to which they involve state medical associations, specialty societies, and the local medical community. The Fourth Scope of Work specifically directs PROs to meet with physician representatives on a regular basis to discuss the concerns of the local medical community and the development of quality improvement projects.

We have discussed physicians' concerns with HCFA, and we understand that the Fifth Scope of Work will require each PRO to choose many of its quality improvement projects from an array that have been selected by HCFA. We hope that such a provision will help to strike an appropriate balance between projects that have demonstrated validity and reliability and the need for PROs to have the flexibility to address quality concerns that are more regionally or locally based. We also continue to advocate to HCFA that PROs must work closely with state medical associations and representatives of local medical communities in the selection and development of educational materials that would be disseminated to Medicare beneficiaries.

The AMA urges both the subcommittee and HCFA to ensure that physicians be directly involved in the ongoing refinement of the PRO Fifth Scope of Work so that the positive movement that has been made in the PRO program during the past two years continues in the future.

FUTURE OF THE PRO PROGRAM

As the Subcommittee considers options to transform the Medicare program and to provide for incremental reforms of the current health system, we would like to underscore the AMA's support for the educational, non-punitive direction of the PRO program and for the opportunity for practicing physicians to provide input into numerous aspects of the program. Physicians must continue to play an active role in any public or private sector effort to develop national medical quality and performance standards.

The AMA urges the Subcommittee to consider the following important principles as a guide in the development and evaluation of any quality and performance standards, if coupled with either Medicare transformation or health system reform efforts. Standards and measures shall:

(1) Have demonstrated validity and reliability;

(2) Reflect current professional knowledge and available medical technologies;

(3) Be linked to health outcomes and/or access to care;

(4) Be representative of the range of health care services commonly provided by those being measured;

(5) Recognize the informational needs of patients and physicians;

(6) Recognize variations in the local and regional health care needs of different patient populations;

(7) Recognize the importance and implications of patient choice and preference;

(8) Recognize and adjust for factors that are not within the direct control of those being measured; and

(9) Respect and enforce patient and physician confidentiality.

In addition, data collection needs related to standards and measures should not result in undue administrative burden for those being measured.

CONCLUSION

PROs have not historically had a history of positive relationships with physicians or health care providers. Their continuing responsibility for protecting beneficiaries has in the past created a tension between partnership and regulation. Nevertheless, during the past two years, physicians have reacted in a very positive fashion to refinement in the Medicare PRO program. A public/private partnership is key to developing and implementing a successful, broad-based quality management initiative. The AMA intends to continue to closely monitor and actively participate in the future direction of this program.

As the Subcommittee continues its efforts to reform the Medicare program, we urge you to use the significant improvements that have been made in the PRO program as an example of the potential for positive change. The AMA looks forward to continuing its participation in a partnership with patients, the Congress, and the Administration to further improve the quality of care.

Chairman THOMAS. Thank you, Dr. Nelson.
Mr. Warden.

STATEMENT OF GAIL WARDEN, PRESIDENT, HENRY FORD HEALTH SYSTEM ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. WARDEN. On behalf of the American Hospital Association, its 5,000 institutional members and 50,000 individual members, I am here today both as chairman of the board of trustees and, of course, as president and chief executive officer of the Henry Ford Health System.

Our organization represents a broad range of institutions ranging from independent community hospitals, to health care systems, to fully integrated provider networks, and also represents organizations like my own which have not only large delivery systems, but large managed-care plans as part of the organization.

We, in almost every case, represent organizations that have a lot of pluralism in terms of the financing of health care. Most of us have some managed care, some have a lot of managed care, and all have some or a lot of fee-for-service patients. We believe that in the environment we are now operating in, intense private sector competition will continue for the immediate future, and a restructuring strategy built on coordinated care represents the best window of opportunity to do better from a quality and patient satisfaction standpoint, and to save money.

I would like to make three important points. First, hospitals and health systems believe a high level of accountability for quality can be achieved and that the Federal Government has a right to expect it. Second, coordinated systems are the foundation for high quality care with much improved cost performance and patient satisfaction. Third, we believe the Medicare Program can learn a lot from what has happened in the private sector in the last few years.

Our organization has a very strong commitment to accountability to our various constituencies and to the public and we believe there are four key factors that relate to that accountability. First, our ability to demonstrate the ability to deliver high quality care. To do that, we believe that there has to be initially a credentialing and licensing activity, there has to be board certification of physicians, there has to be Medicare certification and there has to be a focus on standards needed or coordinated care delivery models that combine inpatient, outpatient and preventive activities under forms of bundled payment, including capitation.

Currently, hospitals and health plans are subject to review by both the Joint Commission on Accreditation of Health Care Organizations, licensing agencies and, of course, if we have health plans, the National Committee for Quality Assurance. We believe revisions of the Health Care Financing Administration's standards in proposing changes to conditions of participation for hospitals were a positive change, as were the changes made in the PRO system.

The second factor is in performance improvement, which involves a highly disciplined examination of clinical processes. In our opinion, the improvement of clinical processes is where the real op-

portunity for economic discipline exists, finding new ways to eliminate waste, duplication and failure to manage episodes of illness.

Like a number of other speakers today, I believe much of this is built on the concept of continuous quality improvement as an approach to quality in our member institutions, combined with benchmarks and best practices that have been developed across the country and shared in networking between these institutions.

Third is our belief that coordinated care brings opportunities to measure and improve the continuum of integration of care, using such systems as CRISP, the Consortium on Research and Indicators of System Performance, which measures about 26 indicators in comparing performance and quality across 19 different health systems.

We also believe that the kind of networks that have been formed by GPIN, the group practice improvement network, where they share clinical process improvement changes, are great opportunities for us to improve quality and patient satisfaction, also that accountability means providing the information that we have available. We believe the expanded use of the HEDIS data set and other similar kinds of programs that are going to focus on not only just quality, but also the opportunity for improving performance in such areas as immunization rates are important.

Finally, in the area of coordinated care, we believe that the challenge that we have before us is the opportunity to manage the entire continuum of comprehensive health services—through coordination within the same organization and through networking of provider systems.

As that occurs, the lessons that we have learned from the Agency for Health Care Policy and Research are important tools for us to be able to begin to improve outcomes. We also believe that there is a lot to be learned in the private sector in terms of what has happened in the last few years for not only controlling costs, but improving quality.

We refer you to the CBO projection that a shift from fee-for-service health care to coordinated care in Medicare and Medicaid would reduce service utilization by approximately 8 percent. Because it offers a full range of services with bundled payment, coordinated care improves the clinical processes and can achieve cost reduction and patient satisfaction.

We believe that there are some important lessons to learn from the private sector. I think the most important one is that the Medicare Program is the largest purchaser of health care services and as such should take some of the same approaches to purchasing health care services from providers across the country that the private sector does.

I think that as they do that, they have a right to expect certain standards of quality. They have a right to expect certain standards of the sharing of information, and also should be expected to provide the right kinds of information to consumers so that consumers will have the same kinds of information that employers receive from providers. If the Medicare system takes a prudent purchaser kind of approach, I think that the beneficiaries will benefit, the providers will benefit, and it will be a more cost-effective system. Thank you very much.

[The prepared statement follows:]

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the United States House of Representatives
on
Medicare and Private Sector Health Care
Quality Measurement, Assurance and Improvement

March 21, 1995

Mr. Chairman, I am Gail Warden, president of the Henry Ford Health System in Detroit and chairman of the board of trustees of the American Hospital Association (AHA). I am pleased to testify today on behalf of AHA's 5,000 institutional and 50,000 individual members.

Hospitals and health systems are partners with Medicare -- the nation's largest purchaser of health care -- in serving the health care needs of the nation's elderly. AHA is grateful to share the expertise of its diverse membership, whose everyday efforts to improve the quality of the health care system illustrate the types of change Medicare should undergo in the coming years. Our membership encompasses a wide spectrum of health provider organizations: individual hospitals, health care systems, and fully integrated provider networks. These organizations were some of the first to use quality assurance techniques that are commonly discussed today, such as quality improvement, credentialing, consumer satisfaction surveys, and performance reports.

I am here today to share with you our experience. My goals are threefold. To show:

Coordinated care systems are the foundation upon which high quality care can be built.

Medicare can learn from the private sector's experiences in achieving and measuring quality.

How a high level of quality can be assured.

QUALITY THROUGH COORDINATED CARE

The foundation for building a higher quality health care system is coordinated care. When health care purchasers and providers are responsible for the full continuum of care -- from pre-natal services to long-term care -- they can track an individual's overall health status or follow a patient through an entire episode of care.

The new integrated delivery systems that providers, insurers, and employers are building can achieve a high level of quality because they can answer questions about everything from preventive services to surgical processes; they can take responsibility for the quality of the providers they select; and they can help people navigate the often-complex maze of medical decision making. For consumers, this means better, more efficient care from a system that is easier to understand -- a marked improvement over the fragmented and sometimes duplicative traditional health care delivery system.

For Medicare beneficiaries, coordinated care means greater ability to meet their needs and to deliver preventive care. More and more, coordinated care is covering all Medicare services, plus coverage for vision, dental, preventive services and even hearing aids -- benefits that most "Medigap" policies don't provide. Many coordinated care plans eliminate the 20 percent co-payment seniors must pay for doctor visits, and at the same time eliminate mountains of claim forms. These may be key reasons why a survey conducted by the consulting firm of Frederick/Schneiders for AHA found that Medicare enrollees in coordinated care plans are as satisfied with their overall care as those in traditional fee-for-service.

Most importantly, coordinated care networks can bring Medicare beneficiaries a connected health system, with everyone who provides care -- doctors, hospitals, nurses and others -- linked together and communicating with each other at every stage of treatment and service.

Moving the Medicare program toward coordinated care is an idea that makes sense and is one that many people believe will not only improve quality but also save money. According to the Congressional Budget Office (CBO), a shift from fee-for-service health care to coordinated care in the Medicare and Medicaid programs would decrease the use of medical services by an average of 8 percent.

MEDICARE CAN LEARN FROM PRIVATE SECTOR

As the largest single purchaser of health care services in this country, Medicare should take advantage of the opportunity to emulate the successes and avoid the pitfalls of the private sector's recent innovations. The provider arrangements and mechanisms for quality assurance and improvement that Medicare encourages will have a tremendous impact on how all such services are designed.

What lessons have private sector purchasers taught us? They began by trying to find the best value. Worried about costs, employers looked for health plans that could deliver services efficiently, but also answer their questions about quality. Haltingly at first and later more boldly, they urged their employees -- their "beneficiaries" -- to change plans, and sometimes to change providers. And while they found some initial employee resistance, acceptance and satisfaction grew. The search for more efficient, high-quality care has continued to lead more people into coordinated care.

Purchasers also found they have the power to affect the quality of service that is delivered. Large employers have helped create a high standard of care by requiring health maintenance organizations they contract with to be accredited by the National Committee for Quality Assurance. Medicare has also encouraged providers to achieve a high performance level through a private accreditation organization -- the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). When hospitals and other facilities are JCAHO-accredited, they are "deemed" to have met the Medicare program's conditions of participation -- standards that must be met before they can receive reimbursement from Medicare.

In addition, at the local level, business coalitions are taking a greater interest in quality by encouraging plans and providers to share information on such things as consumer satisfaction, preventive care and use of medical services.

However, as coordinated health plans took root around the country, opportunities arose for some to profit by not delivering sufficient care. Along with greater efficiency came health plans that expected people to drive long distances for care. Along came the "utilization review overseers" who sometimes went too far in suggesting that a particular treatment wasn't necessary. And along came shorter "lengths of stay" as an indicator of quality, even though it can often be argued that a longer stay means better care. In other words, some managed "care" plans did little more than manage "costs."

A health plan with an effective quality accountability process in place would avoid these pitfalls. As more beneficiaries choose coordinated care systems, the Medicare program can

also avoid these pitfalls by creating processes to assure accountability for quality. I'd like to share a framework, developed by hospitals and health systems, for doing just that.

A FRAMEWORK FOR MEASURING QUALITY PERFORMANCE

Once health care systems have the organizational structure in place to deliver services, how can they demonstrate and measure the quality of service they provide? Our members have found that there are many layers to this question, and have identified a four-part strategy to help health plans and providers measure their quality performance:

> **Demonstrate the ability to deliver quality care** -- A plan or provider must demonstrate that the necessary structures to assure quality care -- including physical plant, equipment, personnel, financing, quality assurance process, and credentialing procedures -- are in place before even opening its doors.
>
> **Improved performance** -- once the doors are open and services are being delivered, is there an ongoing process to look at how well the system is working?
>
> **Provide information for choice** -- Health networks and providers should look at how delivering care affects the individuals who receive it. This will drive people's choices about plans, providers and treatment options.
>
> **Improve the health of the community** -- Finally, the system must be able to answer questions about its effect beyond just individual service delivery -- in other words, how has it improved the health of the community?

Demonstrate the ability to deliver quality care

Currently, hospitals and health plans are subject to review by organizations like JCAHO and various state licensing agencies. Medicare conditions of participation are another example of standards that establish an organization's ability to provide quality care. These processes have traditionally focused on specific facilities. In the evolving health care climate, however, certification standards must do more than certify a single facility or organizational structure. They must also look directly at patient care, at coordination between providers, and focus more on the results of caregiving.

There cannot be a true focus on the patient when only one part of the patient's care is being addressed. As more and more episodes of care and prevention of illness are shared by different providers, it is critical to deal with the coordination among those providers -- both practitioners and facilities, and fully integrated health maintenance organizations. Technical quality of care at one site is just part of the puzzle. The pieces must be put together so they present a complete picture of what happens to the patient. The revisions the Health Care Financing Administration (HCFA) is proposing to their conditions of participation for hospitals, and changes in JCAHO standards a few years ago, went far in moving the focus onto the patient.

Both efforts attempt to move toward looking at how patients experience care by including new requirements for hospitals in such areas as patient rights and initial patient assessment. This is a good step forward, but these and other efforts to establish minimum standards should move further towards considering all aspects of a patient's care.

Improve performance

There are three ways to measure the performance of a hospital or health system: clinical expertise; the result of care; and the patient's perception of or satisfaction with that care. Every health provider or system should have an internal process to identify which practices and services need improvement, as well as which are exemplary -- "best practices," as they are called in the health field. Once this information is in hand, it should be shared with practitioners and others who are in a position to use it to improve services.

While this is primarily an internal process, hospitals and health systems recognize the need for external organizations to help them compare their performance with similar delivery systems. We see this as a potentially more positive role for the traditional Peer Review Organization (PRO).

Historically, the PROs have focused on individual clinical errors and used that information for payment denials or other punitive actions. HCFA has recognized that, in a new era of health care delivery, a more effective approach is called for. It has re-designed the PROs into the Health Care Quality Improvement Program. The new program focuses on patterns and outcomes of care, and uses this information to educate providers. Though they will always be known as PROs, there is a radical difference from the old PRO program. The new program is an effort to move the PROs from a punitive role toward a new, collaborative partnership with local providers.

We applaud this change, but we also recognize that it is a dramatic change and a challenging one for the PROs. For it to be successful, the PROs must work in partnership with providers from the identification of a problem or best practice, to the completion of the quality improvement loop: sharing relevant information with the individual practitioners it can benefit. Performance measures should not be merely be imposed on providers, but developed with them at the local level. HCFA's new approach will be successful if it complements and enhances the internal improvement process.

Many performance improvement efforts focus solely on clinical expertise. While we do not want to move totally away from technical performance, it is important to recognize the experiences and perceptions of individual patients as well. This brings us to the other areas of performance improvement -- the functional result of care, and consumer satisfaction measures. For example, looking at how soon a patient can walk after hip replacement is as important as how well the physician does the operation. So is how patients felt about how they were treated. Increasingly, consumer focus groups have revealed that people's perceptions of how they were treated is an important measure of the quality of their care.

Provide information for Choice

The third part of the quality strategy is to provide consumers with useful information to choose plans, providers and treatment options. Many of the current efforts to develop information useful for choosing plans came as a result of purchasers looking for ways to compare plans. The National Committee for Quality Assurance has been a leader in this area. It has coordinated a joint process among purchasers and health plans to develop useful measures for choosing health plans -- the Health Plan Employer Data Information Set (HEDIS). HEDIS looks at such things as immunization rates, provision of prenatal care, asthma inpatient admission rates and financial systems that help employers compare the quality of different plans.

Individual consumers, however, need different measures. If they're healthy, they want to know what the plan costs. If they've got diabetes, they want to make sure the plan has doctors experienced in treating their disease. They want to know where they have to go for treatment, and if other people are happy with the plan.

Efforts to develop useful information for individual consumers are in their infancy. As they evolve, it is important that the needs of individual consumers be considered separately from those of group purchasers.

Hospitals and health systems have extended the definition of "choice" to also emphasize the choices people make after they're in a health plan. We believe the most important consumer choices are not just the occasional decision on a health plan, but ongoing, everyday decisions about health -- decisions that many individuals feel at a loss about how to make. For example, how does an individual choose the treatment that is best when there are several options with different outcomes?

The Picker Institute, a non-profit service organization operating with support from the Commonwealth Fund, is a pioneer in this area. The institute was founded to explore ways that health providers can better meet the needs of individual patients. It developed a survey that asks patients their perceptions of how good their care was. If information like this were collected on individual providers it would serve a dual purpose: to give consumers very specific measures about how other people experience care; and to give the provider very specific information identifying areas for improvement.

Questions like "Were you satisfied, somewhat satisfied or very satisfied" are no longer adequate. The Picker Institute got specific, asking patients: whether anyone at the hospital went out of their way to make them feel better; whether they were told about the daily routine; whether they were told how much discomfort to expect before a test; whether they had a relationship of trust with any hospital staff other than the doctor in charge.

Improve the health of the community

Quality health care requires more than simply treating illness -- it also requires promoting community health. Community health improvement is a responsibility that hospitals and health systems take very seriously. It is central to AHA's vision of the future of the health care system.

To focus on the needs of individuals, health care delivery systems must focus on the environment and community in which those individuals live and work. That may mean looking at stress on the job, or nutrition at home, or violence in the neighborhood. By focusing on the needs of individuals and the community, the health care system naturally becomes more accountable to the community. For instance, it does not help the community if a provider has the best cancer treatment facility around, but prenatal nutrition and drug use are its primary problems.

That is why our vision of the future includes coordinated networks of care that are responsible for the health status of a defined population. And that is why more than 3,400 hospitals, health systems, and local organizations have expressed interest in AHA's Community Care Network Demonstration Project. The project, a collaborative effort of AHA's Hospital Research and Educational Trust, the Catholic Health Association of the U.S., and VHA Incorporated, is supported by a $6 million grant from the W.K. Kellogg Foundation. Its purpose is to support the development of community-based networks of care dedicated to improving their communities' health.

CONCLUSION

Many new thoughts and ideas were born during last year's national health care debate. Steps to assure quality were remarkably consistent in various bills, and sparked work that should continue through purchasers, like Medicare and its hospital and health plan partners, and the private sector, like large employers and business coalitions.

We all are partners in the world's best health care system. As partners, America's hospitals and health systems believe coordinated care is making our health care system even better. We look forward to our continued work with Congress and HCFA to help the nation's elderly citizens share in this improvement.

Chairman THOMAS. Thank you.
Dr. Osheroff.

STATEMENT OF WILLIAM J. OSHEROFF, M.D., VICE PRESIDENT AND MEDICAL DIRECTOR, PACIFICARE OF CALIFORNIA, ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA

Dr. OSHEROFF. Thank you, Mr. Chairman. I am Bill Osheroff, a family practitioner and medical director for PacifiCare of California and here to testify on behalf of GHAA and its 375 member plans.

The purposes of my remarks are first to further acquaint you with the day-to-day quality assurance activities of an HMO; two, to briefly describe some of the external oversight mechanisms that currently review us from a quality perspective; and third, to review with you some of our methodologies and results for member satisfaction surveys.

There have been profound changes in the approach to quality improvement activities in the last several years and these certainly have applied in the HMO industry as well. Whereas we used to perform quality assurance, which was largely driven by individual case review, we are now much more involved with data-driven systems approaches to quality improvement activities, population orientation and the issue of accountability, which relates to HEDIS and Delmarva that we heard about this morning.

In terms of the daily activities at PacifiCare that relate to quality assurance, we have approximately 250 to 275 medical groups and IPA's under contract. Prior to contracting with any one of those delivery systems, we perform an extensive preassessment evaluation including review of the physicians offices, medical charts, the administrative programs and systems in place.

We also do extensive physician credentialing that is designed to meet NCQA accreditation standards. We perform a number of clinical studies and other CQI activities including currently a diabetes management study. We are looking at pap smears. We are looking at participating with CMRI in some very important studies related to treatment of breast cancer and the inappropriate use of drug therapies in the elderly.

Other activities include case reviews, which we cannot get away from, and technology assessment. We have heard something about technology assessment in the development of guidelines this morning. We do that as well. We have an elaborate and formalized system for developing guidelines that we then publish to our providers.

This activity has led to a number of concerns we have had over the years. A year and a half ago we developed an ethics Committee whose membership includes a member of our Secure Horizons Program. That Committee provides us with an opportunity to have a very rich dialog regarding such issues as patient autonomy, individual determinism, equity or fairness and a variety of other very difficult ethical issues which we currently find ourselves dealing with and which all plans must.

Currently and in the last 2 years, we have been reviewed by a number of external agencies, including HCFA. We have had site visits by the California Department of Corp.s, the Department of Insurance, and HHS. We have gone through last month our second

NCQA accreditation survey and the month before that a review by the Utilization Review and Accreditation Commission. We have been visited recently by the Digital Equipment Corp., CALPERS, Southern California Edison, and the list is quite lengthy.

We applaud the efforts currently that HCFA is initiating to bring some consistency to this external review business. We find it extremely burdensome from a time resource management perspective and from a cost perspective and would look for any assistance in developing more efficient ways of performing this.

We measure member satisfaction in a number of different ways. We have what we call a member satisfaction tracking system, which in 1994 indicated that 94 percent of our senior members judged that the plan performed as well as or better than expected. Ninety-five percent indicated that they were very satisfied with the program and 99 percent indicated that they would continue with the plan.

The second way we measure satisfaction is through complaints, and we have traditionally seen a very low level of complaints, less than five per thousand members per year.

Our recent disenrollment rates for voluntary disenrollments, to be distinguished from involuntary enrollments, which are people who are deceased or move from our service area, indicates for the month of February a .68 percent disenrollment rate. We track 20 different categories, but the most common reason for leaving Secure Horizons, 56 percent of the individuals indicated leaving to join another risk plan, which makes a statement about the competitive nature of this business in the Southern California market.

The second leading reason for leaving is preferred traditional Medicare. Twenty-eight percent of the folks go back to Medicare. A very distant third is 4.5 percent who decline continued membership based on not wanting to change physicians. There is additional information in the written testimony as well.

I would welcome your questions and we at PacifiCare, as well as the other GHAA plans, look forward to continuing the dialog and providing at least a portion of the solution. Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF WILLIAM J. OSHEROFF, M.D.
GROUP HEALTH ASSOCIATION OF AMERICA

Mr. Chairman, Members of the Committee, my name is William Osheroff, M.D. I am Vice President and Medical Director with PacifiCare of California. PacifiCare is a network model HMO, which means we provide services through a network of contracted medical groups and Independent Practice Associations (IPAs). We have 650,000 commercial members and 310,000 Medicare enrollees under a product called "Secure Horizons". I am testifying on behalf of the Group Health Association of America (GHAA), the leading national association for health maintenance organizations (HMOs). GHAA's 375 member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs.

GHAA and its member plans are pleased that the Committee is focusing on quality issues in your hearing today. We come before you as health plans that provide care for about one-fifth of the nation's population -- and that offer the nation's most systematic approach to health care quality improvement.

My testimony will focus on three issues, especially as they relate to the Medicare population:

1. Describe HMO quality assurance activities, using PacifiCare as an example.

2. Briefly review current quality standards for HMOs, including the oversight by regulators (State and Federal) and private review companies.

3. Provide the results documenting HMO quality and consumer satisfaction. This will draw upon both published literature and PacifiCare specific results.

<u>HMO Quality Assurance Systems</u>

The last few years have seen a profound change in the basic approach taken by HMOs to quality assurance (QA). The early efforts in QA were directed at outlier identification, and used chart review as the principle means of case findings. The theory was that there were problems that needed to be addressed.

Influenced by the professors of CQI and TQM, HMOs are beginning to turn their attention to more data driven, systematic approaches to identifying opportunities for improving care and service. The theory in this model is that systems of care can be developed which improve the quality of care and service for <u>populations</u> of patients, not just the patients of the "outlier" physician. It is an approach that uses information, physician education and evaluation of "best practices" to improve care and service.

While the evolving internal quality systems differ among HMOs, there are four general aspects of continuous quality improvement:

- Collecting data on utilization, patient satisfaction, physician practice patterns, and performances, that allow for a clear definition and articulation of areas in need of improvement.

- Developing an intervention strategy, based on the data assessment, patient needs, scientific evidence, and clinical experience.

- Implementing the strategy -- frequently involving system changes or modification of physician practice patterns.

- Measuring outcomes and evaluating results to determine what works.

This should be viewed as a continuing, and, in a sense, "circular" process, with measurement and

assessment leading to efforts to improve care, and further measurement leading to further interventions.

In this way, the philosophy of QA is changing. The structure of the QA program at individual HMOs however has certain common elements. These include a QA/QI Committee. This typically consists of the plan medical director, participating plan physicians and various staff members. The role of the Committee is to oversee the various plan CQI activities including:

- Provider Credentialing - physicians, etc.
- Development of Screening and Preventive Health Guidelines - These may be guidelines for pediatric immunizations or flu shots in the senior population.
- Plan Studies - Studies are used by the plan to test various hypothesis, see what effects specific action plans will have on the quality of care or service, or to establish baseline information that may be critical in evaluating future activities.
- Case Reviews - Individual case review is still a necessary activity in specific circumstances. The committee provides a mechanism whereby cases may be reviewed, evaluated, categorized and followed up. This can involve a specific corrective action plan or the tracking and trending of cases over time.
- Oversight functions - The Committee is often responsible for overseeing the QA activities of providers with whom the plan contracts. In this way, an integration of QA activities can be achieved across the whole spectrum of care being provided. These may be:

  Medical groups
  IPAs
  Mental Health providers
  Vision providers
  Pharmacy providers
  Dental providers

While HMO quality improvement programs are carried out plan-wide and are designed to benefit all members -- Medicare, Medicaid, and commercial -- HMOs can use their quality systems to focus on specific initiatives or interventions that can improve a particular aspect of health care delivery for a defined subset of members. Preventive care initiatives are one example of the wide range of quality improvement activities commonly undertaken by HMOs. Some "best practices" related to childhood immunization provide good examples:

- 96 of 125 HMOs responding to a November, 1994 survey reported that they have implemented a program to improve childhood immunizations. The majority use provider education, patient education, and improved data collection -- and most use multiple strategies.
- About half of the plans focus on all enrolled children under the age of 2, but others focus their efforts on specific target groups, such as families of under-immunized children or the low-income population.

When asked to cite the factor motivating their development of the immunization interventions, more than one-half the plans cited quality assurance or pediatric department staff work -- quality monitoring and assessment that stimulated the development of a program to improve childhood immunization rates. And the results of specific programs are impressive.

- John Deere Health Care developed strategies in 1993 that increased the Measles/Mumps/Rubella immunization rate from 65% to 94% for commercial enrollees, and from 39% to 66% for the Medicaid population.

- Mercy Health Plan in Philadelphia increased the immunization rate for its Medicaid-eligible children from 46% to 57%.

Another example of quality intervention is in the area of pediatric asthma. The Harvard Community Health Plan found that this chronic condition was the most common cause of hospitalization for the children it served. Rather than focusing on treatment of acute episodes, the plan developed a comprehensive approach to managing this chronic disease, including:

- Outreach to identify high-risk patients;
- Development of an individualized care plan, including education and counseling; and
- Education on how to measure lung function so that the use of anti-inflammatory drugs can be targeted and appropriate.

The results are very promising – initial data indicate that the program reduced hospitalization for these pediatric patients by 79% percent, and emergency room visits by 86 percent.

Plans will vary in their targeted areas based on demographics, utilization or QA data, etc.

HMO Quality Systems

Stated simply, 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 (FFS) 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 care and quality issues;
- Provision of comprehensive services across the spectrum of inpatient and outpatient settings, allowing a full range of quality interventions; and
- Clinical and fiscal accountability for the health care of a defined population -- allowing population-based data collection, analysis, intervention, and monitoring -- and fixing accountability for performance.

HMOs have made quality improvement systems a key component of their approach to care across all of the populations that they serve. Their quality approach has traditionally included a focus on the three classic dimensions of quality assurance:

- Structure, which includes ensuring appropriate professional qualifications, adequate records, proper organizational arrangements;
- Process, which encompasses the steps involved in provider/patient interactions; and
- Outcomes, which involves determining whether medical interventions achieve desirable patient results.

While HMOs continue to maintain such approaches, they have in more recent years led the way in moving toward continuous quality improvement in health care, as noted above.

PacifiCare Quality Assurance/Improvement System

We have developed a complex, multidisciplinary QI program at PacifiCare of California. The committee structure supporting these activities is depicted in the Attachment.

The basic function of our QA committee is consistent with the above comments. In addition, we have four regional peer review committees. These committees provide direct input from over 30 of our participating providers. Much of the work of these committees is to review individual medical records, develop action plans, and to review proposed guidelines, policies and procedures.

Our Technology Assessment Committee, begun in 1990, has reviewed a substantial number of medical interventions for purposes of determining where they should fit in the daily practice of medicine and for when they may be appropriate. This group draws heavily on published literature and specialists in the appropriate field of practice. These are routinely sent to all our provider groups.

The Ethics Committee has been in place for 15 months. Its members include an outside, nationally recognized ethicist, a benefits manager for a large commercial employer, a Secure Horizons member, legal and regulatory representatives, a physician provider, a social worker, case management nurse, and a sales and marketing individual.

The practice of medicine is becoming more complex as we deal with new technologies and their applications. The Committee recognizes and promotes the values of the individual in health care decision making, the issues of autonomy and equity (fairness) and the difficult problems of futile treatment, patient non compliance, and responsibility.

We have trained our case management nurses in ethics and mediation skills which are proving extremely valuable in dealing with difficult medical situations. We plan to publish a report of these activities so others may learn from our experience.

We have two (2) Benefits Committees -- one for commercial products and one for government programs (Medicare and Medi-Cal). The committees ensure that our determination of benefits is consistent with regulatory requirements, coordinated with our providers and among our various departments.

Quality Standards for HMOs

Federal and state governments and private accreditation organizations working with large employers have established a wide array of quality standards, and GHAA has long supported strong quality standards for health plans.

Federal HMO Act: The federal HMO act and regulations require HMOs, as a condition of federal qualification (53 percent of HMOs are federally qualified), to have internal quality assurance programs that:

- Stress health outcomes.
- Provide review by physicians and other professionals of the processes followed in the provision of health services.
- Use systematic data collection of performance and patient results, interpret these data for practitioners, and institute needed change.
- Include written procedures for taking appropriate remedial action, in the case of inappropriate or substandard services, or when services that ought to have been furnished have not been provided.

Medicare HMO/CMP requirements: Medicare's regulations for participating HMOs and competitive medical plans (CMPs) incorporate the federal HMO act requirements for internal quality assurance programs. In addition, HMOs and CMPs participating in Medicare must maintain an agreement with a utilization and quality control peer review organization (PRO) for external review of care.

The PRO review process is moving from a focus on individual cases toward assessment of trends and patterns of care and outcomes much the same as described above. PROs review a sample of the enrollees HMO/CMP, looking at care furnished over a twelve-month period. Action plans are developed by the HMO/CMP in cooperation with the PRO to address any problems encountered, and the PRO then conducts a targeted review to determine that the problem is corrected.

GHAA has been working with HCFA in its efforts to improve the PRO review process and to focus it on performance measurement that is consistent with the evolution of quality review in the private sector. A pilot project (the "Delmarva" project) has identified and refined a set of specific clinical indicators, including certain "core" measures (time to the first visit for new enrollees, mammograms, frequency of visits/services; and flu shots) as well as some specific measures related to diabetes. This year, a selected group of HMOs and PROs will begin to work together to test these measures for an 18-month period. The goal is to develop information that will help improve PRO oversight and that will be useful to HMOs in improving the quality of care.

State requirements: The states also set quality requirements for HMOs. According to the most recent report available, 42 states have adopted some type of quality standards. The report describes "...myriad variations in the regulatory schemes by which States seek to assure their citizens' high quality health care". These include internal and external review requirements, as well as requirements related to licensure of providers enrollee satisfaction, medical records, and other matters.

The National Association of Insurance commissioners (NAIC) has adopted a model HMO Act for use by states seeking to regulate HMOs, and 28 of the state HMO acts are based on NAIC model. The model act requires HMOs to file a description of their quality assurance program, and requires that quality assurance plans include a number of specific elements.

Private accreditation: Private accrediting organizations also set standards for HMOs and assess whether the plans meet those standards. The three major groups are the National Committee for Quality Assurance, the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), and Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

The NCQA is the most widely used and has gained the respect of major employers across the country. It is considered the "gold standard" for HMOs -- not an industry average or basic standard for operation. The NCQA sets specific standards and reviews plan performance in a number of areas:

- o The quality assurance system -- including its effectiveness in improving quality and service;
- o Credentialing process for providers;
- o Utilization management;
- o Member rights and responsibilities;
- o Preventive health services; and
- o Medical records.

PacifiCare of California was originally granted full accreditation by the NCQA in 1992. We were the first Medicare risk HMO to be so designated.

The NCQA has also worked with employers and health plans to develop a standardized set of comparative information for health plans to report. The Health Plan Employer Data and Information Set (HEDIS) is comprised of 60 performance measures designed to give employers and consumers objective information on health plan performance. HEDIS is the first step in the development of a standardized set of performance measures for HMOs.

A comparable effort is underway to develop "report cards" on HMOs that will be useful to consumers in making informed choices. As such efforts become more sophisticated, it will beimportant for consumers to have data on the fee-for-service sector that permits an additional dimension of comparison.

The Results

Discussion of different quality models and systems is irrelevant in the absence of results. The success of HMOs in improving quality of care has been documented again and again, as studies show care provided in HMOs to be as good or better than care provided in fee-for-service (FFS) plans.

A comprehensive review of the literature published from 1980-1994 appeared in the May 18, 1994 Journal of the American Medical Association. It analyzed 16 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 FFS 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 FFS 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 FFS. The largest difference was for cervical cancers: almost 60 percent of HMO members were diagnosed at the earliest stage, compared with 39 percent of FFS patients (American Journal of Public Health, October 1994).

- HMO appendicitis patients were 20 percent less likely to suffer a ruptured appendix than appendicitis patients in a FFS setting, according to a study of hospital records in California (New England Journal of Medicine, August 18, 1994.

- Women in HMOs were more likely to obtain mammograms, Pap smears and clinical breast exams than women in FFS 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 in FFS (CDC/NCHS Advance Data No. 254, August 3, 1994).

Another recent review reported by Joan Meisel, PhD, MBA at Stanford University entitled "Quality of Care in HMOs: A Review of the Literature" reaches the same conclusions -- that HMOs do not compromise the quality of care and are rated superior to fee-for-service in many important ways.

Finally, HMO members -- elderly and non-elderly -- are more satisfied overall with their health plan than FFS 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 FFS Medicare enrollees for every level of health status.

At PacifiCare we measure member satisfaction in several ways. First 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. These results show that 95% of surveyed members are satisfied with the plan and their medical group. Ninety four (94) percent believe the plan performed as good or better than expected. Ninety nine (99) percent report they 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 <5 complaints per thousand members per year (4.64 for CY 1994.).

The third indication of member satisfaction is the enthusiasm of the seniors for this product in new markets. Secure Horizons is a tremendous value for the senior. Not only do they receive Medicare benefits, but Secure Horizons provides a pharmacy benefit and dental benefit. Further, we provide services that include aerobics classes and counselling on a variety of health related topics.

Kern County (Bakersfield) is an example of a new market and how quickly seniors will embrace a managed care approach. In three years, we have enrolled 14,376 new members in this market. There are 61,436 seniors in Kern County. Thus we have enrolled 23% of the county's senior population in a short period of time.

Perhaps a more important indication of satisfaction than enrollment rates is disenrollment rates. People can join a plan, but little is gained if they disenroll in a short period of time due to dissatisfaction.

The following table summarized the data for February, 1995:

Voluntary disenrollments	2,078 (63.3%)
Involuntary disenrollments	1,206 (36.7%)
Total	3,284 (100%)

"Involuntary disenrollments" represents deaths or individuals who move from our service area. Average membership during this month was 301,776. The voluntary disenrollments represent 0.68% of the membership. This is extremely telling.

The ten most frequent reasons for voluntary disenrollment are as follows:

	No. of Members	%
1. Joined another risk plan	1,182	56.0
2. Prefer traditional medicine	590	28.4
3. Doesn't want to change physician	94	4.5
4. Other	65	3.1
5. Lock-in features too restrictive	23	1.1
6. Benefits are insufficient	16	0.8
7. No/little choice of specialist	8	0.4
8. No/little choice of PCP	7	0.3
9. Failure to refer/authorize	6	0.3
10. Doctor couldn't improve condition	3	0.1

As you can see, the voluntary disenrollment rate is very low. The major causes of disenrollment relate to the competitive environment in which we operate, and the difficulty in transition from FFS medicare for some members. Only 23 members (out of 300,000+) found the HMO lock-in features too restrictive.

We believe these results indicate a very high level of satisfaction with our plan.

Mr. Chairman, HMOs provide high quality care to 50 million members today – and are working to continue to improve the care that we provide in the future. The GHAA would be pleased to work with the committee as you examine the issue of quality in health care. I wish to extend to you and your Committee an invitation to visit our plan and gain first hand knowledge of our operations. I would be happy to answer any questions that you may have.

COMMITTEE RELATIONSHIPS

Chairman THOMAS. Thank you very much, Doctor.
Miss Braun?

STATEMENT OF BEATRICE BRAUN, BOARD MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. BRAUN. Mr. Chairman, my name is Beatrice Braun from Spring Hill, Florida. I am a member of the board of directors of the American Association of Retired Persons. AARP appreciates the opportunity to appear before the Subcommittee today to discuss quality oversight in the Medicare Program.

As you can imagine, when we hear from our members about quality issues, they do not usually express their views in policy talk. For this reason we have attached to our testimony a checklist of key aspects of quality from a consumer perspective. We think that these 10 items, such as competence, compassion or bedside manner and communication help to capture what is needed to ensure continuing consumer confidence in the quality of care.

This hearing occurs on the eve of the 30th anniversary of Medicare. During the past three decades we have witnessed the evolution of a system that has provided security and peace of mind for millions of our citizens based upon the delivery of high quality medically necessary services.

As we debate Medicare's future, we must not forget our responsibility to preserve its strengths, including its current Quality Assurance Program, and to change it only in ways that will continue to improve the health status of beneficiaries. AARP believes that a strong system of quality oversight must continue to be a key component of the Medicare Program.

Because Medicare is being confronted with both tighter budgets and growing needs, beneficiaries must have confidence that the quality of the services they receive will not suffer in the face of these financial pressures. Maintaining a quality health care system begins with protecting Medicare's benefits package and includes preserving the affordability that has always been key to Medicare, along with the freedom to choose providers and health plans. The basic assurance of a system of comprehensive affordable care is the foundation for all of our quality improvement recommendations.

In our written testimony, we have detailed a number of specific initiatives that will help preserve and enhance quality within the Medicare system. AARP has been pleased to work with the public and private sectors in these areas.

Specifically, we note the following: First, we applaud efforts by HCFA and NCQA and the Joint Commission to develop comparable measures of performance in health plans and to release data to the public. To be successful, these initiatives will require providers to submit standardized data, which is not currently being done by some managed health care plans. HHS could further this goal by requiring standardized data collection for all public programs.

Second, we are encouraged by efforts of AHCPR and others to conduct outcomes research and develop clinical practice guidelines. This enormous task requires public-private collaboration. Guidelines have not yet been developed for many important conditions, particularly chronic conditions of older persons.

Third, we are encouraged by efforts to develop useful consumer information and to communicate with Medicare beneficiaries. Such information is an important component, although it will never be sufficient alone to assure quality.

Finally, we support efforts to strengthen current quality safeguards. Medicare appeals and oversight by peer review organizations are vital to consumers and we urge HCFA to continue to improve their functioning.

As the Congress considers ways to restructure the Medicare Program, preserving and enhancing quality must remain a priority. Strengthened safeguards will be needed in new delivery systems, because while they may reverse incentives toward overservice, they pose a potentially greater risk of underservice.

Thank you for this opportunity to present AARP's views on some of the major policy issues concerning Medicare's Quality Assurance Program. We would be pleased to work with Members of the Subcommittee on ways to improve the quality of care for all Medicare beneficiaries. Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF BEATRICE BRAUN
AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and members of the Subcommittee. I am Beatrice Braun from Spring Hill, Florida. I am a member of the AARP Board of Directors. I appreciate the opportunity to appear before the Subcommittee today to discuss quality oversight in the Medicare program.

This hearing occurs on the eve of the 30th anniversary of the Medicare program. During the past three decades, we have witnessed the evolution of a system that has provided security and peace of mind for millions of our citizens based upon the delivery of high quality, medically necessary health services. As we debate Medicare's future, we must not forget our responsibility to preserve its strengths, including its current quality assurance program, and to change it only in ways that will continue to improve the health status of beneficiaries.

AARP believes that a strong system of quality oversight must continue to be a cornerstone of the Medicare program. There are few aspects of the program that matter more to beneficiaries than preserving and enhancing the quality of care. Because Medicare is confronted, today and for the forseeable future, with both tighter budgets and growing needs, beneficiaries must have confidence that the quality of the services they receive will not suffer in the face of these financial pressures.

Today, we are discussing ways to improve the quality of care in both fee-for-service and managed care settings. Regardless of how beneficiaries receive their care, we must be vigilant so that all – including those who are sickest and most at risk -- receive appropriate, affordable, high quality care. While a system involving greater enrollment in managed care offers the potential to improve the quality of care, this potential will not be realized unless there are rigorous protections against the risks of underservice and poor quality care. It is fair to say that beneficiaries' perception of the quality of care in these new delivery systems will be driven not by stories of unnecessary care avoided but by "horror stories" of needed care deferred or denied.

What do consumers mean by "quality" of health care? Most importantly, it is the assurance that they will be able to have their health care needs met when they need care and by providers whom they trust. This implies that the Medicare benefits package that older Americans depend upon today should not shrink, and in fact, should expand to include coverage for significant gaps, such as prescription drugs. Affordability is also central to beneficiaries' view of a quality health system -- beneficiaries' out-of-pocket costs cannot continue to grow such that they can no longer afford access to care when they need it. Choice of providers and of delivery systems is another valued component of the current Medicare system; indeed, Medicare beneficiaries' health coverage options need to be expanded, as has occurred for the under-65 population in the private sector. But this should not be done at the cost of reducing Medicare's benefit package, increasing beneficiaries' out-of-pocket costs, or jeopardizing Medicare's broad insurance pool, which permits risks to be spread and makes affordable health care possible.

Quality of care goals

AARP believes our quality of care goals should be:

- To assure individuals that they will be able to have their health care needs met, as well as to improve the overall health of various populations.

- To preserve choices for consumers that result in the delivery of comprehensive, affordable care, as well as to to provide for the skilled management of care.

- To prevent the withholding of necessary and appropriate care, as well as to avoid delivery of unnecessary or inappropriate care.

- To improve systems of care through the application of continuous quality improvement approaches, as well as to ensure the detection and cessation of practices threatening individual patient well-being.

- To enhance consumer decision-making capability through disclosure of treatment options, risk-benefit considerations, and outcomes, as well as to strengthen mutual respect and trust between practitioners and patients.

Improved Performance Measurement Across All Care Settings

"If you can't measure it, you can't monitor or improve it." In the private sector, organizations such as the National Committee for Quality Assurance (NCQA) and the Joint Commission of Health Care Organizations (JCAHO) are playing leadership roles in the difficult task of developing comparable measures of performance in health plans and health care organizations, and in releasing these data to the public. In the public sector, the Health Care Financing Administration's (HCFA's) efforts to develop indicators of quality of care in all settings, including home health and skilled nursing facilities, as well as in physician offices and hospitals, are vitally important. We believe that the new performance measurement systems being developed in both the private and public sectors should include measures of access to and timeliness of care, appropriateness of the setting and treatment, and premature hospital discharge. As soon as possible, these measures should encompass the entire range of care delivered and a wide range of clinical conditions, especially chronic physical and mental disorders. (For example, knowing that a plan performs well for someone with diabetes doesn't necessarily mean that it does so for patients with other conditions.)

We are pleased that private accrediting bodies and the Department of Health and Human Services (HHS) are making considerable progress in developing and pilot-testing quality of care indicators in both managed care and fee-for-service settings. However, we urge them to move forward even more rapidly. If the focus is on only a small number of conditions and too few measures, quality of care could be imperiled if providers "study for the test" (e.g., focus their resources on the few conditions being studied to the detriment of patient care in other areas).

Standardized Data Collection

The key to a comprehensive performance monitoring program -- and to providing useful consumer information -- is a uniform data collection tool. This tool should have uniform definitions that permit comparisons of health encounters, regardless of the source of payment or setting, at the same time that it protects patient privacy and confidentiality. Such a tool would help consumers make "apples-to-apples" comparisons and would reduce the cost and administrative burdens on providers and plans.

Currently, some managed care plans cannot report basic utilization data, such as the number of patients seen with a specific diagnosis and what treatments they received. Hence, as a first step, HCFA should consider requiring Medicare and Medicaid managed care organizations to collect the data on the forms used in the fee-for-service setting for documenting and reimbursing ambulatory and hospital care. (These forms, the HCFA 1500 and the UB'9 respectively, include data on patient age and gender, place of service, diagnoses, and procedure codes.) Since the majority of the nation's providers are already familiar with these instruments, they may be the most practical foundation upon which to build. Additional data elements essential to providing a comprehensive picture of care – such as medications currently being used and functional status -- could be added over time.

Clinical Practice Guidelines and Outcomes Research

The growing movement to expand medical effectiveness research and outcomes research -- in order to identify when services are beneficial and when they are not --

holds great promise for improving quality and reducing the costs of medical care. The major "products" of this movement are clinical practice guidelines to guide practitioner and patient decisions about appropriate health care for specific clinical conditions.

AARP has been supportive of the efforts of the Agency for Health Care Policy and Research (AHCPR) and other agencies within HHS to conduct outcomes research and to develop practice guidelines, which still don't exist for many conditions. Federal support for these efforts is critical, as is the need for private and public sector collaboration in developing, disseminating, and evaluating the use of guidelines in practice.

AARP is particularly interested in seeing expanded outcomes research on and the development of more clinical practice guidelines for chronic conditions. From the perspective of all beneficiaries, but especially those with chronic conditions, outcomes of care should include those that relate to the quality of life, such as physical functioning, social and role functioning, and emotional well-being. Because chronic illnesses cannot be "cured", the emphasis should be on helping individuals cope with changes as the disease progresses, on preventing further disability and optimizing functioning and well-being. For the chronically ill, it also is particularly important to track the continuity of care across multiple settings, including home health care and other long-term care settings, and to assess the interpersonal aspects of care (such as patient-physician communication).

Communication with Beneficiaries

Another crucial need is improved outreach to and communication with beneficiaries, and we are encouraged to see HCFA's new emphasis on these areas. This communication should be a two-way street, in which information is both gathered from beneficiaries as well as provided to them to help inform their health care decisions. Beneficiaries' satisfaction with care reflects both how they have been treated and their health outcomes. In addition to being asked about their satisfaction with care, beneficiaries should also be asked about their health status and health care experiences. For example, research indicates patients accurately report information about their medical care, such as whether they received their test results and were told whether further care was needed. These patient-based data, which can be used to construct measures of clinical performance, are a promising, potentially cost-effective, but underutilized method of data collection. Hence, AARP believes that constraints to the use of both patient and consumer satisfaction surveys should be removed as soon as possible. Finally, as HCFA is proposing to do in its new Consumer Information Strategy, information should be provided to beneficiaries in such areas as prevention, treatment options, and to also help them choose among health coverage options.

Consumer Information

There currently are numerous efforts underway in the private and public sectors to provide consumers with information to help inform selection of health care plans and, to a lesser extent, providers. We strongly support efforts to provide consumers with "report cards" on plan and provider performance that present accurate, comparable information in formats that are "consumer-friendly." Accomplishing this goal, however, will take a long time and significant investment. We applaud efforts, such as the recent NCQA pilot report card project for managed care plans, that move us closer to this end.

We also believe that the public sector is in a unique position to foster the development of useful consumer information. Although much maligned, HCFA's hospital mortality reports broke new ground in the public release of outcomes information, and paved the way for the more useful provider-specific data reports that are currently published in several states. The AHCPR has also embarked on several projects that should result in better public information, notably the development of a model consumer survey designed to help consumers make choices among alternative health insurance options.

Consumer information alone, however, is not sufficient to assure quality accountability. We would never want to see the day when Medicare beneficiaries, including those who are very sick and very frail, feel that "caveat aeger" (let the patient beware) is their chief protection.

Due Process and External Quality Oversight

Many of the strategies for improving quality discussed above -- including more comprehensive performance measurement systems and consumer "report cards" - presuppose the future development of better data systems and research methodologies. The "state of the art" is such that there must also be ongoing attention to the strengthening of current quality safeguards, i.e., due process and external quality oversight protections.

Due Process:

The Medicare program must continue to protect beneficiaries from poor care. Currently, such protections include a complaint system utilizing Peer Review Organizations (PROs), informing patients of their appeal rights upon admission to a hospital, and a uniform, national appeals mechanism for medical care denials. As Medicare evolves and beneficiaries enter into different kinds of relationships with providers, these complaint, due process, and appeal mechanisms must be strengthened. In addition, ways must be sought to improve the coordination of protection efforts of state and federal investigatory and disciplinary bodies; PROs should continue to have the authority to make appropropriate referrals for disciplinary action when needed.

External Quality Oversight:

External peer review has been a feature of the Medicare program since the early 1970s. Since the mid-80s, AARP has been actively monitoring the development of the PRO program. While imperfect, the program functions as an important part of the patient protection and quality assurance structure. More specifically, through its federal standards, it provides the structure needed to assure the delivery of high quality care regardless of where one lives, and to hold individual and institutional providers and plans publicly accountable for improving performance.

Recently, the PRO program has undergone a fundamental change from a focus on individual errors to identifying opportunities to improve the mainstream of care. AARP is hopeful that the introduction of a continuous quality improvement model, which seeks to educate and facilitate rather than to punish, will succeed in fostering the delivery of higher quality care.

Among those aspects of the PRO program that are most critical to consumers are:

- **Monitoring access to and quality of care**. Even the best informed consumers will often not be able to tell whether or not they are receiving care based on the best medical practice, especially when they are very ill. Hence there is a need for expert, objective professional oversight to foster care of high technical quality that is based on clinical practice guidelines, when they exist.

- **Consumer representation**. Consumers are represented on the boards of PROs in all 50 states; this consumer representation must not only be maintained but expanded.

- **Community-based initiatives**. An important PRO function is to help practitioners and plans reach quality levels achieved by the best performers. In order to improve performance, PROs are now sparking community-based initiatives that bring together all parties (practitioners, plans, and, occasionally, consumers) to respond

to locally-identified needs. We see these initiatives as promising, and think they will be even more effective if they actively involve consumers.

- **Ongoing quality oversight**. A critical element of PROs' monitoring activities is that they occur on a continuous basis, i.e., ongoing problem identification and problem-solving take place through community-wide pattern analysis.

AARP believes that the Medicare progam must continue to hold plans and providers publicly accountable through ongoing, skilled professional oversight, utilizing a state-based infrastucture that permits an essential presence at the community level.

This by no means precludes the contribution of national accreditation entities, whose efforts in fostering standard setting, continuous quality improvement, and comparative analysis of performance are accelerating. Medicare should continue to work collaboratively with the private sector in pioneering and adopting cost-effective ways to improve quality.

Conclusion

As the Congress considers ways to restructure the Medicare program, preserving and enhancing quality must remain a priority. Strengthened quality safeguards will be needed in new delivery systems because they reverse the current incentives toward overservice and pose the risk of underservice. Improved performance measurement, communication with beneficiaries, and consumer information will be necessary but not sufficient elements of this system; of equally vital significance will be public accountability, accessible grievance, appeals and due process mechanisms, and skilled external professional oversight.

Thank you for this opportunity to present AARP's views on some of the major policy issues concerning Medicare's quality assurance program. Of course, when we hear from our members about quality issues, they don't usually express their views in "policy talk." Hence, we have appended to our testimony a checklist (Appendix A) of key aspects of quality from a consumer perspective. We think that these ten items help to capture what is needed to ensure continuing consumer confidence in the quality of care.

We would be pleased to work with members of the subcommittee on ways to improve the quality of care for all Medicare beneficiaries.

Appendix A

Quality from a Consumer Perspective: The Ten "Cs"

Competence	of providers and health care practitioners
Communication	such as explanation of medical procedures and tests; paying attention to what the patient says
Compassion/Caring	courtesy, personal interest, respect, time
Continuity of care	such as ability to see one's usual provider
Continuum of care	full range of acute and long-term care services
Choice	of delivery systems as well as doctors; more generally, consumer empowerment
Complaint Resolution	timely, accountable procedures for grievances and appeals
Convenience	of location, access to primary & specialist care when you need it; getting medical advice by phone
Coordination	no delays in your medical care; communication among doctors or staff who provide care
Community oversight	state or locally-based organizations monitor quality of and access to care, based on federal standards

Chairman THOMAS. Thank you very much, Mrs. Braun.

Dr. Nelson, your organization probably as much as any has had an ongoing discussion about how you relate to health care changes. We have been focusing on measuring tools, quality versus cost. Do you folks believe that there is a way to create a measuring device that would cut across all of the various delivery mechanisms that we now have; that is, is quality quality, whether it is the old fee-for-service or an HMO or a physician hospital organization or a PPO, or do you think we might need to use slightly different standards for different structures to measure quality?

Dr. NELSON. That is a very good question, Mr. Chairman. The fact is that quality is quality and it can be measured. A couple of premises.

Premise one is we believe that quality controls costs, not the other way around, and that there are three aspects of quality which can be measured and are currently being measured. One is the medical outcome, did the person have the right diagnosis, right tests. Did the patients live or die?

Second and significantly, is patient satisfaction being measured carefully. We talked about the hotel functions of a hospital. Patients want to know if their care giver is actually giving information and how they perceive the quality of care. Third is was it done efficiently, and that can be measured as well. Those quality indicators would work irrespective of the system in which the care was provided. The quality must be provided in any of those systems, and that is our concern.

Chairman THOMAS. Another concern that I know doctors have had is the whole question of practice guidelines. It is the old business such as in our business, if you let me pick the ones, I am more than willing to follow them, but when someone else picks them then I have some concern. You know we will be developing a number of competing practice guidelines.

Is AMA looking at or do you have any mechanism or structure to help resolve a choice question between competing practice guidelines?

Dr. NELSON. Yes, sir. We have put together the practice parameters partnership. This has in it several hundred practice guidelines, and so forth. When there are competing practice guidelines, these groups are brought together to agree to agree. That has occurred. There were three, for example, on gestational diabetes or diabetes in pregnancy, and there certainly needs to be a way to bring those together. Yes, that is being done.

The second answer to your question, if you would come West, and we invite you to Utah you would see that this is being done in a partnership between the private and the public sector where health system reform, which is ongoing in our State. We have a large consortium of people involved in quality which will be from our PRO, private carriers, State health department, and others to get together to do in an ongoing basis so we can agree to agree.

We believe that this can be done. We believe that it must be done. As a matter of fact, our health reform in Utah is being based on the premise that costs saved, which we must see up front from this process, will be used to give care to those who currently do not have it, and it is working.

Chairman THOMAS. Do you have examples? Earlier with the HCFA panel and Dr. Lee, we talked about some early success stories or breakthroughs in terms of utilizing guidelines or quality control.

Do you have any examples or is it too early to talk about specific changes that were dramatic or helpful?

Dr. NELSON. There are three. The most dramatic is in a disease called adult respiratory distress syndrome or ARDS. It is a disease that is a almost uniformly fatal, with death rates of around 90 percent. Before the implementation of practice guidelines that were generated by the practicing physicians, our death rate, too, was around 90 percent.

We now have a 44 percent success rate, meaning people who live, and the best part is, by following the guidelines developed by our physicians, we are saving in the neighborhood of $40,000 per case.

The second simple example is in the issue of wound infections after surgery. National standards suggest that 2 to 4 percent of the time that ought to occur. In our hospital it was 1.8 percent before initiating the guideline, 0.4 percent afterward.

We saved three quarters of a million dollars in 1 year in our hospital because we didn't have the infections to treat. You wanted a dramatic one; it used to take 21 days to get your little card that said you could be a member. Now it takes 4 days. By quality methodology, we found four desks on which the card sat and no one knew the reason why. We eliminated those. So, we have three simple breakthroughs, the point being that, yes, it can be done. It is being done and it does not just have to do with clinical medicine. It has to do with all aspects of health care.

Chairman THOMAS. I think that probably more than anything else, telling some success stories to encourage people to take a serious look at it and move forward probably does a better job than anything else. I have some questions for the other members of the panel, but I know the gentleman from Nebraska wants to inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Mr. Warden, I have heard testimony earlier today about mandating health care institutions and doctors in terms of getting sound testing requirements and monitoring some of the things that they are doing from a government standpoint. Being a free market, conservative, entrepreneurial capitalist, I believe that we need to keep government out of that as much as possible.

I know there is a role for Government. In your opinion, what would be the best avenue to follow? Is it a role that Ms. O'Kane talked about in using the National Committee for Quality Assurance? Is your particular hospital following some of the things that they do in NCQA or do you think that it would be better to follow a more regulatory approach that maybe we heard in testimony earlier today by some of the earlier witnesses?

Mr. WARDEN. I think, Mr. Christensen, that the best approach is one in which there is kind of a partnership between the private and public sector in which the accreditation or certification system resides in the private sector, but there is an ongoing dialog with the public sector about what their expectations are.

We found that both with the Joint Commission on Accreditation of Health Care Organizations and with the National Committee for

Quality Assurance that the kind of approach where we voluntarily participated with them and had the opportunity to do so in developing standards, and then agreed to adhere to those standards as part of their accreditation or certification process, is the most workable one, and I think that it is probably also the more cost effective compared to a more regulatory approach.

Mr. CHRISTENSEN. If that is the case, then what role do you think the Federal Government has and to what extent might we be required to fund research to support evaluations in government policy changes and making this information available to the public?

How much and to what degree should government fund these various studies? If you look at our last panel, less than 5 percent of the funds in each one of the respective groups came from the Federal Government, whereas, other testimony we heard placed it at a more significant amount.

Mr. WARDEN. I think that government has a role in helping to develop tools and approaches. In most cases in the private sector we do not have, unless we get a grant from a foundation, we do not have the sources of dollars to be able to do that because it is not something you would consider the patient should pay for.

However, in our own organization we found that just as the doctor on my right from the AMA has done, we found that once we have some information and understand the kinds of approaches that can be taken, much of it can be done at the local level. We have done it in about 10 different conditions, and each one of them, I will not go into the examples, but with each one we have had the same kind of savings and the same kind of increased patient satisfaction.

The important thing is that there are mechanisms, as AMA has stated, to enable us to share this information between organizations and to network so that we continually learn. Outcomes research and practice guidelines are not something you develop, and then they just exist forever. Medical information is changing all the time and it has to continually be improved.

I think basically the successful strategy requires a public-private partnership, and a lot can be done in the private sector.

Mr. CHRISTENSEN. I agree. I want to make sure that we try to keep as much as possible in the private sector. I have just seen the efficiency of the Federal bureaucracy and it is not something that I want to trust to further studies and testing, giving the government the opportunity to go unfettered with their discretion. I think it is something we have to be very careful of.

I agree with what you say, but am very skeptical of the Federal Government. I appreciate your testimony.

Chairman THOMAS. I thank the gentleman. I am concerned as well, Dr. Osheroff—one of my big worries is that as we move into the regulatory area here, which government drives itself toward, we do not get into the situation as we have with some other activities in which you have a competing State and Federal structure, and that instead of having a harmonious working relationship you are required to operate under two different standards with the double paper work. Our goal is to not create another torture weapon out of quality standards, but to provide a clear yardstick by which consumers can make that decision.

Ms. Braun I noticed in your testimony that you said, Medicare beneficiaries health coverage options need to be expanded, as has occurred for the under 65 population in the private sector.

One of our goals in this Congress is to make sure that the seniors have a wide range of choice, and choice is the key that they get to choose. In these new managed-care programs, as is done in the private sector and with the government health programs, you oftentimes have a season or a period of choice in which you choose a plan.

We discussed earlier about the difficulty of a 1-month, for example, election structure. Does AARP, or do you have any feeling about creating an annual enrollment period like we seem to have more and more now as a common practice in employment situations?

Dr. BRAUN. I think AARP would be concerned about making that change at this time because I think the ability to disenroll does act as a help in the quality area. The other thing, since we are hoping that more and more Medicare people will move into managed care, If think the fact that they know that they can disenroll if it is not working out for them, I think will be a drawing card in helping them to try it out because older people, as you know, tend to feel insecure in changes. I think it is a help, also from that point of view.

Chairman THOMAS. Well, as the rest of the world continues the change in the health care delivery and the seniors talk to their children about their managed care programs, we are creating an atmosphere where it is a little more receptive. I was impressed with the 28 percent figure which I consider fairly low. A major decision for a number of folk is in a different world, although that different world promises through a total integrated preventive care structure some benefits that are not currently available.

I normally do not do this with witnesses but, Ms. Braun, since you are here representing AARP, I would like to ask you a personal question.

Dr. BRAUN. All right.

Chairman THOMAS. I have a partial answer to it but I do not know the reason. I was curious, coming from Florida, I know in California and in the northwest, and in Florida there are a number of managed care programs that are available. I understand you have not chosen to go that route.

Dr. BRAUN. No, I am not. This morning I am testifying certainly as a consumer, a member of the AARP board of directors. I am also a physician and I think that I sort of act as the primary care physician in my own care and my husband's care.

Chairman THOMAS. See, I did not have that information available to me.

Dr. BRAUN. I am sorry.

Chairman THOMAS. That is a help in understanding the choices that you made.

Dr. BRAUN. There is another reason though, Mr. Chairman, I think this will apply many other places, also. We in our county just got our first managed care about 3 months ago for Medicare. I am sure there are lots of areas in the country where—in fact I was

talking to some other AARP people from other areas like Idaho and so forth where there really is not very much managed care at all.

Chairman THOMAS. In the heartland of the country, that is one of the things we are going to grow.

Obviously, then, you are qualified by far more than the age criteria to testify with AARP. I would ask you from your professional viewpoint, are things going in the right direction? When you talk with other seniors, when you have your AARP meetings, are people talking about, "experimenting with the idea of managed care"? Are people giving us good stories about the successes that they have had more often than not? What is your personal observation?

Dr. BRAUN. I think many people are anxious. The fact that they do not need supplemental insurance, that they get more coverage and so forth is definitely a drawing card.

I think more and more they are trying out managed care. As you know, in Florida, we have had concerns about managed care that it has not done very well, but I do think that people are moving. My understanding is that actually 1.5 percent of Medicare beneficiaries are moving every month into managed care. I really appreciate the fact, and AARP does, that this is a voluntary situation because it will gradually grow.

Chairman THOMAS. It will remain voluntary, but obviously quality standards such as we are trying to begin to achieve here will be very helpful.

Dr. BRAUN. Yes.

Chairman THOMAS. Final question. You heard the earlier panels talk about the desire for a relatively extensive checklist and I believe your testimony indicated to a certain extent as well.

I am concerned about the desire to heap far more information on folks to make a decision than perhaps they want and that to a certain extent tends to be confusing rather than helpful.

From your perspective, again, in terms of knowing people who are faced with this decision, would it be helpful to have a good housekeeping seal of approval for some structure in which they have trust, such as the Medicare structure approved programs, without necessarily having to go into the detail to allow people to have sufficient information to make a choice from a long checklist?

Dr. BRAUN. I think probably it would be helpful—

Chairman THOMAS. The best answer is both, I know.

Dr. BRAUN. Yes. But, I think it would be helpful to have, as it were, a seal of approval, but I think there are many Medicare beneficiaries who would appreciate having the kind of information that employers are looking for when they are looking at health plans and deciding what they are going to give their employees and so forth. I think there are a lot of people that would utilize that kind of information. It would be helpful.

Chairman THOMAS. One last question, in trying to create a program where people choose an alternate route, and there may be savings, do you think it would be useful if the program was set up where people could share in the savings of their chosen route, and perhaps that savings could be passed on to the consumer if a choice is made available? Would that be an added incentive along with the enhanced benefits?

Dr. BRAUN. I think the enhanced benefits is more of a drawing card than anything else at the present time because there is a great deal that is not covered by Medicare and some people that fall into that lower group above poverty, but still not really wealthy cannot afford Medigap insurance. So, it is really valuable for them to move into something else.

Chairman THOMAS. Prescription drugs is one of the items very often available and that is a nice addition.

Dr. BRAUN. Very true. Community-based care, that kind of thing, as those experiments go on, pilot projects go on and so forth, I think they will be great drawing cards where long-term care will also be covered.

Chairman THOMAS. The gentlewoman from Connecticut, did you have a question?

Mrs. JOHNSON. In listening to the Chairman's questions to you, Ms. Braun, and the panel, one of the things I am wrestling with in my own mind is, is it necessary to have different mechanisms to oversee the quality of managed care systems if seniors join those systems? Are they adequately protected by the same oversight mechanisms that are in place for everybody else in that managed care system?

See what I mean? In other words, in your testimony, Ms. Braun, you look to preservation of the existing mechanisms to protect seniors from inadequate care and so on and so forth. It is my observation that through the casework in my office, those mechanisms are working very well. I get many fewer complaints as an elected representative from people in managed care systems than I do from seniors in Medicare.

I do not see any clear case as to why the Federal Government should layer on new oversight mechanisms onto managed care plans that are already out there serving people of every other age just because we allow seniors to join them. See what I mean?

Dr. BRAUN. I do see what you mean, but I think there are concerns about something that would replace the PROs now if they were gone. There are certainly things that seniors do need to be protected—for instance, chronic illnesses and treatment of chronic illnesses and so forth, which are really not being given much attention so far. I think there really are some areas.

It may be that at some point the accreditation or some kind of ongoing monitoring being done generally will be applicable, also, but I do not think we are at that point yet. I think we need to continue with having PROs at least for the present.

Mrs. JOHNSON. Consumer education, that kind of information is necessary, and the education that goes along with being able to understand the information, but I am concerned about a Federal initiative to put a specific new requirement on managed care plans unless there is a clear case to be made. I appreciate your talking about chronic disease.

Do any of you have a comment on that whole issue? As we give seniors options, do we have to layer on new levels of regulation?

Mr. Warden.

Mr. WARDEN. I think the only suggestion I would have is I think that in addition to the chronic care issue, that it probably would be helpful to have HEDIS and the data research center develop

and include some report card mechanism to measure things that relate to health status of seniors.

Second, I think health education should include not only how the system works but also some of the strategies that individuals can carry out in terms of improving their own health status.

Dr. OSHEROFF. Despite the current nature of our current measurement and reporting system, we would agree with performance measures specifically related to the senior population and would support the development of those programs.

I think one area where we see a lot of duplication is in external review arenas where we are visited by three different state agencies in California—HCFA, and NCQA, NURAC—and a whole parade of private companies coming in wanting to look at our quality assurance activities, all using different standards.

I know there have been some discussions at HCFA to try to gain some efficiencies by making those standards at least more consistent across-the-board and perhaps have one review or perhaps two as opposed to six or eight would be, I think, very beneficial.

Mrs. JOHNSON. I would be very interested in a simple one-pager on all the people that review you. We have really squandered billions of dollars in America over the years doing this in the hospital sector. The hospital sector is smaller than the managed care group sector. We simply cannot repeat that mistake in the managed care sector.

We may want some overlap or some checks and maybe the role of Medicare as a spot checker or whatever, or maybe looking at specific senior issues in that managed care plan. I do think this issue of overlap is an important one.

Dr. Nelson, were you about to contribute?

Dr. NELSON. Yes, ma'am. I was going to say, it would—it seems to me the appropriate Federal role is to help set parameters for us or empower us as clinicians and others to do the quality improvement work. For example, the Federal Government might help determine that these be patient oriented, that they be physician driven, that they be science based or something like that.

Empower us to do the work that is being done.

I also think there needs to be an issue of patient choice. What kind of choice does the senior want the make, not only in receiving the care, but what care they wish to receive and how?

Mrs. JOHNSON. I did think, Ms. Braun, your comment that seniors need the security of knowing they can disenroll as opposed to open enrollment which has systemic merits in terms of management of the system and cost control and things like that, was an interesting point and does also apply to this issue of oversight and quality.

It is some combination of these factors, that can enable us to provide good oversight and to focus on quality without encumbering the system. If there is one thing we have learned through the private sector, it is that quality of care can be improved and number of services covered can be expanded if we have a certain respect for the ability of the policies on the front line to manage and change themselves, and it has always been hard for government to be involved and not squelch invention and change. I am concerned about that.

Mr. Houghton, do you have any comments?

Mr. HOUGHTON. No, no questions.

Mrs. JOHNSON. I thank the panel very much for your time this afternoon, your attention, and appreciate your contribution.

Thank you.

[Whereupon, at 2:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY OF AMERICAN CHIROPRACTIC ASSOCIATION

Thank you, Chairman Thomas, for this opportunity to testify before the subcommittee on the important issue of Medicare and private sector health care quality measurement, assurance and improvement. On behalf of the American Chiropractic Association's (ACA) 23,000 members and the millions of patients they treat every year, I am delighted that the subcommittee has decided to address the important issue of quality assurance in our nation's health care system -- especially as it relates to Medicare. We are especially pleased that one of the central concerns of this hearing is the application of the research conducted by the Agency for Health Care Policy and Research (AHCPR) in the Medicare program. This is of particular interest to the ACA since the AHCPR recently published very significant and positive findings regarding the treatment of low-back pain through one of the chiropractic profession's primary treatment modalities -- spinal manipulation.

We are also pleased that the subcommittee wishes to discuss the effectiveness of current quality assurance mechanisms in the managed care portion of the Medicare program. We have great concerns about this issue, as it has been our experience that covered chiropractic benefits are routinely denied in the Medicare HMO setting. This has a decided effect on the quality of care provided through HMOs, as chiropractic services have been found to be highly cost effective with preferred outcomes.

ACA Supports Quality Standards

The ACA compliments you, Mr. Chairman, for your laudable efforts through these hearings to highlight the importance of ensuring that the highest standards of quality are observed both in the private sector health care system and in Medicare. The ACA wholeheartedly supports federal initiatives to bring common sense and rationality to a system that too often overlooks issues of quality, adherence to scientifically-based standards and appropriate measures of treatment outcomes.

In furtherance of ACA's commitment to empirically-based professional clinical standards, in 1990 it endorsed a set of clinical practice standards known as the Mercy Center Guidelines -- so named for the California location where they were developed. These guidelines specify recommended practices for the conditions that doctors of chiropractic (D.C.s) normally treat and were developed by a broad cross-section of the profession according to established consensus methods. We believe that our endorsement of the Mercy Center Guidelines demonstrates ACA's commitment to quality assurance and appropriateness of care.

To the best of our knowledge, ACA's support for a set of practice guidelines has preceded similar action by other health care professions. ACA is proud of the leadership position it has taken in this area and we would encourage our colleagues in other health care professions to join us by adopting similar approaches to combat unnecessary variation in health practices and high health care costs. Given the fact that only about 15% of all medical interventions are supported by valid evidence,[1] the health care professions bear an enormous responsibility for supporting, conducting and disseminating research on "what works best" in the diagnosis and treatment of health care conditions. The ACA wants Congress, and this subcommittee especially, to understand that it fully supports efforts to promote science-based standards of care, continuous quality improvement, accurate measures of health care outcomes and patient satisfaction surveys. We stand ready to work with you toward these goals.

Patient Satisfaction

ACA believes that patient satisfaction should be a major component of any system designed to measure health care quality and improvement. We encourage broader application of this aspect of quality assurance under federal health care programs and urge the committee to incorporate such proposals under any appropriate legislation it considers this year.

Chiropractic patients tend to be highly satisfied with the care that they receive -- a key reason

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[1] Smith R., "Where is the Wisdom: The Poverty of Medical Evidence," *British Medical Journal* 303:798-799, 1991. (Quoting David Eddy, MD, Professor of Health Policy and Management, Duke University.)

that as much as 15% of the population currently sees a chiropractor for health care services.[2] For example:

* One study found chiropractic patients were three times more satisfied with their care than were patients of family physicians.[3]

* A Gallup Survey found that 90% of chiropractic patients felt their treatment was effective while 80% had most of their expectations met.[4]

These findings on patient satisfaction compare extremely favorably with those of any other health care profession and help explain the immense popularity of chiropractic care.

Not only are patients highly pleased with the care they receive from their D.C., but chiropractic care has been proven extremely cost effective. As the subcommittee is aware, a majority of the conditions chiropractors treat pertain to neuromusculoskeletal (NMS) problems -- up to 88% according to ACA's 1994 Annual Membership Survey. In light of that fact, ACA is proud that research demonstrates high rates of cost effectiveness attributable to chiropractic care. Research indicates that D.C.s treat NMS conditions more cost effectively than do other providers. For example, a recent study found that for treatment of all NMS conditions treated by all types of providers, "chiropractic users tend to have *substantially lower* total health care costs."[5] (emphasis added) These important findings -- which have been corroborated by follow-up research[6] -- should come as no surprise, since chiropractors treat patients in a conservative drugless, non-surgical manner that helps them avoid the expensive hospital setting.

The high levels of patient satisfaction with -- and the cost effectiveness of -- chiropractic care should not go unnoticed by federal policymakers. We encourage this subcommittee to adopt policies that will help D.C.s more fully integrate into both private and public health care systems. Unfortunately, the chiropractic profession still labors under institutionalized impediments to full participation in many segments of the health care system. We fear that such impediments are based more on bias and ignorance rather than on science and empirical evidence. We are hopeful that through forums like these, Mr. Chairman, we can begin to set in motion polices that will lead to more complete assimilation.

The Importance of AHCPR Research

Since one of the main focuses of this hearing is the application of AHCPR research to the Medicare program, ACA is compelled to comment on one of that agency's most recent and perhaps most important findings. We are extremely pleased that the high quality of chiropractic care was recently re-emphasized by an AHCPR guideline on the treatment of low-back pain in adults. According to the guideline released last December, a multi-disciplinary team of researchers has determined that spinal manipulation is a *recommended and effective* form of care for the pervasive, multi-*billion* dollar a year malady of low back pain. Since low back pain will afflict 8 out of every 10 Americans at some point in their lives, we are hopeful that the guidelines will have significant implications for federal and private health policy.

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[2] United States Government Printing Office, Alternative Medicine: Expanding Medical Horizons, A Report to the National Institutes of Health on Alternative Medical Systems and Practices in the United States, NIH Pub. No. 94-066, December 1994, p. 121.

[3] Cherkin, D.C., MacCornack, F.A., "Patient Evaluations of Low-Back Pain Care," *Western Journal of Medicine*, Vol.150, November 3, 1989.

[4] Demographic Characteristics of Users of Chiropractic Services, The Gallup Organization, 1991.

[5] Stano, M, et al, "The Growing Role of Chiropractic in Health Care Delivery," *Journal of American Health Policy*, Vol.2,No.6, November/December 1992.

[6] Stano, M, "Further Analysis of Health Care Costs for Chiropractic and Medical Patients," *Journal of Manipulative and Physiological Therapeutics*, Vol.17, No.7, September 1994.

The ACA is especially pleased with the AHCPR findings since doctors of chiropractic are the leading experts in spinal manipulation, delivering almost 95% of all such services rendered in this country.[7] This is an important fact to remember -- doctors of chiropractic are the predominant practitioners of spinal manipulative therapy. To suggest that other types of health providers are performing spinal manipulation to any meaningful degree is simply inaccurate. Such procedures have never been taught in medical schools and osteopathic colleges long-ago de-emphasized courses in manipulative techniques. When spinal manipulation is needed, doctors of chiropractic are the providers of choice.

AHCPR Guidelines Warrant Changes in Federal Health Policy

Despite the AHCPR's conclusion that spinal manipulation is a preferred treatment for low back pain, Medicare and other federal programs continue to adhere to antiquated rules and regulations that erect barriers to this care. While Medicare provides coverage of manual manipulation of the spine performed by chiropractors, coverage is restricted through the requirement of a non-covered diagnostic x-ray. While an x-ray is required under the statute, if performed or ordered by a D.C., it is not covered, despite the fact that every state licenses D.C.s to perform x-rays. Thus, if a beneficiary wants spinal manipulation from a D.C., they are forced to pay for the required x-ray themselves or have it taken by some other provider that Medicare will reimburse for the service. This an obvious barrier to chiropractic spinal manipulation that has the effect of channeling beneficiaries from D.C.s to other, more expensive providers.

In our view, this structural impediment to chiropractic care contradicts AHCPR's finding about the efficacy of spinal manipulation. With D.C.s providing the *overwhelming majority* of these services, it makes little sense from a public policy perspective to discourage beneficiary access to these providers. We are working with subcommittee member Congressman Phil Crane and others to rectify these coverage restrictions and we hope that the subcommittee will see fit to incorporate remedial language in the appropriate legislative vehicle this year.

Unfortunately, Medicare is not the only federal health program that restricts access to chiropractors -- and thus to spinal manipulation. While over 85% of employer-provided health plans offer some coverage of chiropractic care, federal programs either limit or totally exclude these services. For example, not all health plans offered through the Federal Employees Health Benefits Plan system (FEHBP) provide this coverage. In fact, it has recently come to our attention that the FEHBP Blue Cross/Blue Shield plan available in the state of Georgia *specifically excludes spinal manipulation services*. In addition, under the military's CHAMPUS program no chiropractic services are available despite the fact that D.C.s are eligible to serve as commissioned officers in the military. Veterans health facilities only allow coverage of chiropractic care on the referral of an M.D. -- and there is little evidence to suggest that this ever occurs. In addition, the National Health Service Corps refuses to permit D.C.s to participate in that program despite the fact that D.C.s are educated and licensed to perform a wide range of primary care diagnostic and treatment services regularly performed by other primary care providers. And these are just a few of the most obvious examples.

If the AHCPR guideline process is to have any meaningful impact on the Nation's health care system, federal health agencies ought to adhere to the findings that it generates. Given the extent of low-back problems in society today and the multi-billion dollar cost of treating these conditions, federal health policy should encourage and facilitate the availability of chiropractic services in America's health delivery system. Unfortunately, as it now stands, such coverage is either specifically excluded or discouraged.

HMOs and AHCPR Guidelines

We are disappointed to learn that federal programs are not alone in ignoring AHCPR guidelines. Recent data indicates that only about 40% of health maintenance organizations (HMOs) have

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[7] Shekelle, PG., et al., The Appropriateness of Spinal Manipulation for Low Back Pain: Project Overview and Literature Review, RAND Corporation, Santa Monica CA, 1991.

adopted any of the various guidelines developed by the AHCPR process.[8] It is, therefore, of little surprise when one learns that 16% or fewer of HMOs offer chiropractic services,[9] since spinal manipulation services, including related diagnostic services, are hardly ever provided by any health professional other than a D.C. Given the great magnitude of evidence on the cost effectiveness of chiropractic care, it is unfathomable that the HMO industry has not seen fit to adopt the AHCPR guidelines or to provide spinal manipulation to a much greater extent.

HMOs claim to provide health care services more cost effectively than other delivery systems. Yet in light of the near total exclusion of chiropractors from the HMO industry, one wonders if factors other than cost effectiveness and enrollee well-being are behind the lock-out of these practitioners. ACA hopes that the exclusion of D.C.s from the HMO industry is not the result of the bias and ignorance of a bygone era in our Nation's health care history. If such bias still exists, however, we hope that it can be overcome by scientific processes such as those that the AHCPR research represents. If HMOs and other managed care entities are truly interested in providing quality health care at affordable costs, then they should adhere to the AHCPR low-back pain guideline by increasing the availability of spinal manipulation services. Therefore, we would strongly urge Congress to carefully oversee and review the implementation of the AHCPR low-back pain guidelines in the managed care industry.

Medicare HMOs

Unfortunately for Medicare beneficiaries, the HMO industry's failure to provide chiropractic services also extends to HMOs with Medicare risk contracts. As stated above, the only chiropractic service currently recognized as a covered physician service by Medicare is manual manipulation of the spine. Eventhough this is an extremely limited benefit, the fact remains that it is a bona fide "physician service" under Medicare Part B, and thus, all Medicare beneficiaries, including those enrolled in managed care organizations, are entitled to it. Yet, a great deal of evidence indicates that Medicare HMOs are systematically denying enrollees spinal manipulation by chiropractors. It is our opinion that HMOs are obligated under the law to provide the same level of service (i.e., *all* Part B services, including manual manipulation of the spine by a chiropractor) regardless of whether the beneficiary is enrolled in an HMO or remains in Medicare fee-for-service. There is ample legislative history supporting this view. To wit:

* "To qualify to receive payment in this way, a health maintenance organization would have to be one which provides:

  . . . .

  (2) *all* the services and benefits of both the hospital and medical insurance parts of the program; ..." (emphasis added.)[10]

* "[T]he conferees expect that *HMOs will make available*, either directly or under arrangements, *such services covered under Part A and B that would otherwise be available to beneficiaries in an area in the absence of HMOs.*" (emphasis added.)[11]

* "Each competitive medical plan *must provide to its Medicare enrollees at least the health services listed under Parts A and B of Medicare* which are available to individuals residing in the geographic area served by the plan." (emphasis added.)[12]

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[8] Bernstien, A., et al., 1994 HMO Performance Report, Group Health Association of America, p. 10.

[9] Marion Merrell Dow Managed Care Digest/HMO Edition 1993, p. 23.

[10] H.R. Rep. No. 29-231, 92 Cong. 2d Sess., reprinted in 1972 U.S. Code Cong. & Admin. News 4989, 5078.

[11] Conf. Rep. No. 92-1605, reprinted in 1972 U.S. Code Cong. & Admin. News 5370, 5385-86.

[12] S. Rep. No. 97-494, 97th Cong. 2d Sess., reprinted in 1982 U.S. Code Cong. & Admin. News 781, 810-11.

In view of the fact that D.C.s are the primary deliverers of spinal manipulation services, that spinal manipulation by a chiropractor is a lawful Medicare Part B physician service, and that HMOs are required to offer all Part B services, it is an outrage that Medicare beneficiaries enrolled in managed care organizations continue to be denied this service. Regardless of whether HMOs are legally required to provide this service -- which we believe they are -- the new AHCPR low back pain guideline makes it is more clear than ever that, *from both a public policy and health care quality point-of-view*, Medicare HMOs ought to be providing spinal manipulative services. With the subcommittee's interest in promoting quality health care services within these organizations, we feel that clear, congressional directive language is necessary to require Medicare HMOs to comply with the law, and the AHCPR low-back pain guideline, by providing spinal manipulation services via chiropractors.

Managed Care Coalition

As managed care's emphasis on containing costs has grown, the ACA and other health care organizations have become increasingly concerned about fundamental issues of consumer choice, access and quality. Health care consumers, including Medicare patients, deserve a certain level of protection against managed care's shortcomings in these areas. Public desire for these protections was quite evident during last year's health reform debate when several bills contained important consumer protection provisions.

Over the last several months, ACA has been working within a coalition of health providers and consumers to develop a legislative package designed to improve consumer choice and health care quality in managed care settings. The package seeks to build on the current managed care system in the following ways:

* ensure an adequate choice and mix of types of health providers;
* improve the quality and availability of plan information for consumers;
* create grievance procedures for consumers unhappy with a plan's services;
* establish 'due process' provisions for providers; and
* establish quality assurance mechanisms.

The package has a strong focus on health care quality. Current and prospective health plan enrollees would be guaranteed access to a whole new range of information on coverage provisions, benefits and exclusions, the amount of premiums set aside for administration and marketing of a plan versus the percentage spent on the provision of health care, the ratio of enrollees to providers, any financial arrangements or incentives that would limit services offered, enrollee satisfaction statistics, and quality indicators for the plan and its providers. In addition, the proposal would require the Secretary of Health and Human Services to encourage health plans to adopt quality assurance and quality improvement mechanisms and to encourage further conducting of outcomes research.

We feel that these specific elements of our coalition's package -- by vastly improving consumers' knowledge about their health plans -- will result in continuous quality improvement in managed care. Empowering health care consumers with such information will help drive health plans to make decisions based on enrollee health care needs more so than on financial considerations. In our view, the protections and information disclosure requirements contained in our proposal should be extended to all managed care enrollees including Medicare beneficiaries. We hope that the subcommittee will give serious consideration to this package of consumer friendly provisions as part of any Medicare legislation considered this year.

TESTIMONY OF HON. JAMES V. HANSEN
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. CHAIRMAN, I appreciate the opportunity to submit testimony on behalf of *HealthInsight*, the medicare peer review organization (PRO) for Utah and Nevada.

This organization has provided quality improvement services for Medicare and Medicaid since 1974. However, over the last five years, *HealthInsight* has devoted significant energy to help HCFA understand that improving quality in health care is more than just finding the bad apples in the system. As a model in the PRO community, this organization has worked to find more effective and efficient uses of federal dollars in assuring health care quality is maintained and improved.

One recent study, involving McKay Dee Hospital and physicians from my district, looked at radical prostatectomies in men age 75 and older. *HealthInsight* hypothesized from available data and medical literature that this procedure is over utilized in men over age 74. So, rather than impose regulations or penalties, they brought Utah urologists and other health professionals together as a team to discuss the diagnosis and treatment of prostate cancer. There are generally three management options given to a man who is diagnosed with localized prostate cancer: (1) radical prostatectomy - a major surgery, (2) radiation therapy, and (3) conservative observation management - watchful waiting.

Currently, radical prostatectomy and radiation therapy are the most common forms of treatment. But we all know each presents the risk of long-term complications that some of us would view as diminishing our quality of life (incontinence and impotence). The watchful waiting approach is considered when an individual has a life expectancy of ten years or less. Because localized prostate cancer grows very slowly, older men are very likely to die of other causes before cancer has any effect on their health. And those who choose watchful waiting avoid the risks of possible side effects associated with other treatment.

Information about these treatment options was sent to the medical community. The project team recommended that the underlying principal in managing disease must be informed patient choice. The team also recognized that radical prostatectomy or radiation therapy in patients 75 or older customarily should be unusual treatment options. Then, Utah surgeons and urology specialists were sent 1991-1992 prostatectomy rates for their own practices -- the data showed them their proportion of radical prostatectomies in patients over 74 compared to other physicians in the state. They were also shown a county by county comparison for the state of Utah.

Since that project was completed, 1993 and 1994 data show a significant decrease in the number of radical prostatectomies performed on men over age 74. These data show that if the rate of radical prostatectomies had continued to grow at the expected rate, consistent with the 91-92 numbers, approximately $9.4 million MORE would have been spent on this procedure in Utah alone during those two years. This example hints at the potential of community-wide improvement projects to protect health, improve the patients outcomes, and save valuable health care dollars.

As we examine ways to save federal dollars, yet maintain a level standard of care, we need to take a look at the work of *HealthInsight*. They provide significant benefits, not only to federal health programs, but to our communities at large. Through collaborations with state government, providers, consumers, insurers, researchers and others, *HealthInsight* works to ensure ongoing improvement in the quality and effectiveness of care delivered in Utah and Nevada. PRO's aren't just looking for the bad apples any longer-- they are bringing the professionals together on multiple projects to improve everyone's care.

This approach to quality management helps local health care providers come together and share valuable knowledge. Such relationships create trust and stability within our system and allow for a better transfer of information. And that translates into better care for me and you. Personally, I would rather have my physician respond to community efforts to improve care than grudgingly treat me according to a mandate from the federal government.

Mr. Chairman, *HealthInsight* is working within the PRO community to share their knowledge and promote more effective ways to meet their federal contractual obligations. As a fiscal conservative, I support federal contractors who honor their agreement and work to improve a system, rather than gouge it. As you review the PRO program, I urge you to consider the positive impacts *HealthInsight* has had in the community as well as the effective and efficent manner federal dollars have been utilized in assuring health care quality is maintained and improved.

ISSUES REGARDING GRADUATE MEDICAL EDUCATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MARCH 23, 1995

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ISSUES REGARDING GRADUATE MEDICAL EDUCATION

THURSDAY, MARCH 23, 1995

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

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

[The press release announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 14, 1995
No. HL-6

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARINGS ON ISSUES REGARDING GRADUATE MEDICAL EDUCATION -- A VISION FOR THE FUTURE

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will conduct the first of a series of hearings on the topic of graduate medical education. **The hearing will take place on Thursday, March 23, 1995, in the main Committeee 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. 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:

Since the inception of the Medicare program in 1965, Medicare has reimbursed teaching hospitals for the program's share of the cost of training physicians and other health professionals, and the generally higher costs of operating tertiary-care academic health centers. With the advent of the Medicare Prospective Payment System in 1983, Medicare hospital payment for graduate medical training and certain teaching hospital service costs has been separated into direct and indirect reimbursement for medical education.

Medicare pays for the allowable cost of direct graduate medical education activities at teaching hospitals, including reimbursement for training and related overhead costs, and salaries and fringe benefits for medical residents and other health professionals. Medicare is expected to reimburse teaching hospitals $1.9 billion for the direct costs of graduate medical education in 1995.

The Medicare indirect medical education adjustment compensates teaching hospitals for the costs of the additional tests and procedures which occur in those hospitals related to the training of medical residents, as well as the fact that these hospitals tend to treat sicker, and generally poorer, elderly patients who require more intensive services. In order to cover these extra costs, teaching hospitals receive a higher payment per case than other institutions. This per case add-on is currently set at approximately 7.7 percent for each 10 percent increase in the ratio of full-time interns and residents to the number of beds in the hospital. In 1995, Medicare is projected to spend $3.6 billion on the indirect medical education adjustment.

In announcing the hearing, Chairman Thomas said: "A revolution is underway in health care which has significant implications for the future health manpower needs of the nation as well as the destiny of our major teaching hospitals. As we consider significant Medicare and health reforms, the Health Subcommittee will examine carefully current graduate medical education and teaching hospital policy, and the effect Medicare policy improvements can have on the ultimate direction for both graduate medical education and academic health centers."

FOCUS OF THE HEARING:

This hearing is the first of a series on the topic of graduate medical education with the goal of developing a Medicare health professions education and teaching hospital payment policy relevant to the emerging health care system and the long-run medical and financial concerns of Medicare beneficiaries. The hearing will examine alterative policy directions regarding the

training of future health professionals, the medical manpower needs of the evolving health care system, and the financing of teaching hospitals. Current Medicare payment mechanisms for graduate medical education and teaching hospitals will be reviewed.

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 by the close of business, Monday, April 3, 1995, 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.

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

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

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

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

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

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Chairman THOMAS. The subcommittee will come to order.

We want to welcome you to the first of a series of hearings on graduate medical education. These hearings hopefully will lay a base for the development of new Medicare policies on reimbursement for graduate medical education and the payment for services in teaching hospitals.

These new policies should be consistent with the medical and financial concerns of Medicare beneficiaries and the evolving health care marketplace.

To meet these goals, we will be looking for new ideas and better ways of using our Medicare resources and, in some instances, repeating ideas of 10 years ago that we did not listen to at that time.

The question before us today is: How do we provide incentives for making the training of doctors and health care professionals more relevant to the needs of Medicare beneficiaries in the emerging health care marketplace, which is also consistent with our objectives for maintaining our superior hospital system and containing Medicare cost growth. These challenges will obviously be a critical part of our broader task to preserve and improve the Medicare program.

There is a growing consensus that the Nation needs more primary physicians and fewer specialists. We know that the mix of primary care practitioners and medical specialists in training is not consistent with perhaps even the current and clearly the future needs of our health care system.

The key objective in reforming Medicare's graduate medical education payment methods is to develop a policy which will encourage a better balance of generalists and specialists for our health care work force.

Today, Medicare pays for its share of graduate medical teaching by training at teaching hospitals, usually for training in tertiary care academic health centers. Primary care training has generally not been the principal mission of these academic health centers, and these teaching hospitals may never be the best locations to carry on such training, since many experts believe that primary care training, to a great extent, is better accomplished outside the hospital in medical offices or clinics.

At the same time, many of the services provided by our academic health centers depend on residents in specialty training. These training hospitals provide essential medical services for Medicare beneficiaries and other Americans which cannot always be easily replicated in other settings.

In addition, these institutions are responsible for significant advances for medical science and technology.

In many locations, academic health centers not only serve as regional resources for highly specialized services, such as trauma and cancer centers, burn units, and neonatal intensive care units, but also provide much of the medical care needed by the people in surrounding inner-city communities.

Many of the Nation's major teaching hospitals have historically been located in inner cities because that was where they were originally located, and the city changed around them more because they were built in certain neighborhoods specifically to serve the urban poor, which means that academic health centers are often

the major employers in those areas and the principal consumers of neighborhood goods and services as well.

Complicating the graduate medical education issue even more is that the fact that as the health care market moves toward managed care, there is a financial squeeze on such teaching hospitals, because many of the services these hospitals offer can be more cheaply provided in nonteaching settings, and so managed care plans tend to shy away from sending their insureds to these institutions.

Our efforts to encourage Medicare beneficiaries to elect this private-sector option of managed care only intensifies pressures on teaching hospitals. So we are left with the dilemma of how to redirect training programs, while preserving the best of what academic health centers offer, in addition to solving the cost and choice issues which face the Medicare problem.

I look forward to beginning our discussion of these issues today and especially on the ideas of individuals who have thought about this problem for a long time.

And with that, I would yield to the ranking member, the gentleman from California, Mr. Stark.

Mr. STARK. Mr. Chairman, thank you.

This hearing is propitious. Every list of cuts in Medicare that have been floated by the Republicans suggests that Medicare support for teaching hospitals should be slashed. We are about to slash billions and billions of dollars from children's programs to pay for tax cuts for the rich. I suppose one of the good things is that these tax cuts for the rich will inure to many of the same physicians who will be out of work when we close the centers of excellence under the Republican plan to cut a couple of hundred billion out of Medicare.

Scheduling the hearing at this point allows us to express our support for teaching hospitals and opposition to rather mindless cuts in the Medicare program without understanding how it relates to the overall medical delivery system in our country.

The issue of indirect medical education adjustment is not really about formulas or regression analyses or whether we should have 4.5 or 7.7 percent. I might add that every 1 percent we cut takes a half a billion dollars a year out of these centers of excellence. But that is not the issue.

I think the issue is, say, that a hospital is performing a mission in the inner city. It is no accident that two-thirds of our teaching hospital payments go to disproportionate share hospitals. These hospitals have the lowest margins of all hospitals. And I am not willing to attribute that to bad management or lack of entrepreneurship or lack of interest in the profit motive.

I am willing to attribute that to a mission that is humane and may not be understood by the majority, but it is a system that tries to help everybody without regard to their income.

Along with the pressure that these institutions will feel with cuts in Medicare spending, these hospitals are also under pressure due to this push toward private health plans and contracting Medicaid and Medicare to the so-called profit sector.

What health plan, what Humana, what Prudential, in its right mind, if they have one, would sign a contract with a hospital whose

costs are inflated because of the presence of large numbers of people who cannot and do not pay or who provide research in skills that the average hospital cannot?

Why should these private hospital plans contribute to the cost of training the next generation of doctors when they can get away without paying their fair share?

Our unwillingness to require private health plans to contribute to these costs, which teaching hospitals cannot avoid, may mean that the very children the Republicans are so worried about assuming the debt of future generations will wake up with no debt and no medical care either.

This does not mean that the indirect medical education adjustment or the direct graduate medical education adjustment period by Medicare cannot be changed. It should be. And we Democrats on this committee proposed such a cut last year.

The difference is, the cut was coupled with a program which assured every American health coverage, so that the debt and charity care in these safety net hospitals would have been a thing of the past.

Our bill proposed to require private health plans to contribute to a pool of funds used to support graduate medical education. The bill reduced support for nonprimary care residencies and increased support for primary care residencies.

Mr. Chairman, this approach is the right one to reducing Medicare's support for these hospitals, and is as valid today, even more valid in the absence of health reform, than it was in the previous Congress.

So I conclude with a plea, Mr. Chairman, that the debate center around these issues and the role of teaching hospitals in our health care system and the appropriate way to assure that all benefits from them should be the central question and not ways to raise money to give tax cuts to the rich.

Chairman THOMAS. I thank the gentleman.

Our first panel—and I would ask the panelists to come up—will be Dr. Shine, Dr. Heyssel, and Dr. Ludden.

And to provide an additional introduction of Dr. Heyssel, who is former president of Johns Hopkins Medical Institutions, is a fellow who is somewhat familiar with that geography, the gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

I just really wanted to welcome Dr. Heyssel to the Ways and Means Committee. I know he is not a stranger here in Washington.

We were very blessed to have Dr. Heyssel in Baltimore heading up the Johns Hopkins University Hospital for many, many years, and his visionary leadership in our State really, I think, added to the reason why Maryland was able to develop such a successful hospital reimbursement system.

He is a friend. He has helped me personally in developing my own views on health care, and it is a real pleasure to welcome him to the committee.

Dr. HEYSSEL. Thank you, Congressman Cardin.

Chairman THOMAS. Thank you, doctors, very much. And I will tell you that your written testimony will be made a part of the

record, without objection, and you may proceed in any way you see fit to inform this panel.

Let us start with Dr. Shine, and then we will move across.

STATEMENT OF KENNETH SHINE, M.D., PRESIDENT, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES, WASHINGTON, D.C.

Dr. SHINE. Thank you, Mr. Chairman. It is a pleasure to be with you.

As I indicated in my written testimony, my experience or my comments are based on experience as a trainer of cardiologists, internists, and serving as dean and provost of a medical school.

I currently serve as president of the Institute of Medicine, but it should be clear that my comments today are personal comments, although the Institute has studied a number of these issues and concurs, for example, with the observations you have made about the importance of generalism.

I want to go directly to the principal proposal that I would like to make and to try to elucidate that in terms of the issues you raise.

I believe we should immediately place a freeze, an absolute freeze, on the total number of graduate medical education positions funded in the United States and certainly the number of those positions funded through Medicare, and hopefully, in fact, all positions. I want to try to convince you that that is a sensible thing to do.

As you have pointed out, the fundamental problem is both the question of having an adequate number of generalists versus the question of the total number of physicians, particularly subspecialists, in the country.

I believe there is evidence that market forces are working on generalism in a very effective way. Salaries for generalists are rising. As managed care increases its activities, they are, in fact, scooping up generalists to a significant degree. Salaries for subspecialists are declining. And I believe there is very good reason to be optimistic.

If you look at the data from medical students, you will find that over the last 3 years medical students who have indicated an interest in careers have gone from 14 percent of graduating students to 23 percent indicating an interest in generalism, and I think these young people are smart. They know where the jobs are going to be. They know what the market is doing. And I think they will continue to move into generalism.

The dilemma, however, is that in the absence of any limits, we keep training more and more physicians, and that surplus involves lots of people who become subspecialists for a variety of reasons.

Why will the market not work to control the total number of physicians?

It will not work for several reasons. First, because institutions, as you have heard and know, can use resident physicians to provide care. At the present time, these trainees are a subsidized form of service, and it is to the advantage of institutions to add more residents under a variety of circumstances in order to get the work

done. And so medical students and others are told that there are good opportunities in these particular areas.

Second, in the absence of any limits, the number of international medical graduates who come to this country has continued to escalate.

Now just to make this as clear as possible, between 1988 and 1994, the number of residents in graduate medical education programs increased from 84,000 to almost 104,000, 20,000 more each year. Each of those residents represents 35 to 40 years of professional service. So in terms of the health care system, we add 4,000 residents a year, which is what we have been doing; you basically are creating a cost center for 160,000 physician years.

Now one of the questions would be: Well, if the price comes down, if subspecialists charge less or receive less, why will that not ultimately decrease the supply?

Well, there are several reasons. One is that the pipeline is very long. It takes 7 to 10 years for people to prepare.

But more important, practicing in the United States is very attractive to international medical graduates, and over the same time period, the number of international medical graduates has gone from about 7,200 to over 18,500; that is, 11,300 more international medical graduates have gone into residency programs over that same period of time.

The effect, then, is that the forces are to increase the number of physicians.

Let me just conclude by arguing that if you have a cap, if you have a freeze, that it does several things for you.

First, it reduces the rate of rise of costs, because it is harder to add more people. At the present time, if an institution has an accredited program, it can add more residents.

Second, it has the effect that if one is going to have more generalist positions in your program in a particular institution and you are frozen, you have got to diminish the number of subspecialty slots.

Third, we all believe that people need to have more training at sites outside of the hospital, and we want to see the rules change so that individuals can take care of senior citizens in the community and so forth.

Right now, if you change the rules, that is dangerous, because there will be the tendency to increase the number of residency slots to provide high-tech care. In the presence of a freeze, if you had a fixed number of people, you can use them in a variety of community slots. They can do preventive care; they can work on Medicaid and managed care programs and so forth without running the risk that you will continue to escalate the number of individuals.

Let me just conclude by saying that I am concerned about the issue of payment to these institutions. As you made reference in your statement, as more and more Medicaid and managed care occurs, there is going to be less and less support for this activity.

And I do believe that if managed care organizations and other payers were required to make some contribution to medical education on a percentage basis, that that would have the effect of providing support and a level playingfield, so that one managed care organization was not giving an advantage to another by virtue of paying for some education. And I think we ought to consider that.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF KENNETH SHINE, M.D.
NATIONAL ACADEMY OF SCIENCES

Mr. Chairman, Ladies, and Gentlemen:

My name is Kenneth Shine, M.D. I currently serve as President of the Institute of Medicine (Institute) of the National Academy of Sciences. As Chief of the Cardiology Division at the UCLA School of Medicine, I was Program Director for a subspecialty training program in cardiology. As Chairman of the Department of Medicine at UCLA, I was the Program Director for training in all aspects of internal medicine, including general internal medicine. As Dean and Provost at UCLA, I was responsible for training programs in all of the medical and surgical specialties. I helped to develop an outstanding program in family medicine residency at UCLA. For many years, that program was one of the few that was physically based at the core facility of a major tertiary care academic medical center. As Clinical Professor of Medicine at Georgetown University School of Medicine, I continue to teach and see patients with interns, residents, and fellows. Although the Institute and many organizations with which I have belonged have issued a variety of statements with regard to graduate medical education, my comments this morning are my own, and I do not represent any organization or the Institute in making these remarks.

In many ways, the system of graduate medical education in the United States is the envy of the world. This is reflected, among other things, in the large and rapidly growing number of international, i.e., foreign, medical graduates who seek their training in American teaching hospitals. The funding of this program has depended critically on medical education payments through the Medicare program. Such payments have been critically important to our society in many ways. They have provided salary support to young medical graduates, many of whom now leave medical school with debts of $100,000 or more--debts that have the pernicious effect of encouraging graduates to seek careers in highly compensated and technologically driven aspects of medical care, often at the expense of the country's needs for generalist physicians. The payments allow economically disadvantaged and underrepresented individuals to obtain graduate medical training. Payments through the Medicare program have allowed hospitals to provide outstanding care to Medicare recipients, to poor and underserved populations, and to the very sick patients with complex illnesses who require all of the technological and personpower skills of these institutions.

But the reimbursement system has had a series of unintended consequences. It is these consequences that I wish to address. I shall make the following recommendations.

1) The number of graduate medical education positions funded through DME and IME money should be frozen at current levels. If possible, the total number of graduate medical education positions irregardless of funding sources should be frozen at the same time.

2) Institutions should be in a position to assign residents to activities in the outpatient or ambulatory environment at local and at distant sites, including community health centers, community-based centers for care of the elderly, managed care organizations, urban and rural locations.

3) Within the reimbursement formulas, some disincentives for subspecialty training and increasing incentives for generalist or primary care training should be included.

4) Assignments of residents should be based on the need for experiences which offer an adequate balance between generalist and subspecialty care, preventive as well as curative care services, and as part of multidisciplinary groups of health

providers, including advanced practice nurses, physician assistants, and community health workers.

5) Hospitals should be encouraged to develop alternate providers, advanced practice nurses, physician assistants, and health workers to provide service in urban municipal hospitals, rather than depend on GME to provide services.

There is increasing evidence that we are educating and training far too many physicians for our country's needs. Professor Weiner at Johns Hopkins has estimated that we will have an excess of 163,000 physicians in the period between the year 2000 and the year 2020, the vast majority of whom will be subspecialists (151,000). Evidence for the surplus of physicians is already apparent in the number of subspecialists who are currently being laid off by managed care organizations or who are being told that they must be retrained as primary care providers. In some cases, no such retraining is offered, but the effectiveness of training to turn a subspecialist into a primary care provider remains in doubt. As the efficiencies of managed care are felt, requirements for subspecialists are diminishing rapidly. In this sense, market forces are at work and, in many respects, these market forces are constructive. For example, the beginning salary for generalists is rising steeply as organizations bid for their services. In southern California, the starting salary for a general internist has risen by 35 percent to 40 percent. Similar kinds of changes have taken place around the country.

Market forces do seem to be having a significant effect upon the choices of medical students as they think about the kinds of training and careers to which they aspire. This is reflected in the increase in the number of graduating medical students who, according to the Association of American Medical Colleges, have indicated their interest generalist careers. From 14 percent of graduating students indicating a generalist interest three years ago, the number has increased to 23 percent and is likely to continue to rise as these students understand the job opportunities and income possibilities.

However, market forces alone will not solve the problem of the increasing physician surplus, and the current organizational structure of the IME and DME programs have much to do with this problem. First, the current law provides that institution may add additional residents to accredited programs largely at their own initiative. Under these circumstances, the amount of both DME and GME monies, which they receive, is increased. The effect is that public monies are used to subsidize salary and support of residents, who then provide services to patients in these institutions. Given the health care needs in large urban centers, hospitals have been rapidly adding residents. In 1988-89, there were 84,273 total number of physicians in graduate medical education in the United States. By 1993-94, the number had risen to 104,159, an increase of 20,000 physicians with an average increase of 3.9 percent per year. Since the average physician practices for 35 years to 40 years, the effect of this is to add 140,000 to 160,000 physician years of service to the nation's health care system, which are costs to be borne by the overall health care system. Even though individual compensation salaries or reimbursements may decline in response to market forces, the addition of a large number of individuals, who will be in surplus as a consequence of a cost reimbursement approach through the GME support, is illogical. Although the number of graduates of American medical schools has been relatively constant over the last decade, the number of foreign medical graduates in graduate medical education has increased from 7,227 in 1988 to 18,593 in 1994. This is an increase of approximately 11,300 physicians, accounting for approximately half of the increase in total graduate medical education positions. Which leads to the second important point. Although market forces will decrease reimbursement, so long as there are unlimited numbers of positions available, international medical graduates still will find opportunities and incomes in the United States attractive enough so that they will continue to fill this rising number of positions.

While increasing the supply of physicians has produced some marginal redistribution of physicians to smaller communities, in fact, the need for physicians in

rural communities and underserved urban communities remains very high and is not likely to be solved solely by flooding the market with physicians. Other strategies, including professional, technological, and management innovations will be required to meet these needs.

There have been many proposals by organizations to limit the number of positions under graduate medical education. The most common proposal is that they be limited to 110 percent of the number of graduates of American medical schools. Such a rule requires significant downsizing in the number of residents at the present time. I strongly urge the Congress to change legislation so that, at the very least, the total number of positions supported using Medicare monies be frozen at the current level. The effect of a freeze would stop this increase of almost four percent per year in the number of physicians added to the workforce. If an institution wished to add a resident without the use of GME funds, they could have that opportunity, although I believe an absolute freeze makes even more sense. Under a freeze, an institution could shift residency positions from program to program, and residents could be assigned to multiple non-hospital sites without increases in the total number of residents.

This leads me to the second major flaw in the current system. The formulas for reimbursement in graduate medical education lie predominantly on calculations and services related to inpatient beds. This has two effects. First, it causes institutions to keep a disproportionate number of positions in subspecialty areas employing technology on an inpatient basis. Secondly, it means that the educational experience is often disconnected from the real needs of society and of the health care system. Medical education must move increasingly into ambulatory services not only at the hospital but into the community, urban and rural, for all segments of society.

The managed care industry emphasizes that it may take them 18 months to prepare a physician, even those with generalist training, to practice appropriately in the managed care environment. We must use limited resources in health care to provide services for all elements of society, including the poor, the elderly, and the underserved, in non-hospital sites, with the extensive use of non-physician providers as part of a team that can emphasize preventive services, consult with young parents about illnesses before they make use of the much more expensive emergency room to receive needed care, and to emphasize preventive programs. Under current circumstances, institutions cannot construct educational programs for their residents based on either the long-term social or professional needs, but rather organize these programs in order to meet the requirements for reimbursement. Under circumstances of the freeze, institutions ought to be allowed to plan resident educational activities based upon educational requirements for physicians and the overall health care needs of the community in which they work. Under such circumstances, residents might spend substantial amounts of time in neighborhood health clinics rotating through managed care organizations and otherwise providing services that are the most cost-effective and useful way to improve health in the community. Under these circumstances, if an institution wished to increase the number of residency positions in the generalist or primary care specialties, it could do so but only by reducing the number of positions in the subspecialties. A freeze would then begin to ameliorate the potential long-term cost to society of producing too many physicians with public subsidy and would create a set of conditions in which the more appropriate assignment of residents, according to social and educational needs, would become rational for all concerned. Indeed, one could support the arguments previously made that the formula for reimbursement might be altered so that a higher premium is offered to institutions that substantially change the ratio of generalists to specialists. Those of us concerned about graduate medical education are also worried that residents have been added and assigned according to the work needs of the institution rather than to the education needs of a student. Under a freeze situation with some premium for generalist physicians in comparison to subspecialty physicians and increasing flexibility for educational program directors to make assignments to a variety of training sites, this goal of emphasizing education versus service would, in fact, result in better service in the right places, according to the patients needs.

Let me conclude with two other observations. First, Medicare has been a critically important source of support for graduate medical education. But all of society benefits from these education programs. The entire health care system, including managed care organizations, clearly require the workforce that is generated through these program and clearly benefit from their existence and from their quality. Creating some form of all-payor system, in which all insurers and managed care organizations, as well as Medicare and Medicaid provide a small percentage of their revenues toward education, would go far to both spreading the burden and acknowledging the responsibility of all public concerned parties. Moreover, it would deal with an important problem for academic health centers as more and more Medicare recipients are care for in managed care organizations. As this practice increases, direct medical education costs are no longer paid since these are included in the premium received by the managed care organization from Medicare. When the managed care organization negotiates with a teaching hospital, it is under no obligation nor does it ordinarily include in its rates any consideration of the training capacity. Prudent policy would, at the very least, require such organizations to include such support in proportion to their Medicare enrollees, and, as I suggested, from a public policy point of view, I believe the burden should be shared in relation to all health care coverage.

I want to emphasize the fragile nature of our academic health centers at the present time. These centers are truly gems nationally and internationally. They are the sources of the research that has fueled the biotechnology industry, the medical device industry, and many other productive elements of our society, contributing not only domestically but representing a large proportion of exports which contribute positively to the trade deficit. They are important employers and they are critically important to provide, on the one hand, the most highly specialist care for the most desperately ill in our society, and, on the other hand, a very large proportion, perhaps as much as 45 percent or 50 percent of the care to poor and underserved. As the private sector organizes more and more health care into managed care where price is the overwhelmingly important factor in negotiating contracts with academic health centers, income streams to these centers for both professional and other services are under enormous pressure. Faculties in these centers organized practice plans beginning in the early 1970s, in which they accepted the responsibility that a significant amount of the money that they earned in billing patients would not go into salaries but would support education and research. The Association of American Medical Colleges has estimated that over $800 million per year in patient care revenues goes directly to the support of research, and another $1.6 billion or more goes for the cost of education, including medical student intern residency and fellowship education. I believe that this is a gross underestimate, and that the amount of cross-subsidy from patient care may be closer to twice this amount. Whatever the figure, the development of increasing price competition is rapidly reducing the amounts available to these academic health centers for research and education. They are downsizing. They are developing a whole variety of mechanisms to accommodate to the changing health care delivery scene. But I believe all of us should be acutely aware that they are at considerable risk in this whole process for economic viability in general and, more specifically, for purposes of this hearing, they are at enormous risk when it comes to maintaining important educational programs. I believe that the investment of Medicare monies in medical education is an excellent one for our society and, if rationalized both in terms of numbers and formulas by which the reimbursement is provided, is critically important to academic health centers, their educational mission, and their capacity to provide care in their communities. In the current deficit reduction mode, I would remind you that these educational costs for Medicare represent less than a one percent investment of our trillion dollar health care enterprise. There are many opportunities for improving this system, but I urge the committee to carefully consider the potential long-term benefits to our society of obtaining more value for these funds rather than simply reducing the amounts of money available.

Thank you for allowing me to make this presentation.

Chairman THOMAS. Thank you very much, Dr. Shine.
Dr. Ludden.

STATEMENT OF JOHN M. LUDDEN, M.D., SENIOR VICE PRESIDENT FOR MEDICAL AFFAIRS, HARVARD COMMUNITY HEALTH PLAN, BOSTON, MASS.

Dr. LUDDEN. Thank you, Mr. Chairman.

I am John Ludden. I am senior vice president for medical affairs at the Harvard Community Health Plan (HCMP) where I have practiced psychiatry for more than 20 years.

HCHP, as you may know, is now a partner in what is the largest and oldest HMO in New England, a nonprofit HMO. We have just about 1 million members, and we have 16,000 physicians. And perhaps most interesting to this committee is our long-term relationship with some of the Nation's preeminent teaching hospitals at Harvard and related to Dartmouth as well as to Brown.

I would like to concentrate on about three different areas.

One, I would like to review again some of the background of the current professional education and graduate medical education from the HMO perspective, to talk a little bit about the HCHP experience as a model of a teaching HMO and to add to some of the recommendations which you have already heard for future action.

In my view, education is a classic example of a public good and not a marketplace commodity. GME, as you have stated, is necessary, so that our society can educate physicians for the future to take care of our children and grandchildren. But this marketplace is changing and has changed radically, and it calls for changes both in how we finance GME and what that GME does.

And furthermore, to add to that difficulty, I would just like to comment that changes in GME also require changes in undergraduate medical education which are more significant and, believe it or not, even more difficult to finance.

Well, as you have already heard, GME comes to us primarily through cross-subsidies from service dollars that are received by teaching institutions and physicians, and Medicare has been the main focus for that at the Federal level.

As we compete in a marketplace of HMOs in a region like New England—and I think this is true in other HMOs—we are increasingly having difficulty doing what we, as HCHP, already do on a voluntary basis, to support and finance GME.

We do not experience difficulty from our major teaching hospitals in their providing to us cost-effective and high-quality care, sometimes at underlying costs that are lower than those of some of the larger community hospitals; that is, until you add in the requirements that they face for medical education.

As you have already heard, the changes in the health care marketplace also call for changes in the supply and the skills of professionals.

Obviously you have already heard about the importance of recruiting and finding and training more generalists. What you may not have focused on yet is that physicians in the new world of health care require an expanded set of skills.

HCHP and other HMOs have found recent graduates of GME programs incompletely prepared for primary care practice. Because

of that, the medical leaders at HCHP and Group Health Association of America have focused on a new set of competencies and skills which are required, skills in cost-effective delivery, skills in interpersonal care, and especially in teamwork and obviously in providing effective care and in managing care and referrals. These are primarily skills that can be found in ambulatory settings. And we need to shift our attention away from the hospitals to such ambulatory settings.

Let me just comment very briefly on the fact that HCHP is a model of a teaching HMO. We have put money into teaching, research and community service from the very beginning of our 25-year history, including a teaching center and the first ever Department, cosponsored with Harvard Medical School, of Ambulatory Care and Prevention, which we cofund with them.

We have developed new programs in primary care education with the Brigham and Women's Hospital, sponsored primary care residencies at other Harvard-affiliated hospitals, and have sponsored a psychiatry residency program with HMS.

We are looking to do this further, and we have presently been required really by marketplace pressure to reduce our contributions, so that this year we will still be spending $2.5 million directly on programs for mostly graduate, but some undergraduate, medical education.

Let me try to skip to just four things in conclusion.

First, you have already heard of the importance of allocating financing appropriately to the sites of training, so that it can be focused on the new marketplace.

Second, HMOs and other organizations should be able to receive direct credit or reimbursement for their ongoing expenditures directly in support of medical education, including GME.

Third, you have heard about the increase necessary in primary care. I believe that financing should also be included for nonphysician primary care education.

And fourth, such GME financing should be broad-based and separate from service delivery costs, so that in this competitive marketplace we can assure that education costs are quantified, justified, and directed appropriately.

I would be glad to work further with you and answer any questions later on. Thank you.

[The prepared statement follows:]

TESTIMONY OF JOHN M. LUDDEN, M.D.
HARVARD COMMUNITY HEALTH PLAN

Introduction

Mr. Chairman and members of the Committee, I am John Ludden, MD, Senior Vice President for Medical Affairs of the Harvard Community Health Plan (HCHP). HCHP is a partner in the oldest and largest health maintenance organization (HMO) in New England. Our recent merger with Pilgrim Health Care creates a healthcare organization providing care and coverage to nearly one million members through 16,000 physicians and 110 hospitals in Massachusetts, Rhode Island, New Hampshire, Maine, and Vermont. These include some of the nation's preeminent teaching hospitals, including Brigham and Women's (Harvard), Mary Hitchcock (Dartmouth) and Rhode Island Hospital (Brown).

I am pleased to have the opportunity to testify today, and would like to:

- o review background on current issues in health professions education from the HMO perspective;
- o describe the HCHP experience as one model for a "teaching HMO;" and
- o provide recommendations for future action.

Issues

Education is a classic example of a "public good". Graduate medical education is necessary if our society is be assured that future generations of physicians will be available and skilled at providing care for us, our children, and our children's children.

But, as this committee knows, that education now takes place in a rapidly changing health care marketplace. That marketplace calls for changes in our current graduate medical education financing models, the supply and skills of physicians and other practitioners that we educate, and our educational approaches.

Financing: Graduate medical education has traditionally been financed partly through cross-subsidies from service dollars received by teaching institutions and physicians. Medicare has been the principal federal source of such financing for graduate medical education, with funds flowing to and through teaching hospitals in the form of indirect medical education (IME) and direct medical education (DME) payments.

This committee is well aware that increased competition and the rapid evolution of managed care are a significant, market-based success story in health care. HMOs like the HCHP are proud of our role in that change. But we must also recognize that our success in developing market-based competition for financing and delivering health care services has some consequences that have to be addressed. And one of them is that our current service-based mechanism for financing graduate medical education cannot survive. It is increasingly difficult for teaching institutions and physicians to pass along the extra costs of education to payors as part of their service delivery. And HMOs that presently try, on a voluntary basis, to support and finance GME face the same problem -- a competitive market that limits premium increases which are the source of financing.

Professional supply and skills needed: The changes in the health care marketplace also call for changes in the supply and skills of health professionals.

First, I would reinforce what you have undoubtedly heard from others. We need more generalist physicians -- and non physician practitioners -- who care for patients on a long-term basis with a focus on prevention and health promotion.

Second, we need physicians with an expanded set of skills. HCHP and other HMOs have found recent graduates incompletely prepared for primary care practice. Because of this, medical leaders who are part of the Group Health Association of America (GHAA) have defined a set of core competencies for primary care physicians. Among the skills needed are:

- o Skills in the cost-effective delivery of quality health care;
- o Interpersonal and teamwork skills;
- o The ability to provide effective care to diverse populations;
- o Skills in managing care and making appropriate referrals;

Educational models and sites: Finally, the graduate medical education financing and delivery system must adapt to this new environment and produce the physicians with the skills necessary. The significant shift in services from inpatient to ambulatory settings leaves residents trained in hospitals ill-equipped to function as ambulatory care practitioners. Educational models must adapt -- with more education provided in ambulatory settings such as those available through HMOs -- and the financing models must adapt to make payments available to those sites of training.

HCHP's Commitment to GME

Since its founding in 1969, Harvard Community Health Plan has been committed to teaching and research: the HCHP corporate mission statement notes: "Our strong service program also supports teaching, research and community service."

HCHP has been a national leader in defining the role of HMOs in graduate medical education. HCHP continues its commitment to these areas through its financial support for programs designed to develop innovative methods of delivering quality care, and to training future physicians. Let me provide some examples: our growing participation in medical education led to the creation of the HCHP Teaching Center and our co-sponsorship, with Harvard Medical School, of the Department of Ambulatory Care and Prevention (DACP), the first medical school department in the country to be established and sited in an HMO. Its mission: the development of educational and research programs for preventive medicine and for the practice of medicine in the ambulatory setting.

- HCHP and the Brigham and Women's Hospital have jointly developed a new model of primary care training for the practice of adult primary care internal medicine. The program is specifically designed to allow each resident to achieve the broad competencies required for successful and satisfying primary care practice.

- For 20 years, HCHP has also sponsored primary care residency programs with the Cambridge and Mt. Auburn Hospitals, and in collaboration with four other Harvard institutions, sponsors a psychiatry residency program, which is now the largest in the United States.

- HCHP has been exploring the possibility of establishing a more comprehensive training program for primary care pediatricians interested in HMO experience, in conjunction with Children's Hospital and Boston City Hospital.

- The HCHP Foundation also funds several fellowship programs, including a mental health fellowship, which focuses on applications of brief psychotherapy in the HMO environment, and the Thomas O. Pyle Fellowship, which focuses on the appropriateness and effectiveness of medical care.

These activities have been supported through the HCHP Foundation, funded from premium revenues. It was originally intended that the HCHP Foundation would receive 1 1/2 percent of premium income, with about one-third of this percentage devoted to the development

of teaching programs. However, as I noted earlier, the market limits the ability to invite such financing, and HCHP provides such examples.

Over time the demands of the marketplace have reduced the percentage contribution to the HCHP Foundation so that it is well below one percent, with a consequent decrease in the percentage set aside for teaching. In recent years, the HCHP Foundation has received a budgeted dollar amount, adequate to maintain ongoing programs, but no longer on a percentage basis. In 1995, HCHP's Foundation expects to spend over $2.5 million on support for defined programs in medical education. These programs include graduate medical education but also include a growing commitment to undergraduate training and to innovative programs focused on the doctor/patient relationship, nursing education, and, for example, the pregnant teen violence prevention program.

But, as savings in health care costs become more and more a part of the competitive marketplace, these contributions are questioned. As the market continues to force HCHP and other managed care organizations to become even more cost competitive, the impact on programs for teaching and research will be dramatic.

Conclusions/recommendations

We seek a highly skilled workforce of health professionals for the future. If we are to produce that workforce, changes must be made in our graduate medical education programs.

Allocation of financing/site of training: GME financing should not always be directed through hospitals. Financing should follow the resident and support clinical education and training in hospital and non-hospital sites, especially including ambulatory care sites. HMOs and other organizations should receive direct credit or reimbursement for ongoing expenditures that directly support medical education, especially including GME.

The proportion of training slots for primary care should be increased: To improve the imbalance between specialists and primary care providers, an adequate number of residency slots must be in primary care.

Financing should be designated for non-physician primary care: The HMO community recognizes the importance of non-physician practitioners in the provision of primary care, and believes that some GME funds should be designated to finance the education and training of such practitioners.

Long-term, financing should be broad-based: Financing for graduate medical education must ultimately be broad-based, and separated from the service delivery costs. Such a separate financing system is required by the increasingly competitive marketplace, and necessary to assure that education costs are quantified and justified.

Mr. Chairman, I would be pleased to work with the committee and its staff as you develop proposals for changes in financing health professions education, and to answer any questions that you may have at this time.

Chairman THOMAS. Thank you very much, Dr. Ludden.
Dr. Heyssel.

STATEMENT OF ROBERT M. HEYSSEL, M.D., SEAFORD, DEL., FORMER PRESIDENT, JOHNS HOPKINS HEALTH SYSTEM

Dr. HEYSSEL. Mr. Chairman, Congressmen, ladies and gentlemen, I am Robert Heyssel. I was for 20 years president and CEO of the Johns Hopkins Health System.

Chairman THOMAS. Doctor, I would tell you that the microphones are very unidirectional, so you need to get right in front of it.

Dr. HEYSSEL. OK, thank you.

In Baltimore, Md. I thank you for the opportunity to give my view on graduate medical education.

In the mideighties, I chaired a task force funded by the Commonwealth Fund of New York, looking into and examining the health and the future of the academic health centers. Then as now, our concern was the maintenance of the mission of education, both undergraduate and graduate, and patient care and discovery in those institutions, which I believe are the best in the world and really the basis for our excellent medical care in this country.

A prominent part of that report, which was called "A Prescription for Change," dealt with issues surrounding graduate medical education. In preparation for this testimony, I looked at that again, and there is very little that I would change, either in terms of the findings or the recommendations with regard to graduate medical education.

That was published in 1985, and not much has happened since then.

There were a number of issues identified then which are with us now. The first issue is cost and how those costs are paid.

Most of the direct and indirect payments for resident education is from hospitals themselves, which in turn add those costs to inpatient bills, Medicare, and where they can, private payers as well. That source of payment is in jeopardy from both government payers and private insurers, as all payers seek lower cost hospitalizations and alternatives to hospital care. This is particularly true of managed care organizations in this country.

Second is the issue of size and specialty distribution in graduate medical education. As managed care becomes a dominant means of financing and controlling the costs of medical care, we are probably producing more physicians than the country will need, fewer generalists, and more specialists and subspecialists of certain kinds than we need.

Third is the issue of the control of graduate medical education. As amply documented in the 1985 report, which incidentally I have asked the staff to make available those portions of the report related to graduate medical education, the control of funding of graduate medical education is separate from the control of the length of the training programs, the content of those training programs, and requirements for accreditation of programs, all of which are set by RRCs and the Accreditation Council on Graduate Medical Education.

This, in effect, controls the costs, the ultimate costs. And they have no responsibility for the costs or getting the funding. That is left to the hospitals.

The issue of sites of education and educational support is also entwined in that. As more graduate medical education is conducted in outpatient settings, as is necessary if we are going to emphasize primary care, payment through hospitals as the primary source needs reexamination. In effect, I think we need to form some consortia between those organizations involved in outpatient care as well as the hospitals.

Funding, then, should be broadened. All payers should contribute to a pool for GME. They, after all, also profit from GME. The training of generalists, as noted earlier, is terribly important to managed care organizations as well. So there should be a pool from all premiums or other sources, as well as from Medicare and Medicaid.

There should not be an attempt, in my judgment, to set numbers of trainees by specialty, specified sites where training is conducted, or the mix of specialties in those sites. I think consortia, as I noted, should be encouraged. I think the marketplace is beginning to have a real effect on career choices of physicians, as was noted earlier, and will in the future.

Support should be assured for 3 years of graduate medical education, essentially the length of time for accreditation in primary care specialties. Certain programs, such as general surgery, may require longer than that and should be supported to first accreditation. And I think really support to first accreditation should be the general rule.

For specialties or subspecialties requiring longer, I would suggest that support would have to be found either from the individuals themselves, which was true in the past, professional fees of sponsoring training programs, private scholarships, or other sources.

And then finally support should be limited to the number of graduates in any given year from accredited medical schools in the United States.

There are many details behind my comments, but I will be glad to answer any questions. Thank you.

Chairman THOMAS. I want to thank all of you for your succinct statements, and obviously there are going to be a series of questions from us. And we will start with the gentlewoman from Connecticut.

Mrs. JOHNSON OF CONNECTICUT. I think your recommendation that we should limit the number trained is a very interesting one.

Within that envelope, how has this issue of specialists versus generalists been working out?

I read something recently that indicated that the majority of medical students now are looking for residencies in some kind of family care environment or are interested in that specialty.

Is that true? In other words, is the problem of too many specialists and not enough generalists being addressed in the real world out there?

Dr. SHINE. There are two answers to that. First in terms of the percentage, this year, for example, approximately half of graduating medical students selected residencies in areas which we would call general areas. In fact, there will be attrition, because a certain

number of those, even though they started in internal medicine, will end up as subspecialists, and it is more likely that you will be looking at something in the range of 30 to 35 percent of those people ultimately remaining in a generalist or a primary care environment.

Mrs. JOHNSON OF CONNECTICUT. Is that higher than 5 years ago?

Dr. SHINE. Yes. And that is the reason that I made the point that I think the trends in terms of the distribution are in the right direction.

The dilemma, from my perspective, is that the absolute number continues to rise so rapidly that even though you increase the proportion who become generalists, the absolute number of subspecialists just continues to skyrocket.

Mrs. JOHNSON OF CONNECTICUT. Well, we looked at this issue in the last Congress. One of the suggestions was for the government to determine how many in each area should be trained.

I am very uncomfortable with that, and I am interested in how rapidly you sense the market is redirecting our resources.

I am far more comfortable with the limit on the total number. And I think that is interesting in the context of Dr. Heyssel's comment that we should not reimburse for foreign medical education.

Do we subsidize foreign medical students in our system to the same degree that we subsidize citizen education in our system?

Dr. SHINE. We do not subsidize at a Federal level the medical students. It is the fact that foreign medical graduates, international medical graduates, who enter our teaching hospitals, in fact, get treated the same way as Americans.

I would emphasize that I agree with you about micromanaging the work force. One of the reasons why I am enthusiastic about an absolute cap is it still leaves within the various organizations the flexibility to decide how they are going to do the distribution. It lets market forces work, but it stops the notion that we are going to have a lot of very good, talented young people who spend long periods of time in training who are not going to have work. People whose training is being heavily subsidized, as your comments suggest, by the States, by the medical schools, by the universities and by the Federal Government.

That is not a good investment of our resources if, in fact, they are going to be largely underused subspecialists.

Dr. HEYSSEL. I would comment, I think in that regard that one of the reasons it is important to limit the length of time that you are going to support to first accreditation is that right now the penalty for spending 8, 9 years or going onto a subspecialty career in internal medicine is just not there.

There is obviously a lost opportunity cost, but it is relatively small, and it is fairly easy to go on and get the training as a subspecialist.

Mrs. JOHNSON OF CONNECTICUT. We now subsidize medical education through Medicare. Should the subsidy situation be different for foreign students being trained in our system than for citizens being trained in our system?

Dr. SHINE. That is going to be hard to do.

Mrs. JOHNSON OF CONNECTICUT. What I am thinking of is, every State university charges out-of-State students more than they charge in-State students.

Dr. SHINE. I understand that. The dilemma is a certain number of those international medical graduates are Americans who went overseas and are coming back. And the question is again: Does the fact that they got their education overseas mean that they should——

Mrs. JOHNSON OF CONNECTICUT. Well, I am looking at really noncitizen/citizen——

Dr. SHINE. And then there is a separate question of the noncitizen. And the dilemma there is that in many parts of the country, those people are, in fact, providing care during their training which is considered very critical.

And second, there are some extraordinarily talented people who come that way.

Mrs. JOHNSON OF CONNECTICUT. But they are talented. It is also a way of exporting a phenomenal level of achievement in American medicine which is important. There ought to be concern among Americans to be willing to train foreign medical personnel.

Dr. SHINE. Right.

Mrs. JOHNSON OF CONNECTICUT. But I do think we need to look to foreign governments for some of the kind of support that our government provides to the medical training setting for foreign students from countries that can afford it. I mean, it is one possible way of looking at this. I just thought I would get your thoughts on it.

Then the last question I wanted to ask, because my time has expired, this specific issue about having the right to move residents through outpatient and ambulatory environments: Are you prohibited by Federal law, by Federal regulation, by tradition of accreditors—what prevents you now from having residents rotate through those kinds of settings?

Dr. SHINE. The rules with regard to reimbursement are based primarily on ratios that are connected to beds and which limit the amount of time that the people can spend offsite.

Mrs. JOHNSON OF CONNECTICUT. OK, thank you. That helps.

Chairman THOMAS. The gentlewoman's time has expired.

The gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Dr. Ludden, in your testimony, you indicate that HMOs have a great success story, and I suspect that if you live in the Boston or Cambridge area or if you live in the East Bay of San Francisco area where you either have your institution or Kaiser Permanente, that is true.

But if you live in Florida where you have IMC or Southern California where you have had Paracelsus, the HMO managed care community has some warts and marks that they might like to live down. If they were all as good as your institution, we would have a simpler problem.

But you have been—and you are today complaining a little in your testimony about the fact, as I read it, that we pass money through in graduate medical education, and you somehow have to

pay this out of your pot, and because your competitors do not, you are at a disadvantage.

Am I reading what you are saying right?

Dr. LUDDEN. Yes.

Mr. STARK. But I think you are wrong. You are a recipient of a block grant, and that is a term you are going to hear more of, unfortunately.

In the adjusted average per capita cost (AAPCC) you actually receive funds the same as other institutions, because the way in which we reimburse you through Medicare, we lump in your share of the graduate medical education or indirect medical education, so you are really receiving it in your capitated payments.

Now it may not be enough and you may wish it were more, but the fact is, that is how the system is designed. And I just suggest that we maybe ought to change that system for how we reimburse managed care under Medicare, but I do not think that it is fair to say that you are not getting the funds.

And I am also concerned that HMOs have to avoid contracts with teaching hospitals, do they not? They cannot afford them.

Dr. LUDDEN. Have to avoid them?

Mr. STARK. Have to avoid them, sure, or price them so low that basically you will not be very attractive.

Why would you ship out, if you were a Kaiser Permanente—I do not know enough about where you would ship—why would you contract with Stanford or UC-San Francisco?

Dr. LUDDEN. We have—Harvard Community Health Plan has extensive contracts—in fact, 30 percent roughly of the Brigham and Women's Hospital is filled with Harvard Community Health Plan patients every day.

Mr. STARK. You have a unique relationship there. But do you send any to Johns Hopkins?

Dr. HEYSSEL. They should.

Mr. STARK. Of course, they should. We know that, do we not. [Laughter.]

Mr. Cardin has informed me of that. But my point is, it does seem to me that the stand-alone HMOs, Kaiser, cannot afford to deal with Stanford, and in their minds, and I think rightfully so, they do not think they have to. They have a broad range of staff, of specialists. And that does not help Stanford very much. As the HMOs grow in our area, there are fewer and fewer, as they get bigger and afford more comprehensive staffs, who want to go there and pay the higher rates that the teaching hospitals, out of necessity, have had to charge.

How do we solve that?

Dr. LUDDEN. Well, I think a number of us were talking about this requirement for really broadbased financing of GME; that is, broader than simply even Medicare, but broadly across the population, so that we can separate out the public good educational requirements from the service requirements.

As I tried to say, Brigham and Women's can compete very well on quality and cost alone, as long as you take out the requirement that they also provide all sorts of education in the middle of it.

Mr. STARK. Doctor—if I may, Mr. Chairman, just as I finish—you are preaching to the choir.

It has long been a mystery to me as to how Medicare got stuck with supporting graduate medical education. It was an afterthought, as near as I can read, in the legislative history in 1965. But the fact is, we have.

And the idea that the cost, whatever that is, ought to be—for the benefit that the public derives, ought to be spread more fairly across the spectrum, I agree with you.

I am not sure politically we would be able to do that. I mean, we have a structure that is so historic—even with the new Contract With America, I do not think we are going to be able to change that, so we are going to fuss with it and adjust it. And maybe we can do that slowly. So I think in the short time—5, 10 years—we are still going to have to find a way to subsidize, support, reimburse under the structure we have.

Could we erase it and start over?

I would agree with you. But I am afraid that we are locked into this, and we have to worry now about cutting too much out, so that Dr. Heyssel's alma mater can continue to survive.

Dr. SHINE. Mr. Stark, I would just point out that that association with Medicare does provide an opportunity, that as risk-based managed care develops for Medicare patients, looking at the way in which those organizations which choose to take care of Medicare patients, choose to support graduate medical education, is one of the things that I think the committee could look at very carefully.

Chairman THOMAS. The gentleman's time has expired. The gentleman from Louisiana, Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman, and thank you, gentlemen, for testifying today.

Dr. Shine, I am intrigued by your recommendation to freeze all positions in graduate medical education.

When I am home in Louisiana in my town meetings and the issue of health care and rising health care costs come up, I often have one or two lawyers in the audience, and they will stand up and say: You know, the answer to the problem here is to quit restricting admission to medical schools, and you need more doctors. If you had more doctors out there, there would be more competition, and you would get prices down and costs down.

How do I answer them, and how does that gibe with your recommendation?

Dr. SHINE. I think there are three or four answers.

First, both the State and the government do not make the kind of investment in the education of a lawyer that it does in the education of a physician.

Mr. MCCRERY. Thank goodness.

Dr. SHINE. Second, by virtue of the subsidy, if you will, for education that comes through Medicare, we are using public dollars in order to influence the work force. And the question then becomes: Is the outcome one that you want?

Third, medical providers are, in and of themselves, cost generators. Whether you are in managed care or any other area, the fact is that the more doctors you have, the more services are provided by doctors, and they are the most expensive.

The issue from my perspective in this regard is: How do you move the system so that, in fact, we are using a spectrum of pro-

viders, including advance practice nurses, physician's assistants, and others who are much more cost effective? That happens because you educate in a different environment, not because you educate more.

And finally, in spite of this incredible increase that has been going on for the last decade or decade and a half, the supply issue alone has not solved the problem of more doctors in urban America or more doctors in rural America. I would suggest to you that is not a numbers issue; that is an organizational and a management issue. We are going to have to change the way we think about health care in rural Louisiana, whether we are talking about the use of teams of providers, managed care organizations that have responsibilities in rural areas, the role of telemedicine.

There are a whole variety of issues. And I think the notion that we are going to solve that by saturating the market has not turned out to be true and will not be true if we just continue in the direction we are going.

Mr. MCCRERY. Well, I appreciate that answer, and I would like to discuss it some more at a later date.

But it sounds to me as if one of the problems is government got involved in the business and started directing resources in certain ways and produced results that are not necessarily those that were intended.

And I find that—and I do not know nearly as much about the health care system as I need to, but the more I get into it and the more I see Federal dollars being spent, the more I see consequences and results that are driven by dollars, Federal dollars, more than they are by the needs of the communities, the needs of the health care system. I am wondering if maybe we ought to examine or reexamine the whole role of government generally in the health care system and in medical education, because it does seem to be driving the system more than it is helping society.

Since you mentioned rural health care and HMOs in the context of graduate medical education, what is the role of managed care in medical education?

Dr. SHINE. I think there is a potentially large role. You heard about one program which actually is quite good, but there are others around the country.

One of the reasons that I think that managed care organizations would, in fact, be willing to contribute to the education costs is that, as you have heard, our current system does not educate individuals in managed care environments, and therefore they are not ready to go to work in those environments when they finish their training.

It would be in the economic interest of Harvard Community Health Plan or Kaiser to have those individuals, and therefore there is an opportunity for those individuals to get more training in those managed care environments.

That is beginning to happen. It is costly, because outpatient education is costly. It is much less efficient to see a single patient in the outpatient than it is in a hospital with a whole bunch of patients.

I would like to comment that I understand the issue of unintended consequences. I used that term in my paper, because what you have described is, in fact, unintended consequences.

I would emphasize, however, that these institutions are very fragile. Right now, we know that they receive somewhere on the order of $2.5 to, I think, closer to $4.5 billion in moneys that come from the practice of their faculties. And those faculties agreed 15 years ago to use a certain amount of that money to do research and to teach. Probably two-thirds of that money that they earn net goes into teaching.

As managed care organizations put the squeeze on academic health centers and those patient revenues fall away, there is going to be not only the problem of what they will pay, but the fact that faculties cannot earn enough money to subsidize the education. That is why these GME moneys are absolutely critical.

My view is not whether they should be spent, but do you spend them in the way that is the most sensible as far as our society is concerned.

Mr. MCCRERY. Thank you.

Chairman THOMAS. The gentleman's time has expired. The gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. First, let me thank the Chairman for holding these hearings. I think they are extremely important and that the future of the academic medical center is indeed somewhat suspect today in the new competitive environment. We need to look at different ways of reimbursing for graduate medical education. Medicare no longer will be able to foot the full bill, and the marketplace is not capable of dealing with these issues. And I compliment all of your testimonies today.

However, it seems to me that you have acknowledged half that problem, and that is that the marketplace does not work as far as a financing mechanism for graduate medical education and that we need a broad-based financial source. I agree with that.

In the bill that we were working on last year, we looked at a way in which all health care plans, not just Medicare but all health care plans, including the self-insured plans and the private insurance plans, contribute to graduate medical education. We then pulled these costs out of the rate base, so that all health centers could fairly compete within the new market.

But on the other side of the equation as to how the graduate medical education dollars should be used as far as training professionals for health services, there seems to be no agreement, and some disagreement, as to what role government should play in order to make sure that we have more people trained in primary health care.

Dr. Shine, I am not that impressed by the increase to 23 percent of medical graduates going into primary health care. The information that we have seen is that we need probably 50 percent. It is going to take a decade before we get the results of the people entering medical training today in the workplace.

And as all of you pointed out, we need to look beyond just physician training, and toward training of other health care professionals in primary health care.

My question is, if the Federal Government establishes the financial wherewithal so that GME can be pulled out of the burdens of the health centers in their rate setting, so they can use it through a pooled source, do we not have a responsibility at the national level to make sure that the training dollars are, in fact, spent to train more people in primary health care?

Dr. HEYSSEL. If I could speak to that, Congressman, I have a problem with setting absolute numerical limits on anything in a profession which is so dynamic and is changing so rapidly over time and where there are new entrants into the field in the sense of providing primary care.

I do not know whether the number is 50 percent or not, who should be generalists, or whether it is 40 percent or whether it is 70 percent in the long haul. And I do not think that any of us could make that judgment with a great deal of certainty.

I remember when I first started at Hopkins, the Federal Government had special programs to train psychiatrists and radiologists because there was a shortage. It is the Federal Government who decided that there is a physician shortage in the late sixties and led to 15 more medical schools.

So I do not know how in a dynamic, changing society you can make those judgments, and I think that the marketplace that is now occurring, plus limiting the amount that you are going to pay and the length of time you are going to pay, will, in itself, begin to take care of the problem.

Mr. CARDIN. I agree with you that I do not know what the exact number is. I disagree in that I do not believe the marketplace will be the best barometer of who should be trained. If history is any lesson to the future, we have encouraged the training of more costly health care professionals, and each one of these individuals have been able to make a comfortable living under the current system.

Dr. HEYSSEL. Congressman, part of that is the absolute distortion in the fee schedules. You know, not all people are really after money. But if you come out of medical school with a significant amount of debt, and you can make significantly more as a procedural cardiologist or as an ophthalmologist or some other thing rather than as a pediatrician, that is going to drive you a little bit in those directions.

Mr. CARDIN. No question.

Dr. HEYSSEL. And if we change some of the incentives that drive people to do those things, I think you would change very rapidly how people behave in terms of entering the profession and doing what they are doing.

Mr. CARDIN. And we have tried that. You have made some of those changes.

Dr. SHINE. But, Mr. Cardin, if I could just comment, in 1978 the institute issued a report recommending 50/50. So I come from a position where 50/50 made sense.

The fact of the matter is, first it is clear that managed care organizations use far fewer physicians, so that if you do the calculations, the number of generalists we require in an absolute sense is not 50 percent of the current work force, because, in fact, what is happening is, their ratios are such that without much of an increase—with some increase, but with nowhere near the kind of in-

crease that you and I thought needed to be present, they, in fact, are going to come close to having the work force they need in terms of generalists.

The dilemma is the fact that the subspecialists begin to grow. And I would just remind you that in Southern California last year at UC-San Diego they hired a cardiologist for $70,000 a year, a gastroenterologist for $72,000 a year, and a general internist for $110,000 a year.

Now I believe my medical students—and I still teach at Georgetown—are smart enough to know that. And I am less worried about the ratio, although again the institute waved that flag going back to 1978. I am much less worried about the ratio now as I am about this enormous surplus of subspecialists.

Chairman THOMAS. The gentleman's time has expired. Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

I come from a little bit of a different background, and so I would like to inquire just to try to learn this. I am a veterinarian by profession, and we work a little differently. The teaching hospitals do get some governmental subsidies, but I do not think in the same way that the practice of human medicine does.

For example, a specialist in veterinary medicine actually makes less than a general practitioner. But yet we still get the best and the brightest who want to be specialists simply because of the love of doing surgery, orthopedic surgery, ophthalmology, whatever it is.

Using that as a backdrop, I just wanted to say that from my experience, residents and interns were slave labor. I mean, my year as an intern, I made $14,000 a year and worked 80 to 100 hours a week, the equivalent of less than $3 an hour.

As I recall, the institutions loved us because the more interns, or more residents, they had, the better they did, because we were very cost effective.

I do not understand why it costs more money per resident on their education.

Do you understand my question?

Dr. SHINE. I am not sure. The fact is that there are a significant number of institutions in the United States which are using residents in a way that is better than it was 15 years ago, but is not inconsistent with the role you described for residents during your training.

That is the wrong reason for having residency programs. Residency programs should be first educational and second, they should prepare people for the kind of practice that they are going to need to use. And that means how do you help elderly people learn to stay in their home, rather than take care of them in the intensive care unit.

So I think what we are saying is that the kinds of changes we want to see happen are ones which have less to do with the acute day-to-day needs of the hospitals where the training goes on and more to do with providing care outside of the hospital, providing care for underserved populations and underserved areas and doing it in a way that is sensible in terms of the long term.

As far as the subspecialist is concerned, what I am concerned about is that we are already seeing underemployed and unem-

ployed subspecialists. We had a recent situation in which several managed care organizations laid off large numbers of subspecialists.

To have a system where you were trained as a subspecialist in veterinary medicine and then find there is not any work, it seems to me, is a tragic misuse of public resources in terms of what the future holds.

Dr. HEYSSEL. If I could comment, that is the reason to limit again the amount of length of time and support you are going to give as well as limiting the number of slots you are going to fund from whatever pool you get it from.

But I also cannot help but remark Dr. Shine, when you said the Institute of Medicine liked the 50/50 ratio, it was also the Institute of Medicine and the committee that I served on that said we need 4 beds per 1,000 population in this country in the seventies, which number seems a little offbase today given the changes.

Dr. SHINE. We guessed the direction but not the velocity.

Dr. HEYSSEL. That is right. [Laughter.]

Dr. LUDDEN. I just want to make the point that the HMO primary care practice frontline, it has to do with the skills and training, not the number of procedures or the number of services that can be done by something which maybe used to be slave labor but certainly is not now.

And that is a terribly important change in the way all of these developments work, so that we concentrate more on putting together those skills. And that really is a different world than it used to be 5 or 10 years ago.

Mr. ENSIGN. Right. Well, during residencies, your pay is very, very low compared to what your services are worth, maybe not at the beginning, but at least your latter couple years of your residency.

But it was looked at as a tradeoff, that you are getting that experience, and you are providing a very valuable service, and you are learning. That is the reason that you are exposed to the specialists and the senior specialists, and that was a tradeoff in the residencies.

I guess my whole question about this is, is it necessary to subsidize number of spots, and how do you do that across the country? Who gets what spots where?

Dr. HEYSSEL. Well, that has always been the dilemma. I guess you could do it at the Federal level and apportion it some way. You could do it at the State level and apportion it some way. And that always seemed to me to get us into the problem of—what should I say—indirect control of who got the slot preferences and so forth.

The other way you could do it is, we know how many medical students are graduating every year, and we know how many years we are willing to support their training after that in graduate medical education. Why not give them a voucher that goes with the student from this pool of money and let them apply wherever they would?

Dr. SHINE. Could I just point out, in terms of my proposal to freeze, I am talking about freezing in place; those institutions would have the same number of physicians as an institution that they have now. But if they want to add generalist positions—and

many will, because they want to do more managed care and Medicaid managed care—they would have to subtract them from their subspecialty slots.

If they downsize, the total number of residency slots in an institution was diminished, you would diminish the total pool. You would not necessarily go and let somebody start a new program.

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

Mr. CRANE. Thank you, Mr. Chairman.

Dr. Ludden, in your conclusions and recommendations, you point out that graduate medical education financing should not always be directed through hospitals, and you go on to state that HMOs and other organizations should receive direct credit or reimbursement for ongoing expenditures that directly support medical education, especially including GME.

Do you think that Medicare should pay any of these entities?

Dr. LUDDEN. I think that however—I mean, we do get payment from Medicare for those patients that we have. What we need to be able to do is to focus our resources and use them in an innovative way directly in medical education as such.

With the money that we have been able to put together over the years, we have been able to affect the training programs of the Harvard and other related institutions in a positive way toward establishing more primary care and making the skills something which are more nearly what we are going to need in the future, so that it has to do with being clear on the spending side that HMOs and managed care need to have the opportunity to effect that change at the local level to make sure we get the right skills.

On the revenue side, which is a lot of what our discussion has been about so far, I would favor a more broad-based approach to financing.

Mr. CRANE. Dr. Heyssel, Dr. Shine, do you share the same view?

Dr. HEYSSEL. The view of a broad-based approach to support and that the money should be able to go to a different entity than a hospital? Yes, I do.

I would think that since hospitals are needed for treatment as well as ambulatory care sites, that an organization that was primarily involved in ambulatory care and a hospital could form a consortium around that, where the money went to that consortium rather than to the hospital alone.

Dr. SHINE. My view is that there is merit to moving it away from payment supply to the hospitals. I would recommend that it be the educational institutions that are responsible for education of trainees, and they ought to be in a position to determine the kinds of sites, the contents of the education that is required, and they would then be able to reimburse the players in the consortium.

In other words, what I am concerned about is that there are obvious exceptions, depending upon locality, but I am concerned that, "a consortium" as to have some kind of a lead agent which is responsible for how the money is used, and I would suggest that it should be the nursing school, the dental school, the medical school, whichever is responsible.

Dr. HEYSSEL. I think there is a problem with that in the sense that the residency review committees and others are, in fact, the

ones who set the content of the curriculum, not the medical schools, which I think is what Dr. Shine is referring to.

And I see no real problem with money going to a consortium that is properly put together. My presumption is it would have to have a board; it would have to have votes; it would probably have to have a corporate structure of some sort that could receive funds.

So I see no problem with controlling either sites or the content under that sort of structure with proper approaches. Medical schools should be a part of that certainly.

Mr. CRANE. Thank you very much.

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

Mr. JOHNSON. Thank you, Mr. Chairman.

You all intrigue me with your differences, and I am amazed that you feel the same way I do. It appears to me from what you are saying, that you are saying there are too many doctors right now. Is that true or false?

Dr. SHINE. I think we are at that point, and all of the signs are that that surplus is going to increase.

Mr. JOHNSON. Then do you think we still need 229 major teaching hospitals in this country? Anybody.

Dr. HEYSSEL. Well, I think 229 major teaching hospitals probably overstates it somewhat, since the really primary affiliated teaching hospitals in the United States number something around 115 to 130, I would guess, and then many others have smaller teaching programs.

I think the question is whether we need to be training as many people as we do rather than how many hospitals we have doing it, number one, and, number two, the question of where the sites of training really ought to be. And I repeat what I have said before: I think those sites of training need to be broadened considerably away from the hospital both for educational reasons and other reasons.

Mr. JOHNSON. Do you think that some of these mobile hospital units that are now being tested in the Southwest could provide some training capability as well?

Dr. HEYSSEL. I think that training can occur wherever there is good medicine practiced.

Mr. JOHNSON. Wherever. Especially with the ability to hook up via satellite with a good doctor somewhere, it would seem to me that we could make use of the really good guys in our country to help train all our doctors.

But it appears to me that—go ahead; excuse me.

Dr. SHINE. One, as far as the number of hospitals is concerned, the market is going to do a lot with regard to that. I mean, the hospitals are consolidating. A lot of those hospitals ——

Mr. JOHNSON. Well, it will and it will not. Does it not depend upon the educational institution involved?

I know the University of Texas, for example, does not want to give up their two medical centers.

Dr. HEYSSEL. I would bet not.

Dr. SHINE. The point is that out of that 229, I mean, we have already begun to see consolidations. We have seen it with the Med-

ical College of Pennsylvania and Hahnemann. We are seeing new configurations taking place.

I think there is going to be a lot of pressure. And I do not know what the number is going to be. It is hard for me to predict that. There are going to be both political and economic forces that influence it.

But as Bob says, the issue from our perspective is how do you get good training. If that is in a mobile unit, if it is a rural system, if it is telemedicine, that is fine.

The one thing I want to emphasize, though, is that it is not necessarily all going to be physician dependent—that is, when you talk about rural sites, when you talk about urban sites, as well as the rest of the system, managed care has learned to use a variety of other providers—nurses, physician's assistants, community health workers—and we have got to get away from the notion that everything is going to have to be done by the doctor.

And second, we have got to have an educational system in which young people learn how to work with those various players in a collegial way, how to interact with them and provide care.

And I think one of my concerns, which may be an implication of your question or an inference of your question, is that while it is true that I would like to have doctors learn from those mobile units, I do not believe we are going to solve the Nation's health problems on the basis of trying to maintain every local site as a—

Mr. JOHNSON. Well, now you have gotten to the good issue. Why is Medicare paying for medical education? See, that is the real issue. Tell me the answer.

Dr. SHINE. I think that it is very clear that it is in the public interest to prepare young people appropriately for careers in medicine and that—

Mr. JOHNSON. But think about Medicare. What is the Medicare system for?

Dr. SHINE. It is for taking care of elderly patients.

Mr. JOHNSON. So we should train young people to take care of young people, so the elderly can have medical care; is that true?

Dr. SHINE. No. What we need to do is to train young people who, in fact, will be prepared properly to take care of elderly people. And second, we need to do that under circumstances in which they are being trained in facilities and in locations, both urban and rural, in which they are able to take care of disadvantaged people, people who cannot travel, people who have a variety of other medical difficulties.

Mr. JOHNSON. Right.

Dr. SHINE. And that is what we are——

Mr. JOHNSON. And in addition—excuse me—the gentleman over here indicated there was some indecision or lack of precise designation by a unit here in Washington, for example, your institute, the National Academy, I do not believe that any one person in Washington or anywhere else can dictate what is going to happen.

All of you seem to say that the system will take care of itself, if you let it. It will sink or rise, whatever is needed. Is that true?

Dr. HEYSSEL. I think it will if the incentives are right. I think Dr. Shine is absolutely right. How many teaching hospitals we are going to have and how big or large they are going to be 10 years

from now, I think is an absolute unknown, because clearly patient care is shifting out of the hospital. It is shifting to simpler sites. And there will be consolidations; they are occurring in many parts of the country now.

So I agree with the point; I do not think in a dynamic situation you can predict absolutely.

Mr. JOHNSON. Thank you very much. I appreciate your straightforwardness.

Thank you, Mr. Chairman.

Chairman THOMAS. Questions? Let me try to pull this together. I have a series of questions to ask.

Dr. Shine, I am really at this point not worried about unintended consequences. My problem is that looking at the current picture, one, in terms of the profile of medical graduate training and where they are and who they are and how it is financed, that we have got a big enough problem with all of the knowledge that we have without worrying about the unintended consequences.

For example, the gentlewoman from Connecticut was concerned about the foreign medical graduates, and you correctly indicated that a number of them are Americans who got their medical training overseas.

We also have the foreign-born medical graduates. And if we begin to deal with that in terms of a limitation, you pretty well can write New York City off the map, since about 30 percent of the graduate medical students in New York fit the profile of either foreign medical graduate or foreign-born medical graduate.

In addition to that, I agree totally with my colleagues who have said that it does not make a whole lot of sense to fund graduate medical education solely out of Medicare, especially when you rely so heavily on the hospital portion, which is a diminishing institution, relatively still significant but relative to the other changes.

So when we are sitting here trying to figure out a way in which we accomplish a clearly desirable societal role—that is, the training of medical students—how do we create or recreate a funding structure that does not put government, as the gentleman from Louisiana said, in the role of determining who gets it, and where they get it. You know, it is almost like an industrial policy for medical education.

I am trying to figure out a way to deal with it.

You folks have offered a couple of solutions, and I want to ask the relative importance of the options as you have presented them to guide us.

Notwithstanding our desire to come up with a completely different way in which we fund—let us just assume we are going to be living with what we have got and we can tweak it a little bit—I understand the direct medical support. I do not fully understand the indirect medical support, except it is another way to get money based upon the patient profiles, and I understand the caseload and the way in which you get disproportionate share because of where you are.

If we could say that Medicare—if we did not change anything else, but we just said Medicare was only going to fund the 3 years, and that is all that Medicare is going to fund—are we a big enough gorilla to drive the structure so that you would then, by virtue of

only funding the 3 years, positively shape the mix in medical education?

Dr. SHINE. I am going to let Bob comment on that.

Could I just, Bob, say that the proposal I made for a freeze——

Chairman THOMAS. Well, I want to get to that.

Dr. SHINE. [continuing]. Deals with the New York situation. I am not proposing downsizing.

Chairman THOMAS. No, I understand that.

Dr. SHINE. But what I am suggesting is—and I think you could be creative; you could have a situation in which you have a freeze, that you provide a certain amount of GME money, and that New York City, for example, to the extent that those institutions began to develop training programs for nonphysician providers in those hospitals, may not lose the money; that is, that there be some reward to them for making those transitions rather than—as you know, they have added 3,000 to 4,000 residents in New York City over a short period of time.

So I think—I am very sensitive to that, and that is why you did not hear a proposal from me about limiting foreign medical graduates at all.

Chairman THOMAS. I understand that. But I have a multiple problem in the area that you discussed, and that is the way in which medical schools and the teaching hospitals operate, that notwithstanding the economics driving folks to pick particular positions, in many situations, given the profile of the patients and the very location of the teaching hospitals and the significant medical and technical aspects involved there, it is a little bit like folks going to college and wanting to take a particular course but finding out it is closed, and there are openings in other areas, and frankly you take what is available.

And many times because of the type of programs and locations of teaching hospitals, you inevitably wind up producing a profile which is not the most desirable. And then you say: We also want these same structures in these same locations to carry out the health care professional training of nondoctors in a context of more and more managed care, where frankly a lot of the training is more interpersonal in administrative skills along with working along with nondoctor health professionals in locations that are not traditional hospitals.

You cannot do that with where they are and the profile of the patients that they have. I agree with the idea of a freezing. I want to pursue the idea of a 3-year limitation. And clearly we want to release the money and figure out a way in which it finds its home at where the teaching—whoever it is and whatever they are doing—is done best.

But we have got to do all three of these things and more. But I cannot, in the timeframe that we are dealing with. This is where I unfortunately agree with my friend from California—I would love to fundamentally change the way in which we finance it, because it does not make sense. It is part of a historical anachronism that grew up, because this was a device that was there, and we hooked it on, and frankly there were political deals made between rural and urban sites. That is where disproportionate share came from, because you could pump money into the urban through dispropor-

tionate, and you got money different ways for rural. That is all the political history of where we are.

If we want to change it, we have to start with where we are. And so if we put a freeze on the total number of folks financed, if we limited the Medicare money to 3 years, and if we figured a way to allow you folk to make the decisions of how you operate within those two parameters, and we created a mechanism to allow money to go where you folks, in your training and teaching and educating capacity, decide best where it should be used—is that a big enough change to have an impact on the marketplace, on the profile of doctors and other health care professionals?

Dr. HEYSSEL. I think the 3-year limitation, if it were absolute, would have a real impact.

I also, I think, said that, you know, there are certain programs that really ought to go beyond 3 years; for instance, surgery, general surgery.

Chairman THOMAS. But can we not find a way to fund that outside of our payment, which then creates a real choice factor there that if folks want it, they are driven to do it.

Dr. HEYSSEL. Congressman Thomas or Chairman Thomas, let me give you a story; let me give you a story, though, which makes me hesitant about making these things change.

For 20 years at Johns Hopkins Hospital, the hospital, unlike most other places, did not fund fellowships leading to subspecialties in internal medicine, in any subspecialty in internal medicine and in some other areas.

And as you are probably aware, we have some of the largest training programs in these subspecialties in the country. And somehow or other, my colleagues on the faculty found ways to get money for that, generally from their own professional fees, I will say, more often than not.

To the extent that that is in jeopardy now, whether that would continue or not—but I am just saying that there are always other sources of funds for people to use, if they really are interested in a particular training program. And they are; that is their stock in trade and understandably.

Chairman THOMAS. No, I agree with you, because we have only complicated the problem because the traditional source of funds—largely from that excellent faculty, making money in the fees and the structure—is less and less available because of the patient profile in medicine.

Dr. HEYSSEL. Right.

Chairman THOMAS. The other concern I have is, you indicated a structure that grew up at Johns Hopkins which was not driven by government funding, but by a felt need.

Does it make sense to redirect where the money goes into the system? That is, do you really believe we can get a top-down reformation, or would it go faster and would it be better if we did a bottom-up; that is, we funded the folk who were looking for the training and the assistance?

And you mentioned, I think, Dr. Ludden, a voucher where folks would go where they believed they were being provided with the best education and training for their particular interest. And I

think today, clearly, it is a top-down structure. I think that has also driven specialties.

My former business was teaching in college, and I always loved to teach specific areas and narrow specialties. Graduate focus is a lot more fun than teaching GE courses. And I think most people get a satisfaction out of working in narrower structures. And they bring people on, and if there is no limit to that, you wind up having the structure itself specialized.

But if the students were looking with less of a reference to the marketplace than perhaps we would like—to the degree that the students are the ones who spend their dollars where they think it makes more sense, I think you get a "small d" democratic structure, but also one that is more market oriented.

What is your reaction to that?

Dr. LUDDEN. I react very positively to that general set of ideas. I think that anything that goes beyond your original statement, which was let you guys figure out what to do with it, which I think is something that has been tried and does not work and just in the ways that have been described here, that the kind of thing that you are suggesting—that is, to have the funding follow the resident—would be very positive and would allow us to be able to work on developing the kinds of innovative programs that are not just what primary care physician spots are open next year, but what kind are going to be open in 10 or 15 years.

Chairman THOMAS. And if you make it the 3-year provision, then it is in part up to those folks to figure out how, if they want to go beyond that, they have got to come up with funding to do that. But we know that we get them as far as we think it is essential that they need to go for society. And if they want to go for themselves, they go beyond that.

Dr. SHINE. My response to your first formulation—you asked the question—my answer would be yes. I think the things that you outlined would make a significant and profound difference.

Second, I do have some concerns about the mechanisms with regard to how you carry out the proposal you have just made in the sense that you have to hold the people who are in charge of the training or the education responsible for the outcomes of the education.

And the question again is: If the financing is separated, you have got to figure out how we connect these in terms of making sure that the overall educational venture is, in fact, a satisfactory one.

I would just point out to you that if you have some flexibility with regard to the rules about where people can train, a lot of the things that are happening in the market now and are happening with public policy will encourage, the "top-down" people to respond.

In New York City, for example, the cuts in Medicaid are clearly—they are inevitably going to move to much more Medicaid managed care. They are going to have to take care of those patients in a much better way outside of hospitals.

If there were flexibility in terms of the ways to pay for it and if those institutions in New York City had the opportunity, I would be very surprised if they were not prepared to enter into a very active program of residency education in Medicaid managed care in the city of New York.

What I am trying to say is, I think there is a potential synergism that is both top-down and bottom-up in terms of what is happening.

But incentives right now historically have not been there. If the incentives get changed, people behave differently, as you well know.

Chairman THOMAS. Well, I think one of the more positive statements that has been made is that I would love to have these structures that obviously have produced some of the finest doctors in the world to continue to work more intensively with nondoctor health professionals, nurses, and others, so that they are educated in the same general structure working with each other, so that when they move out into the health care world, there is not that historical hierarchical relationship, almost dictatorial, because that is not the case in the real world, and it would be very healthy, I think, to pick that up at an earlier period in their development.

OK. I appreciate very much your testimony. You folks are an enormous resource for us, given the time and the history that you have spent, but more importantly your online observations of the changes that have been made and your attempts to adjust in this real-world situation.

We will be back to you as we develop some of these themes in terms of trying to change the funding. It has to change. We want to understand the changes and deal with the unintended consequences as they come.

How far we can go is unknown now, but we have to move.

Thank you very much.

Our next panel—Ruth Hanft, Stuart Altman, and Michael Carter—thank you for being with us today. Any written statement that you have will be made a part of the record, without objection, and you may proceed as you see fit to inform and educate us in this area. And we will start with Dr. Hanft.

STATEMENT OF RUTH S. HANFT, PH.D., PROFESSOR, DEPARTMENT OF HEALTH SERVICES, MANAGEMENT AND POLICY, GEORGE WASHINGTON UNIVERSITY, WASHINGTON, D.C.

Ms. HANFT. Thank you, Mr. Chairman.

Mr. Chairman, members of the subcommittee, I am pleased to be here this morning to talk primarily about the direct support of medical education through Medicare and other sources and also to raise the issue related to the difficulty in supporting primary care and ambulatory care education.

I am a professor at George Washington University. I would like to highlight key points that are in the more extensive testimony that I submitted for the record.

Currently the majority of direct support for GME in the United States comes from public and private third-party payers, the patient care revenues that flow primarily to the hospitals. These revenues support the salaries and fringe benefits of residents and interns. They support stipends or salaries to the teaching physician, the supervising physician, and they support the various ancillary services such as supplies, classrooms, et cetera.

Medicare makes a specific direct education payment to teaching hospitals based on the average per-resident cost at that specific

hospital in a base year inflated by the CPI, and there is a limit on the average payment after the fifth year of training. The formula also includes the ratio of Medicare patient days to total hospital patient days. And in 1994, it is estimated that Medicare paid $1.6 billion in direct costs to teaching hospitals.

This is not the only Federal source of support. Federal direct support also comes from the Veterans Administration and from the Department of Defense in their support of the residents and interns in the VA and the DOD facilities, and this is about 12 percent of the total residency support in the United States.

A number of States recognize direct medical education costs in their Medicaid payments and in their Medicaid reimbursement methodology. States also provide additional support through appropriations to their university hospitals and clinics, which is a declining source of support. Appropriations to county and municipal hospitals also provided support for residency programs. And finally, title VII of the Public Health Service Act provides about $60 million a year for special programs to support primary care education.

Private payers support graduate medical education as well. Although this support is not directly identified, it is incorporated into the cost or the charge base of the hospital. And as you have heard, as discounting continues, this source of support will end.

The major problem is that there is no basic source of support for education outside of the hospital, and as you heard from others this morning, this is where the education really needs to move to support managed competition and the managed care environment.

The Medicare program at the moment, except where the hospital will continue to pay the salary, does not provide support in HMOs, in public clinics, or in other ambulatory care settings that train residents and interns.

Thank you very much. I would be pleased to answer any questions that you might have.

[The prepared statement follows:]

TESTIMONY OF RUTH S. HANFT
GEORGE WASHINGTON UNIVERSITY

My name is Ruth Hanft. I am a Professor of Health Services, Management and Policy at the George Washington University.

Mr. Chairman, members of the Subcommittee. I appreciate the opportunity to discuss the direct support of graduate medical education and the issues related to the current methods of support.

The evaluation, structure and financing of graduate medical education is very complex, involving all allopathic medical and many osteopathic colleges, approximately 1200 teaching hospitals, over 90,000 interns and residents and numerous clinics, faculty, and preceptors. It is also a critical component of the provision of indigent care in the United States.

The major issues today include:

- The size and cost of the enterprise
- The appropriateness of the specialty distribution as between primary care and other specialties
- The mismatch between the structural changes in the health care delivery system, the structure and locus of current training programs, and their financing.

Structure of Graduate Medical Education

Medical education to the MD level is focused within and under the control of the medical school; graduate medical education, in contrast, tends to be hospital-based, with the direction of the program under a program director. The program director may or may not be the Chairman of a medical school department, a faculty member, the director of a hospital service or a designated attending physician at the hospital.

The accreditation bodies and processes are different for undergraduate medical and graduate medical education. Yet the education process should be a seamless continuum. Medical and graduate medical education are a cascade process for clinical education, involving teaching physicians, chief residents, senior residents, junior residents and interns, and 3rd and 4th year medical students. Frequently, particularly in academic health center hospitals, other health professions students participate. In each successive year, the medical student or resident assumes greater responsibility for patient care, moving from observer to participant to quasi-independent provider under greater or lesser supervision of a teaching physician. The degree of independence varies widely and is dependent on the capabilities of the student, the specialty, complexity of the case, philosophy of the program and the teaching physician and in some cases the payment status of the patient.

Residents not only provide patient care while learning but they also engage in research and teach more junior students. Teaching physicians simultaneously provide education and patient care.

There are more than 6000 residency programs approved in the United States, scattered over more than 1200 teaching hospitals, plus clinics. The majority of residency programs are hospital based and have been so historically.

Residency programs are reviewed and approved by residency review committees (RRCs) under the umbrella organization The Accreditation Council for Graduate Medical Education (ACGME), a private sector organization. There is no one organization that sets the total number of residency programs, residents, specialty distribution or sites of training. The RRC's do not directly establish overall residency numbers in the specific specialty but set qualitative standards such as volume of clinical cases, type of cases, etc.

The number of residency programs per hospital varies widely from one program to programs in every specialty and subspecialty. The degree of integration, with medical school faculty also varies widely from programs with no medical school affiliation, a declining number, to integrated medical school program that rotate

among a number of hospitals Most medical schools have multiple hospital affiliations including affiliations with Veterans Administration (VA) hospitals Decisions on the mix and size of residency programs within a hospital are based on multiple factors:

The decision of the hospital to have graduate medical education; the desire of the chairman of the medical school department or division or the chief of service of the hospital to have or supervise a program; service needs of the hospital; clinical volume required for accreditation and faculty availability to supervise the program

While most graduate medical education takes place in teaching hospitals, there has been growing pressure to shift training to ambulatory care settings, and to provide education relevant to practice in a managed care environment. It has become increasingly difficult to provide appropriate graduate medical education exclusively in the inpatient setting, particularly the tertiary care setting, for the following reasons:

- The shift of locus of many diagnostic and treatment services to ambulatory care setting;
- Increasing severity of illness in the inpatient setting which narrows the scope of clinical experience
- shortened length of stay
- the rapid development of HNO's and other managed care arrangement.

However, the methods of financing graduate medical education have been a major barrier to the shift in the locus of education.

Sources of Financing Graduate Medical Education

History of Support

Until the end of World War II, the majority of physicians completed one year of internship and entered general practice. A number of factors changed the picture dramatically during the subsequent two decades. The advances in technology that spawned new knowledge and specialties; the demand for an increased number of medical schools and physicians which stimulated an increased need for graduate medical education, and the rapid growth of private health insurance that helped hospitals expand training programs.

The growth of private insurance and the passage of Medicare opened a stream of funds that could be used to support hospital-based graduate medical education. Hospitals incorporated these GME costs into their charge and cost structures. Medicare, at its inception, included these costs in its definition of reasonable costs. Two sources of funds helped to support GME; salary support for residents and supervisory physicians in hospitals and payments for patient care services to individuals newly covered by public or private insurance. These new sources of revenue enabled teaching hospitals to expand their residency programs to keep pace with expanding medical school enrollment, increase substantially the stipends paid to residents, and pay faculty for supervision of residents. In addition, these funds and physicians fees charged for services provided an additional steam of support for schools and faculty.

With the increased flow of third party payments in the 1970s, issues related to the effect of payment policies on geographic location and specialty decisions of new physicians began to arise, as well as issues of the equity of the financing as between sites of training and sources of payment. Specifically, reimbursement from third party payers has financed a greater proportion of the costs and charges for inpatient services than for outpatient services. Until recent changes in private health insurance policies designed to reduce costs, private hospital insurance rarely required cost sharing by the consumer. In contrast, reimbursement for outpatient services from third parties is usually structured to include deductibles (payment by the patient before the third party will pay) and coinsurance (a percentage of the bill paid for by the patient) and does not cover preventive services. It is therefore easier to support specialty training oriented toward inpatient care than primary care training oriented toward outpatient care.

Currently, graduate medical education is supported through several mechanisms with patient care support (mainly hospital support) dominating. The mechanisms are:

- Reimbursement from third parties for hospital care
- Fees paid to physicians for patient care services in inpatient and outpatient settings
- Special federal and state grants for primary care training
- State appropriations for university hospitals and city and county appropriations for public, general hospitals.
- Federal appropriations for Veterans Administration and Department of Defense hospitals
- Fellowship stipends from biomedical research sources, mainly federal.

Current Federal Support

Medicare Part A pays for graduate medical education through a complex methodology that recognizes direct costs and provide an indirect education adjustment. Reimbursement for both direct and indirect costs goes to the hospital.

Direct costs are calculated by multiplying the historic costs per resident in a base year (increased annually by a cost of living escalator) by the number of full time equivalent (FTE) residents. These costs are passed through as an addition to the DRG payment. There is a further limit on the payment of full costs. Full costs are paid for residents up to first certification in a specialty or five years, whichever is higher.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (PL 99-272 Sec 9202) called for several modifications of what had been an open-ended direct cost pass-through for graduate medical education. These changes were basically designed to limit the growth in cost per resident and to place a disincentive on subspecialty training.

At first COBRA based the allowable cost per resident on the hospital-specific approved per resident amount for the cost reporting period beginning FY 1984. For subsequent periods, the per resident amounts were to be updated annually, based on changes in the Consumer Price Index. The per resident amount is multiplied by the weighted average number of FTE residents working in the hospital to obtain an aggregate approved amount. The law now allows the time residents spend on inpatient care activities outside of the hospital to be included "if the hospital incurs all or substantially all of the training costs in the outside setting." COBRA also applied two weighting factors - one related to length of training and the other to foreign medical graduate (FMG) status.

The factor relating to the length of training places a limit on the number of years a resident can be counted as an FTE. The limit is based on an initial residency period plus one year, not to exceed five years. The exception is participation up to two years additionally in certain geriatrics programs.

Medicare direct graduate medical education support was estimated at $1.6 billion in 1994. Graduate medical education costs are incorporated into the hospital charge base. The amount currently paid by third party payers is unknown.

The federal government, under Title VII of the Public Health Service Act, also provides direct grant support for residencies in general internal medicine, pediatrics and family medicine. While this support has been important in the establishment of family medicine residencies and ambulatory care training in primary care, the funding is relatively modest. Appropriations for primary care programs were $63 million in 1995.

The Veterans Administration provides salary support for residents and faculty in its own facilities. VA residencies account for 12 percent of all residencies. Military medical facilities also provide support for small number of residents.

State Support

The states have considerable discretion in setting hospital rates under Medicaid, including graduate medical education and teaching physician payments. Most states include the direct cost of graduate medical education but not the indirect education adjustment.

In addition to Medicaid payments, states provide support for undergraduate and graduate medical education through a number of different mechanisms. The majority (76) of allopathic medical schools are state schools.

States provide direct support of residencies through specific appropriations. The majority of this support is for family practice residencies.

States also provide operating subsidies to their university hospitals. Sometimes these subsidies are in the form of residents' salaries and fringes, sometimes they are subsidies for indigent care. Some states deficit finance or make up the balance between revenues and expenses.

Critics of current methods of graduate medical education financing have raised three issues:

1. The total number of residents being trained compared to the supply need and the number of US medical school graduates. There are approximately 17,000 graduates of US medical and osteopathic schools and 21,600 first year residents in allopathic programs, plus about 1000 osteopathic positions. The total number of residents in all years of residency has increased from 74,500 in 1985 to 96,500 in 1993. Over 20 percent of residents are not US graduates.

2. Most critics observe that there is an imbalance between the numbers being trained in primary care vs. other specialties. While the Medicare change to limit full support to five years was designed to reduce the incentive for specialty training, it has not yet worked.

3. Perhaps the most important criticism is the problem of supporting out of hospital training.

Primary Care Residencies and Ambulatory Care Training

A recent Institute of Medicine (IOM) study contained a number of commissioned papers on primary care residency and ambulatory care education financing. The following is quoted from the document:

"There are several generic problems in financing primary care residencies outside of the hospital setting. These problems may be of lesser magnitude in support of general surgery or other procedural specialties where patient charges tend to be substantially higher for services. The problems are summarized as follows:

- In the hospital setting, the resident and supervisory physician are paid salaries from hospital revenues with education costs separately recognized by Medicare and Medicaid and historically included in hospital charges. If a personal and identifiable service is provided by the teaching physician, a fee can be charged to the patient or insurer. Residents may not bill fees.

- In the outpatient setting not linked to a hospital (for Medicare) and for outpatient settings in terms of other insurers, the resident's salary and supervisory salary for the faculty must be generated from fees to the patient/third party or from grants from government and/or philanthropy. In the primary care specialties, the fee level, as noted extensively in the literature, are substantially lower than for procedure-oriented specialties. While there are two sources of patient car support for hospital-based or hospital outpatient linked training, there is only one in the nonhospital ambulatory care setting. Payments for physicians services as distinguished from payments for hospital services historically did not incorporate education costs since education was almost exclusively hospital-based in allopathic medicine.

Residents on Duty as of September 1 (Selected Years)

	All Residents		U.S.Medical School Graduates (USMG)		International Medical Graduates (IMG)		U.S. Medical School Graduates
	Total	First Year	Total	First Year	Total	First Year	
1993	96,469	21,616	73,763	15,836	22,706	5,780	15,554
1992	88,620	19,794	69,536	14,924	19,084	4,870	15,386
1991	85,516	19,497	68,499	14,805	17,017	4,692	15,481
1990	82,902	18,322	67,988	14,782	14,914	3,540	15,336
1985	74,514	19,168	62,479	16,495	12,035	2,673	16,319

- The development of faculty practice plans has been on a department/specialty basis similar to the organization of residencies, with the procedural specialties able to generate substantially higher revenues than primary care specialties because of the Medicare and private insurance charge structure. The revenues of these plans flow to the department with some small percentage flowing to the institution. Conceptually, all education, both undergraduate and graduate medical education should be an institutional responsibility. The organization of medical schools on a departmental basis and graduate medical education on a specialty/program basis, combined with the departmental flow of hospital and practice plan revenues leave the medical school institution with a paucity of flexible funds. Institutions that do not receive public appropriations, or where the appropriation is in the form of line items, unless the institutional percentage of practice plan revenue is substantial, have little ability to cross-subsidize. Where cross-subsidies are endemic among the missions of a medical school, they do not operate on an institution-wide basis in the medical schools for graduate medical programs. High earning departments and specialties retain the majority of their practice earnings for departmental and even division rather than institution-wide goals."

In summary, graduate medical education was hospital focused for many years. With the growth of technology and financing and the increase in the number of medical school graduates, graduate medical education expanded in numbers and specialties. Financing from Medicare and private insurance encouraged and sustained the expansion.

Medical and graduate medical education needs have now changed with the acceleration of the development of managed care and societal demands for primary care. This requires expansion of primary care training sites, particularly ambulatory care settings. There is a mismatch between educational needs to respond to managed care, the changing delivery system environment, and the method of financing graduate medical education.

Mr. JOHNSON [presiding]. Thank you, madam. We appreciate your testimony, and we will proceed with the other two gentlemen and then take questions for the panel.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. ALTMAN. Mr. Johnson, thank you for allowing us again to come before this committee. As Chairman of the Prospective Payment Assessment Commission (ProPAC).

Mr. JOHNSON. It is always a pleasure to have you before us. Thank you.

Mr. ALTMAN. Thank you.

I want to switch the discussion, if you will, to where the dollars are. I realize and I do not want to diminish the importance of direct medical education and the discussion you had before about the training of physicians. But most of the money that flows from Medicare for graduate medical education flows in two other sources. One is what we call the indirect medical education adjustment, which is about $3.8 billion a year, and the second is the disproportionate share payments which come from Medicare, which amounts to another $3.4 billion.

You know, we have looked at this at ProPAC in all different ways. And what just astounded me—I was looking at the numbers this morning—a third of all of the money, of all of the Medicare money, that flows to the major teaching hospitals comes from these three sources: The indirect medical education, the direct medical education, and the disproportionate share payments. A third of all of their income comes from these three sources. So we are talking about substantial amounts of money.

As you have heard this morning, there is no question that the changing marketplace is putting our teaching hospitals at a big disadvantage, and we at ProPAC are very sympathetic to their problems. We do believe they should be protected.

But we are increasingly uncomfortable that Medicare now is being asked to disproportionately keep this important engine alive. And Medicare is under the gun. There is no question about it, that its rate of growth is higher than in the private sector, and there are all kinds of ways of looking for cuts.

And I support, and I know the Commission supports, moving away from using patient care dollars to support this public good, as Dr. Ludden said. So we have looked at what we would suggest you do.

And in the short run, we believe that it is appropriate to reduce the indirect medical education adjustment from about 7.7 percent of every 10 percent of the number of resident interns down to 6.7, which is a 1-percent reduction. That is $500 million, and then do that for 2 more years to bring the number down to where our estimates say it should be. So over a 3-year period, you would reduce the Medicare indirect payments by almost 40 percent.

We support, though, moving away from this patient care emphasis and developing some type of pool arrangement, whether it is through some State organization or community consortium that was in Senator Dole's and Senator Packwood's bill, some way of establishing a separate fund.

I want to make very clear, we do not support continuing that fund necessarily at the current levels. I think the discussion you had with the previous panel suggests that we may and probably do exceed the number of physicians we need; we surely exceed the number of specialists we need.

I personally might support a freeze. I think that is, in fact, generous. I think the number of residents could even come down.

I am rather surprised. If you look at the numbers, they have been going like this, and then last year they went like this. So I think if we went back even to 1992, we might be at a more stable base.

What is important is that we take a hard look at what is the appropriate role of government in funding this. Government does have a role, but it should not be—particularly the Medicare should not become the sole source of support. It needs to carry its share, but not be asked to carry it disproportionately. And we at ProPAC have tried to come up technically with a number that will allow you to make the appropriate adjustments.

Just one or two more numbers. By the way, in my testimony, I have given you a lot of information about the changes in the structure of the direct and indirect medical education, where the money goes.

It primarily goes to about 229, 230 of our major teaching hospitals. And these hospitals do disproportionately cover the number of uninsured in this country, and therefore they do need to be protected. But not all of them. Some of them actually are providing very little of such care.

So we would support again this phased reduction down to—from 7.7 down to about 4.7, which would save the country, or use it for other programs, about $1.5 billion.

Thank you very much.

[The prepared statement and attachments follow:]

TESTIMONY OF STUART H. ALTMAN, Ph.D., Chairman
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission. I am pleased to be here today to discuss Medicare's payments to teaching hospitals. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

Hospitals with graduate medical education programs provide numerous valuable services, in addition to the routine patient care they furnish. They frequently treat the most complex cases and are the first to acquire and gain experience with new technologies and procedures. In addition, they provide much of the clinical training for the next generation of physicians. It is not surprising, therefore, that they have higher costs than non-teaching hospitals.

Over the years, the Medicare program has been an important source of revenue to help these hospitals finance the costs associated with their medical education mission. Many teaching hospitals also have been able to obtain higher patient care rates from private payers to help fund their educational activities. This extra revenue from private payers, however, is now at risk. Accelerating price competition is placing teaching hospitals at a disadvantage relative to other hospitals, since many private payers are not recognizing the added costs of maintaining graduate medical education programs.

In addition to the added pressure on teaching hospitals from the move to managed care in the private sector, Medicare's risk contracting program may also disadvantage these hospitals. Under current policies, Medicare's capitated payment amount, the AAPCC, includes average payments for medical education. The capitated payment, however, goes to the managed care organization, and there is no guarantee that they will use teaching hospitals or, if they do, that they will provide the extra payments to these hospitals. This does not mean, however, that managed care plans must contract with teaching hospitals or pay the rates that they did in the past. Managed care plans and teaching hospitals should negotiate their best deals. The challenge for the Medicare program is to find a mechanism to take advantage of the competition in the private sector, while appropriately recognizing the added value of teaching hospitals. We have suggested an approach that I will describe in a few moments.

The growth of managed care and increased competition in the private sector complicates the decisions you must make to constrain the rapid increase in spending for the Medicare program. The Commission believes that teaching hospitals furnish many valuable services to society and that Medicare should recognize the value of these services by providing some extra payments to these hospitals. Nevertheless, there are concerns about the limits to which the Medicare program should bear a disproportionate amount of the broader social responsibility for ensuring that the important contributions of teaching hospitals continue. This is not to say, however, that all the current teaching hospitals are needed or that there is not room for substantial improvements in the efficiency of these facilities or the number and mix of primary care and specialty physicians they produce. I believe, Mr. Chairman, that it is time to reexamine the role Medicare has played in financing graduate medical education and to consider alternative financing systems for the future.

I will begin this morning by briefly describing the important role teaching hospitals play in furnishing care to Medicare enrollees. I will then describe Medicare's medical education payment policies, focusing on the indirect medical education (IME) adjustment, and Medicare's contribution to the financial welfare of teaching hospitals. Finally, I will conclude by discussing some of the problems I see with Medicare's current policies and some alternatives you may wish to consider.

Payments to Teaching Hospitals

Teaching hospitals are an important source of care for Medicare enrollees. There are more than 1,000 teaching hospitals, about 20 percent of all acute care hospitals. These hospitals are responsible for over 40 percent of all PPS discharges and half of

PPS payments. In 1994, teaching hospitals received $34 billion in PPS operating payments for the services furnished to Medicare enrollees (Chart 1). They also received payments for their capital costs, outpatient and other services they furnished, and direct medical education costs.

Of these hospitals, about 230 are classified as major teaching hospitals. Major teaching hospitals are defined as those with 25 or more interns and residents per 100 beds. Major teaching hospitals represent 4 percent of PPS hospitals, but were responsible for 10 percent of discharges and 17 percent of payments in 1994 (Chart 1).

The Medicare program provides two types of extra payments to hospitals with graduate medical education programs. First, teaching hospitals receive an adjustment to their PPS payments to reflect the added patient care costs associated with operating an intern and resident training program. This indirect medical education (IME) adjustment accounted for about 5.7 percent of total PPS operating payments in fiscal year 1994, or about $3.8 billion (Chart 2). As you can see in this chart, the amount of the IME adjustment steadily increased between 1989 and 1994.

Medicare also pays teaching hospitals an additional amount, separate from the PPS payments, for the direct costs of maintaining graduate medical education programs. These payments (referred to as DME or GME payments) cover resident salaries and benefits, the salaries of supervising physicians, office space, and other overhead. These payments totaled about $1.4 billion in 1994. In addition to the allowed salaries, physicians in teaching hospitals who directly supervise interns and residents can bill, under Part B of Medicare, for the services furnished by the residents that they are supervising.

In addition to these Medicare payments based on teaching status, many teaching hospitals also receive disproportionate share hospital (DSH) payments, related to the amount of care they furnish to poor patients (Chart 2). Teaching hospitals received about 67 percent of the $3.4 billion in DSH payments in 1994. The amount of DSH payments also has increased rapidly in recent years.

Indirect Medical Education Payments

Medicare's IME adjustment is a major source of revenue for teaching hospitals. More than 21 percent of Medicare's PPS payments to major teaching hospitals, and 6 percent to other teaching hospitals, comes from the IME adjustment. The amount of the payment depends on a hospital's teaching intensity, measured by the number of interns and residents per bed. Currently, per case payments increase about 7.7 percent for each 10 percent increase in teaching intensity. This increase in payments is substantially higher than the observed relationship between Medicare's operating costs per discharge and teaching intensity. The most recent ProPAC analysis indicates that, on average, a 10 percent increase in teaching intensity is associated with a 4.5 percent increase in Medicare operating costs per discharge. This difference between the observed cost relationship and the actual payments amounted to about $1.5 billion in additional payments to teaching hospitals in 1994.

For several years, the difference between the payment increase and the observed increase in costs has led the Commission to recommend a reduction in the amount of the IME adjustment. In ProPAC's *Report and Recommendation to the Congress, March 1, 1995,* the Commission recommends a reduction in the adjustment from 7.7 percent to 6.7 percent for each 10 percent rise in the number of interns and residents per bed. This is equivalent to a 13 percent reduction in the amount of the IME payments. If enacted, payments to teaching hospitals would decrease about $500 million. ProPAC believes that this should be the first phase of a three step process which will bring the teaching adjustment in line with the additional patient care costs teaching hospitals incur. We chose this phased reduction approach to allow teaching

hospitals time to make the necessary changes in the way they operate and to seek additional funding, if possible.

Graduate Medical Education Payments

Medicare also pays teaching hospitals a share of the direct costs of maintaining graduate medical education (GME or DME) programs. These payments totaled about $1.4 billion in 1994. Direct costs include resident's salaries and fringe benefits, salaries for supervising faculty, and institutional overhead that are not included in PPS.

GME payments are based on a hospital's per resident costs in a base year, updated to the current year. Hospital-specific per resident costs in 1990 ranged from less than $10,000 to more than $100,000 (Chart 3). Consequently, Medicare per resident payments also vary widely across teaching hospitals. Payments are somewhat higher if the resident is in an initial residency rather than in a second residency, or in a primary care rather than a specialty program.

One of the primary factors driving GME (and IME) spending growth is a continuing increase in the number of interns and residents (Chart 4). Virtually all of the growth in recent years is due to increases in the number of residents who graduated from foreign medical schools. There are large differences across states in the number and rate of growth of residents. This increase in the number of residents is especially troublesome in view of the growing concern that this country has an adequate supply of physicians, but too many specialists and too few primary care physicians.

Disproportionate Share Payments

There are now about 40 million people in this country without health insurance. Many of these individuals receive hospital care that is subsidized from other sources of revenue. The hospitals with the largest share of low income individuals qualify for Medicare and Medicaid DSH payments. In 1994, Medicare DSH payments totaled $5.1 billion, with about two thirds of these payments going to teaching hospitals. The federal share of Medicaid DSH payments was $10.7 billion and the combined federal and state share was $18.6 billion in 1994, although we don't have specific information on payments to teaching hospitals. In addition, the private sector has shared in subsidizing care to the uninsured through payments that are higher than costs. This subsidy from the private sector, however, may diminish as competition intensifies. Therefore, as Congress seeks additional ways to slow the growth in Medicare and Medicaid spending, it is important that reductions in DSH payments be carefully targeted so as not to further disadvantage hospitals that treat the largest number of uninsured patients.

The Financial Condition of Teaching Hospitals

The Medicare program has more than adequately compensated teaching hospitals for the costs of treating Medicare patients. Since the first year of PPS, teaching hospitals' PPS margins have exceeded those of other hospitals. Further, over the years the gap between the margins of teaching and non-teaching hospitals has widened (Chart 5). In 1993, major teaching hospitals had the highest PPS margins of any group of hospitals, 11.7 percent (Chart 6). In contrast, the PPS margin was 0.5 percent for other teaching hospitals, those with fewer than 25 interns and residents per 100 beds, and minus 4.0 percent for non-teaching hospitals.

Total hospital margins, which compare all hospital costs and revenues, show a very different pattern (Chart 7). Despite Medicare PPS payments that are almost 12 percent above costs, the total margin for major teaching hospitals in 1993 is only 2.7 percent, the lowest of any group of hospitals (Chart 8). The reasons for these lower total margins are difficult to disentangle. One definitely includes the large amount of uncompensated care many of these hospitals furnish. Others could include

inefficiencies in providing services and difficulties obtaining the revenue from private payers to support the extra costs of maintaining teaching programs. For smaller teaching hospitals the picture is different, with their total margins similar to non-teaching hospitals at 4.6 percent.

Although teaching hospital costs are higher than those of non-teaching hospitals, their costs per discharge have not increased faster than those of other hospitals over the past decade (Chart 9). As we have previously reported to you, the annual increase in hospital costs has slowed dramatically recently. Teaching hospitals have responded to the increasing cost pressures by slowing cost growth to the same extent as non-teaching hospitals.

It is important to point out, Mr. Chairman, that these aggregate PPS and total margins obscure significant variations among teaching hospitals. Even though the aggregate PPS margin was 11.7 percent in 1993, about 18 percent of major teaching hospitals had negative PPS margins (Chart 10). This figure, however, is much less than the 57 percent of non-teaching hospitals with negative PPS margins. Slightly less than 25 percent of both major teaching and non-teaching hospitals had negative total margins.

Next Steps

As I have described, in 1994 the Medicare program provided $5.2 billion in direct and indirect graduate medical education payments plus $2.3 billion in disproportionate share payments to teaching hospitals. These extra payments have helped many major teaching hospitals to avoid severe financial stress and to continue to provide access to care for Medicare enrollees, while maintaining their teaching mission. Accelerating price competition in the private sector is reducing the ability of teaching hospitals to obtain the higher patient care rates from other payers that traditionally have contributed to financing the costs of medical education. In addition, as Medicare's risk contracting program grows, teaching hospitals may not be benefitting as intended from the medical education payments included in the capitated payment.

The growth of managed care in the public and private sectors and the increased competition among insurers and providers will make your task of determining appropriate Medicare policies for teaching hospitals more difficult. While I believe that the reductions in the level of the IME adjustment that ProPAC has recommended are appropriate, it is likely that many of the institutions affected will have serious problems adjusting to them. But I have additional concerns that some policy makers are suggesting even larger reductions or reductions that take effect more quickly. The Commission believes such changes could have very serious consequences for this nation's teaching hospitals.

It appears to me that Medicare increasingly is carrying a disproportionate share of the financial responsibility for training tomorrow's physicians, nurses, and other health personnel. Some of these costs should be shared with private insurers or financed in a totally different manner.

The challenge, therefore, is to find a way for government and private payers to share the responsibility for supporting medical education. One approach that I believe has merit was outlined in Dole/Packwood and other proposed health care reform legislation last year. This approach would create consortia of hospitals, medical schools, and perhaps other community groups such as payers and purchasers involved in graduate medical education. The consortium would receive medical education payments from Medicare and from participating private insurers and distribute them as appropriate. It also may be desirable to include IME as well as GME payments to the consortia, plus the substantial Medicare Part B payments that teaching physicians receive for directly supervising intern and residents. The consortia could provide the incentives to train more primary care and less specialty physicians.

They could also ensure that training moved out of the hospital and into community sites when that was appropriate. Current Medicare policies, in contrast, provide financial incentives to train residents in hospitals, rather than in primary care settings, since the hospital may lose its IME and GME payments if the resident trains in another site.

This approach has another advantage as well. Since hospitals would receive additional payments from the consortia to cover teaching costs, they could negotiate payments with managed care plans for the costs of regular patient care on an equal footing with other hospitals. Such competition with other hospitals may also provide the stimulus for teaching hospitals to improve their efficiency. For this to work, of course, private payers would have to contribute to the funding for the consortia. Managed care plans, however, may find this an attractive way to market their services in a community, if it is known that they have developed relationships with teaching institutions. I believe that the Medicare program should develop a demonstration project to further test this idea.

A demonstration also could explore alternative ways to direct payments to teaching hospitals under Medicare's risk contracting program. As I discussed with you in my testimony last month, numerous improvements are necessary in the calculation of Medicare's capitated payment, the AAPCC, to enhance plan and enrollee participation and to achieve savings for the Medicare program. There also are a number of ways that payments to teaching hospitals could be improved in this program, and ProPAC would be pleased to work with you as you examine alternative approaches.

I would like to note, however, that providing a special pool to fund the costs of medical education should not absolve teaching hospitals of the responsibility to control their costs. As I described, since the beginning of PPS costs per case have grown at about the same rate in teaching and non-teaching hospitals. All hospitals, however, need to continue to improve their productivity and reduce their cost base, and Medicare's policies should continue to encourage this.

In conclusion, Mr. Chairman, teaching hospitals perform many important social functions in addition to routine patient care. In the past, the Medicare program explicitly and private insurers implicitly have subsidized these activities. As competition in the private sector increases, it is likely that the implicit subsidy will diminish. It is not appropriate for Medicare to cover an increasing portion of medical education costs. Nevertheless, you need to proceed cautiously to avoid sudden Medicare policy changes that could endanger the most important teaching hospitals.

For the long term, I believe that we must develop new policies to ensure that government programs and private insurers continue to share the burden of support for medical education, just as they have in the past. We would be pleased to continue to work with you and your staff as you seek better ways to pay for the services furnished by teaching hospitals.

This completes my formal testimony. I would be pleased to answer any questions you may have.

Chart 1. Distribution of PPS Hospitals, Discharges, and Payments by Hospital Group, FY 1994

Hospital Group	Number of Hospitals	Percent of Discharges	Percent of Payments	Payments (In Billions)		
				Total	IME	DSH
All hospitals	5,251	100%	100%	$66.0	$3.8	$3.4
Urban	2,932	80	87	57.5	3.7	3.2
Rural	2,319	20	13	8.5	0.0	0.2
Large urban	1,609	45	53	35.2	2.8	2.1
Other urban	1,323	35	34	22.3	0.9	1.1
Rural referral	246	7	5	3.4	0.0	0.1
Sole community	576	3	2	1.4	0.0	0.0
Other rural	1,497	10	6	3.7	0.0	0.0
Major teaching	229	10	17	11.2	2.4	1.1
Other teaching	481	22	34	22.8	1.4	1.1
Non-teaching	4,221	69	49	32.1	0.0	1.1
Voluntary	3,066	74	76	50.0	3.0	2.2
Proprietary	751	12	11	7.1	0.1	0.3
Urban government	434	8	10	6.4	0.7	0.7
Rural government	1,024	6	4	2.4	0.0	0.1

SOURCE: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1992 MedPAR file from data from the Health Care Financing Administration.

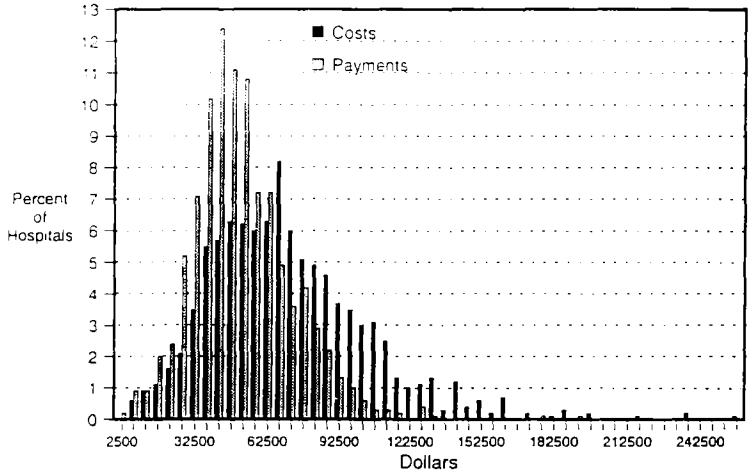
Chart 2. **Medicare Indirect Medical Education and Disproportionate Share Payments, Fiscal Years 1989-1994 (In Billions)**

	IME Payments		DSH Payments	
Fiscal Year	Amount (In Billions)	Percent of Total PPS Payments	Amount (In Billions)	Percent of Total PPS Payments
1989	$2.2	4.8%	$1.1	2.4%
1990	2.5	5.3	1.6	3.3
1991	2.9	5.5	2.2	4.1
1992	3.1	5.7	2.2	4.0
1993	3.7	5.6	2.7	4.1
1994	3.8	5.7	3.4	5.1

Note: IME = indirect medical education. DSH = disproportionate share.

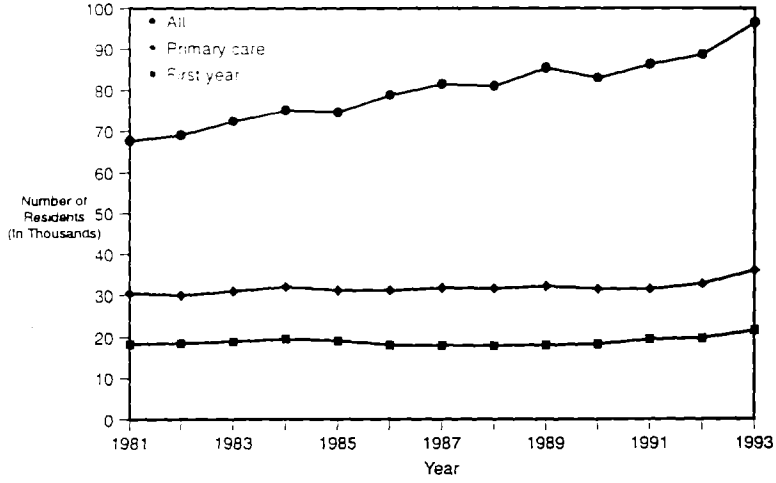
SOURCE: Prospective Payment Assessment Commission, *Medicare and the American Health Care System Report to the Congress*, June 1989, 1990, 1991, 1992, 1993, and 1994.

Chart 3. Per Resident Costs and Payments, 1990



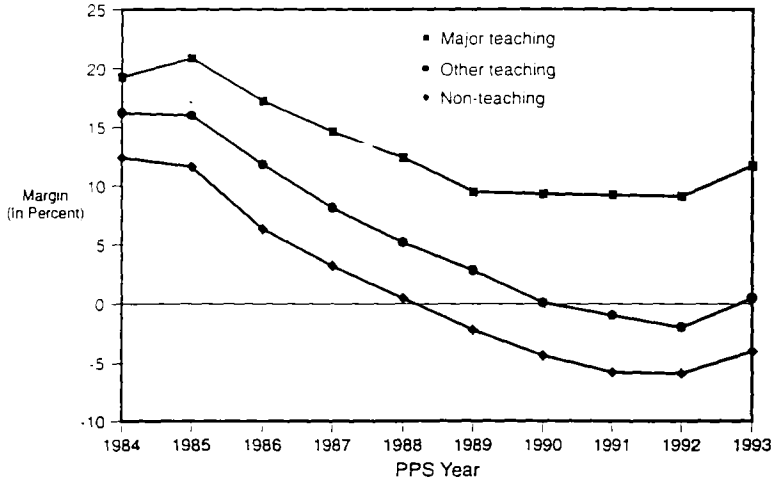
SOURCE. Medicare Cost Report and per resident payment data supplied by the Health Care Financing Administration.

Chart 4. Number of Residents, by Type, 1981-1993
(In Thousands)



SOURCE: Selected medical education issues of the Journal of the American Medical Association.

Chart 5. PPS Margins by Teaching Status, First Ten Years of PPS



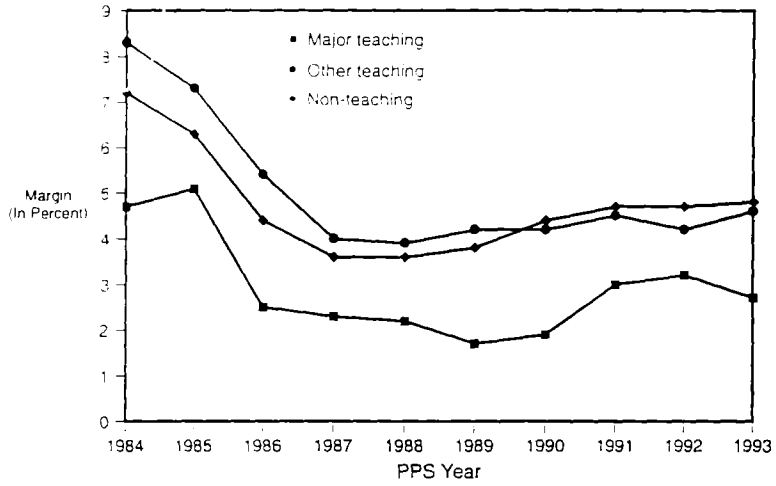
SOURCE. ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 6. PPS Margins, by Hospital Group, First Ten Years of PPS (In Percent)

Hospital Group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8	PPS 9	PPS 10
All hospitals	14.5%	14.4%	9.9%	6.8%	4.0%	1.4%	-0.6%	-1.6%	-1.9%	0.3%
Urban	15.6	15.3	11.0	7.6	4.7	2.0	-0.2	-1.4	-1.7	0.6
Rural	8.4	8.9	3.3	1.1	-0.3	-2.0	-3.0	-3.1	-3.0	-1.8
Large urban	16.1	15.1	11.2	7.5	4.3	1.7	0.3	-0.5	-0.6	1.9
Other urban	15.0	15.5	10.7	7.8	5.2	2.3	-1.0	-2.7	-3.4	-1.5
Rural referral	10.4	10.8	8.6	6.1	4.4	1.5	-0.4	-1.1	-0.2	0.2
Sole community	8.6	7.2	2.3	0.6	-1.9	-3.3	-1.3	-0.4	-1.2	0.6
Other rural	7.4	6.7	0.4	2.0	-2.9	-3.9	-6.3	-6.5	-5.8	-4.0
Major teaching	19.3	20.9	17.2	14.6	12.4	9.5	9.3	9.2	9.1	11.7
Other teaching	16.2	16.0	11.8	8.1	5.2	2.8	0.1	-1.0	2.0	0.5
Non-teaching	12.4	11.6	6.3	3.2	0.5	-2.2	-4.4	-5.8	-5.9	-4.0
Voluntary	14.9	14.9	10.6	7.3	4.4	1.9	-0.3	-1.6	-2.1	0.1
Proprietary	14.8	13.2	8.0	4.6	1.5	-2.3	-4.5	-3.1	-1.8	1.8
Urban government	14.6	14.9	10.2	8.3	5.7	4.2	3.0	1.6	1.4	3.0
Rural government	7.1	6.3	0.3	2.5	-2.7	-4.0	-4.3	-4.7	-5.6	-4.8

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 7. Total Margins by Teaching Status, First Ten Years of PPS



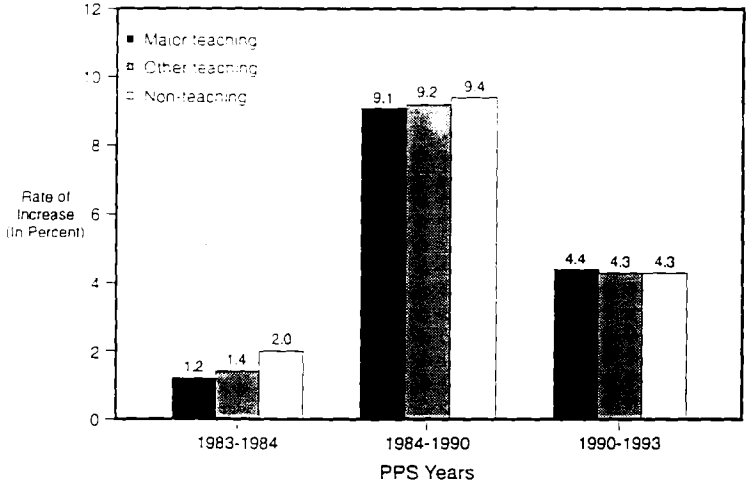
SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 8. Total Margins, by Hospital Group, First Ten Years of PPS (In Percent)

Hospital Group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8	PPS 9	PPS 10
All hospitals	7.2%	6.4%	4.3%	3.4%	3.4%	3.5%	3.8%	4.3%	4.2%	4.3%
Urban	7.8	6.7	4.5	3.5	3.4	3.4	3.7	4.2	4.1	4.2
Rural	4.9	4.6	3.0	2.8	3.4	4.0	4.6	5.0	5.1	5.0
Large urban	7.3	6.4	4.0	3.0	2.7	2.6	2.7	3.3	3.4	3.5
Other urban	7.9	7.2	5.4	4.4	4.5	4.9	5.3	5.6	5.2	5.3
Rural referral	7.0	7.8	5.7	4.9	5.6	5.7	6.5	6.6	6.3	6.0
Sole community	4.7	3.5	2.1	2.3	2.1	3.1	3.9	4.8	5.0	5.3
Other rural	3.9	3.2	1.7	1.7	2.5	3.3	3.6	4.1	4.3	4.2
Major teaching	4.7	5.1	2.5	2.3	2.2	1.7	1.9	3.0	3.2	2.7
Other teaching	8.3	7.3	5.4	4.0	3.9	4.2	4.2	4.5	4.2	4.6
Non-teaching	7.2	6.3	4.4	3.6	3.6	3.9	4.4	4.7	4.7	4.8
Voluntary	7.5	6.8	4.7	3.6	3.6	3.6	3.9	4.2	3.9	4.1
Proprietary	8.4	7.2	5.2	4.7	3.8	3.0	3.9	5.3	5.7	6.4
Urban government	4.3	4.2	1.6	2.1	2.0	3.3	3.2	3.5	4.8	4.3
Rural government	4.3	3.2	2.1	1.3	2.3	2.8	3.8	4.8	5.2	4.4

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 9. Annual Rate of Increase in Medicare Operating Costs Per Discharge, by Teaching Status



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 10. PPS and Total Margins, by Hospital Group, Tenth Year of PPS (In Percent)

Hospital Group	PPS Margin	Percent w/ Negative Margin	Total Margin	Percent w/ Negative Margin
All hospitals	0.3%	54.1%	4.3%	23.8%
Urban	0.6	54.4	4.2	23.0
Rural	-1.8	53.8	5.0	24.7
Large urban	1.9	50.3	3.5	25.5
Other urban	-1.5	59.3	5.3	20.1
Rural referral	0.2	49.5	6.0	8.7
Sole community	0.6	47.5	5.3	25.9
Other rural	-4.0	57.1	4.2	26.5
Major teaching	11.7	17.8	2.7	23.2
Other teaching	0.5	48.2	4.6	19.9
Non-teaching	-4.0	57.2	4.8	24.6
Voluntary	0.1	55.1	4.1	22.2
Proprietary	1.8	47.8	6.4	29.0
Urban government	3.0	52.2	4.3	20.9
Rural government	-4.8	55.5	4.4	27.5

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Mr. JOHNSON. Thank you, sir.
Dr. Carter.

STATEMENT OF MICHAEL A. CARTER, D.N.SC., R.N., DEAN, COLLEGE OF NURSING, UNIVERSITY OF TENNESSEE, MEMPHIS, TENN.

Mr. CARTER. Good morning, Mr. Chairman, and members of the committee. I am Michael Carter, and I am dean of the College of Nursing at the University of Tennessee at Memphis. I am also a family nurse practitioner.

The College of Nursing is a rather unusual entity in that it is an academic-based nursing program and does participate in graduate medical education because of a relationship with our University Hospital in Knoxville.

We prepare certified registered nurse anesthetists in this program, and GME does pay for a part of that. And we began this certified registered nurse anesthetist (CRNA) program in the thirties, making it one of our oldest programs.

I believe, however, that a number of changes are needed, for instance, if the legislative intent of this reimbursement is to be met in the future. As important as reimbursement is to us in the College of Nursing, I cannot tell you the amount of that reimbursement, and that is because the money goes directly to the hospital for a variety of cost-related issues and not to the College of Nursing for its budget. And yet I am responsible for paying for the cost of that program.

I understand that the original aim of Medicare reimbursement was to promote high-quality care for Medicare beneficiaries. In 1965, it was very appropriate that reimbursement be made to hospitals, since that was where the education took place and particularly that is where most nurses were trained.

But that is not the case today. Most nurses are not educated in hospital-based nursing programs, but are educated through universities and colleges and therefore do not qualify for GME.

For example, we have another problem in that our CRNA program in the past could perform all of its training in one hospital, but we cannot do that anymore, because that hospital does not offer all the services, and it is a major teaching hospital.

An example is that there are insufficient epidural anesthetics for women delivering babies for our students to be trained in that procedure, so they must come to Memphis for part of their training.

The situation is far more complicated in training nurse practitioners. We have offered a family nurse practitioner program at the master's level since 1973, meaning that we could not participate in GME for this program. We have graduated hundreds of these providers who are providing primary health care to thousands of persons in the lower Mississippi delta area of this country, one of the poorest regions in America.

None of the education of our nurse practitioner students takes place in a hospital—none of it. They are prepared in community-based clinics in inner-city Memphis and in rural Tennessee, Arkansas, and Mississippi. This also is where they practice when they are finished.

There is not any form of reimbursement available to cover the costs of educating nurse practitioners in these very rural clinics in which they are often one of two providers.

We must change the current system if we are to meet the original aim of Medicare reimbursement in preparing this work force.

To do this, I have two recommendations. First, I believe that we should stop the current payment for hospital-based nursing education programs, completely stop it. These programs prepare people at less than the college level and are not prepared to enter advanced practice. They must go on to college, obtain a baccalaureate degree, and then come into a master's program. The money needs to be redirected to meet the needs that we have, and this means paying for nurse practitioner, nurse midwife, and nurse anesthetist training programs.

The education of these students often does not take place in any hospital, and when it does, it takes place in multiple hospitals.

Second, I think that we need to pay the nursing education programs differently. Nursing education is organized quite differently from graduate medical education and does not tie itself to hospital-based educational programs. Our certification programs do not fit that as well.

This money could pay stipends for students, cover a part of the cost of the supervision of these students, and to pay for the costs of education borne by the primary care clinics.

I believe that if these two changes are made in the current GME reimbursement system that the Nation would be able to greatly expand the critically needed number of nurse practitioners, nurse midwives, and nurse anesthetists who, by the way, provide 85 percent of anesthetic services in rural communities, and that these individuals would expand their role in rural and other inner-city and underserved areas and would not add any new money to the system to do that. Rather we would make much better use of the current investment that Medicare makes in nursing education.

Thank you.

[The prepared statement follows:]

Testimony of Michael A. Carter, D.N.Sc., R.N.
Dean, College of Nursing
University of Tennessee, Memphis

Good Morning. I am Michael Carter and I serve as the Dean of the University of Tennessee College of Nursing. The College in cooperation with our University Hospital in Knoxville, TN conduct a Master's degree program in nursing that prepares Certified Registered Nurse Anesthetists. We began this program in the early 1930's and today graduates of this program provide anesthesia to patients throughout the nation. We would very limited in our ability to operate this program without the money the hospital receives from the Medicare reimbursement. I believe, however, that a number of changes are needed if the legislative intent of this reimbursement are to be to be met today and in the future. As important as the reimbursement is to us, I can not tell you the amount of this reimbursement. This is because the money goes directly to the hospital and not to the budget of the educational program.

I understand that the original aim of Medicare reimbursement for a portion of the costs of nurse education was to promote high quality care for Medicare beneficiaries. In 1965 it was very appropriate that this reimbursement be made to hospitals for nursing education since that was where most of the education took place. Many changes have occurred since then. For example, in the area of preparing Certified Registered Nurse Anesthetists, all education could be done in one hospital in the past. Today, all hospitals do not provide all clinical services. Our University Hospital does not provide enough obstetrical services for our students to learn to competently administer epidural anesthetics. We must have the student leave Knoxville and spend at least one month of their training in Memphis.

The situation is far more complicated in the area of educating nurse practitioners. The College of Nursing has operated a Master's level Family Nurse Practitioner program since 1973. We have graduated hundreds of these providers and they today provide primary health care to thousands of citizens in the heart of the nation. None of the education of our nurse practitioner students takes place in the acute care hospital. They are prepared in community based clinics in inner city Memphis and in rural Tennessee, Arkansas, and Mississippi. When they graduate, this is were they practice. Medicare reimbursement for a portion of the costs of their education is not available to these clinics. These clinics care caring for mostly poor people. There is not any form of reimbursement to cover the costs of educating nurse practitioners in these clinics. We must change the current system of reimbursement if we are to meet the original aim of Medicare reimbursement.

I would strongly recommend the following:

1. Discontinue the current reimbursement for hospital based nursing educational programs. This money needs to be redirected to meet the

emerging needs of Medicare beneficiaries. The need is the greatest for advanced practice nurses- nurse practitioner, nurse midwives, and nurse anesthetists - at the Master's or higher level. The education of these students does not take place in the hospital or in only one hospital.

2. Redirect the current reimbursement to the education of advanced practice nurses. The money needs to be made available to the nursing education program offering the program. This money would pay stipend support for full time students, cover a portion of the costs for clinical supervision of these students, and allow for some payment for the costs of education borne by the primary care clinics.

I believe that if these two changes are made in the current Medicare Graduate Medical Education reimbursement system that the nation would be able to greatly expand the critically needed number of nurse practitioners, nurse midwives, and nurse anesthetists particularly those in rural and other underserved areas without adding new money to the system. Rather, we would make a much better use of the current investment Medicare makes in nursing education.

Chairman THOMAS. Thank you, sir.

Dr. Altman, would you comment on the fact that he wants to take the dollars out of the hospitals?

I have been told that some the hospitals around the country, teaching hospitals, depend on this money, have come to depend on it—I do not know if that is right or wrong—and could absolutely fall flat, totally go out of business, if this funding mechanism were not kept in place. And I am not saying that it ought to be Medicare necessarily.

Maybe you can suggest some way that government can, you know, disengage itself, maybe redirect the dollars without it being Medicare dollars.

Mr. ALTMAN. Well, first, as I understand his testimony, he is focusing only on the amount of money that is being used for nursing.

Mr. JOHNSON. Nursing. I understand that, but I——

Mr. ALTMAN. And it is only what? I do not know—about $200 million. I mean, I do not want to sneeze at $200 million personally, but we are talking about a hospital industry that is consuming, what, upward of $100 billion.

I do not think, in and of itself, that is a lot of money. And I am not in a position to argue whether the hospitals should not play an appropriate role. My sense is that they do play an appropriate role in the training of some types of nurses. But I support his testimony that nursing, like other parts of medicine, is changing and shifting out of the hospital.

So I think it is deserving of a review. I am not so sure that the hospitals should not get a share of it, but whether they should get all of it or not, he may have a very good point.

Mr. JOHNSON. Thank you. I appreciate that.

Mr. Cardin, do you wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Dr. Altman, if I could get you to respond on one part of how the indirect medical costs are handled? As I understand it, Medicare figures in the IMC on a risk contract to a managed care program, even though the health care plan may very well not be using academic centers.

Can we make some adjustments in that philosophy—more quickly than perhaps some of the other issues—to try to make it sensitive to whether, in fact, the managed care programs, are using the academic centers?

Mr. ALTMAN. Well, there is no question that the AAPCC includes all of the payments that go in the Medicare program to the average patient in a fee-for-service environment. So it includes this indirect medical adjustment.

You could make that adjustment. My own personal view is that while you are taking this project on, that is such a small piece of the total, I personally would do it differently.

First of all, you have got to be fair to the system. To the extent that the indirect medical expense (IME) is being paid for—currently it is being paid for by lowering the payments to the other hospitals. The total is the same. The way the calculation is made is that when they calculated the amount of the IME, they took it out of the base, and therefore they lowered the average amount of the average payment to hospitals. So in a strictly technical sense,

a strictly technical sense, if you took the IME out, you should pay it back to the other hospitals.

Mr. CARDIN. I am not sure I follow you there. The cuts that you are suggesting on IME would not be redistributed to other hospitals. You are talking about absolute costs.

Mr. ALTMAN. Well, let me—we have recommended these cuts for a long time. This is about the fifth year we have recommended it. Up until this year, our recommendations had always been to put the money back where it came from, to put it back into the average hospital.

Mr. CARDIN. But not this year.

Mr. ALTMAN. This year we are cognizant of the special budgetary problems that the Congress and the people are facing. And for the first time, we said: If you are going to make a cut, this may be an area to cut out.

Mr. CARDIN. Well, then you still lose me on how it works on a risk contract.

Mr. ALTMAN. Well, no. I think there is a justification for taking the indirect out of the AAPCC. But I think the whole AAPCC structure needs to be readjusted.

Mr. CARDIN. One of the concerns I have about your suggested cuts, while they are logical in and of themselves, is that we don't have a logical system for reimbursing for graduate medical education.

Therefore if you take the type of cuts that you are referring to, whether it is fair or not fair, these facilities are dependent upon those funds. And if we just try to make a system that is not fair in the way it reimburses GME and cut the Medicare contributions without dealing with the overall problems, then we run the risk of really hurting some institutions that have a special role in our system that will not survive in the competitive environment.

Mr. ALTMAN. Well, I do not disagree with that. We have tried to find a number which we thought was appropriate and balanced. There is no magic number here. We think the payment is too high to those institutions.

And I want to make one point. There are big differences within teaching hospitals. There are some teaching hospitals that are making significant money on Medicare and are making significant money overall, and are treating almost zero, or very close to zero numbers of uncompensated care patients.

And then we have others that are running 20 to 30 percent where their bottom line is zero. I think we need a better targeting of that money.

Mr. CARDIN. Absolutely, we agree on that. The formula that we use, the built-in old distribution cost and everything else, does not make an awful lot of sense.

I guess my concern is, I am not so sure we should be tinkering with a system that does not work; we should be restructuring the system.

Mr. ALTMAN. Well, I would not disagree.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. ALTMAN. Except I would disagree about changing the whole structure. The issue is, when you are dealing with the teaching ad-

justment, I just do not know exactly what to do, recognizing how high it is.

Mr. JOHNSON. Doctor, you did not really answer my question when I asked you if—and Mr. Cardin led into it—if these dollars are drastically reduced, are hospitals going to go out of business?

Mr. ALTMAN. Oh, now, if you get—I was just responding to——

Mr. JOHNSON. I know. The nurse part of it.

Mr. ALTMAN. Now when we talk about the big issue, I do get concerned. I mean, I am concerned about several of our major teaching hospitals. I am concerned about what Mr. Cardin said. If we sort of just reduce the amount of money at the same time that the managed care world and competition is squeezing down, I think we run the risk of some of these institutions falling into deep financial problems. I do.

Mr. JOHNSON. Well, I think there has to be some restructure, and I think you are hitting the nail on the head about where to get some of those reductions.

You also said the number of 229 major hospitals or 230. The panel before you corrected me when I used that number, which I got from you, and said 130 or so. Now——

Mr. ALTMAN. Well, it is the definition of "major." You know, there is major and there is major-major. You know, I mean—[Laughter.]

And then there is a major-major-major. You know, before you know it, there is only Johns Hopkins left. So what can I tell you? [Laughter.]

Mr. JOHNSON. Well, if we can keep that one, maybe we will be all right.

Thank you very much.

And Mr. Christensen, did you want to inquire?

Mr. CHRISTENSEN. Sure. I would like to get your opinions on what your vision of a graduate medical education should be. For example, what should the role of the hospitals in graduate medical education be in light of the current budget constraints that we are going to be facing in the next few months. What role should they play?

Ms. HANFT. Well, hospitals have to play a partial role. A physician and a nurse practitioner as well needs some hospital-based training.

The real problem is that the need is for training in HMOs, in managed care environments, and in clinics. And we have a mismatch of what are the educational needs versus the way the funds flow to support that.

Some hospital training is absolutely essential, and hospitals, particularly large teaching hospitals, also have numerous outpatient clinics as part of them, which are a major source of education for both nurse practitioners, residents, and physician's assistants. So you need some of both.

The problem is that the bulk of the funds flow to the hospital, and unless the hospital is willing to support the outpatient training in another locus by continuing the salary, Medicare does not pay for it. And that is the fundamental mismatch that we have in the financing.

Hospital training is essential, particularly for surgical specialties, for real differential diagnosis of complex cases. So you need both.

Mr. CHRISTENSEN. Dr. Carter.

Mr. CARTER. I agree with Dr. Hanft, that the necessity for hospitals is clearly there.

As an interesting point, the hospitals that participate in GME for nursing are not generally teaching hospitals. These are community hospitals. And the nursing program may be the only educational program that that hospital offers.

Those of us that are in systems such as mine at the University of Tennessee, where there is a single board that supervises the hospital and the nursing school, we are privileged to be able to do a small piece of that.

And therefore I think that we need to look very carefully at how that happens. But in the same way, the training cannot take place in one hospital, which has been unwilling to share the salary for that learner, that nurse anesthesia student, to be gone, so it is a difficult question to look at.

Our hospitals, for the most part, do not operate community-based systems, and in our State, where TennCare has become our new managed care arrangement for our former Medicaid, most of the individuals participating are not hospital affiliated.

Mr. CHRISTENSEN. Looking at the contributions that teaching hospitals make, which ones do you think are absolutely essential for us to preserve? Which ones do you think may be something that we could streamline?

Mr. ALTMAN. Well, that is a difficult—that really is a difficult question to answer.

Teaching hospitals play several very important roles. If you are in a big center such as Boston or New York or Houston where you have many, one or two less is not going to change the balance of that city or the health care.

But you could have what might be called even a semi-major teaching hospital in a middle-size Midwestern city, which is the critical deliverer of care in that area and is where most of the individuals are trained.

So I get uncomfortable about using any kind of formula to decide which one should go and which one should not.

In this case, I do believe to the extent that there is this market out there—it is not a market that I grew up learning about in economics, but it is a market of sorts, and therefore I think that may sort itself out, where the students want to go. If you reduce the number of students, you reduce the number of residencies, there will be a self-selection process taking place.

Plus I think some communities are going to hang on hard to what even might be viewed from sort of the elite as second-rate institutions. They may be very important for their communities, and their communities are going to support them.

So I really could not tell you which institutions should go.

Ms. HANFT. May I add one thing to that? If you look at family medicine residencies, they are basically not based in what we call the major 250 or 330 teaching hospitals. Most of those family medicine residencies come out of the community hospitals, and many of them are in smaller communities. That is one area where you cer-

tainly would not want to upend the current environment. Those residencies operate quite differently than the standard residencies in the large academic health centers.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. HOUGHTON [presiding]. Thank you, Mr. Christensen.

Dr. Altman, gentlemen, it is nice to see you. Thank you very much.

I just have one specific question I was going to ask before I was crowned here to take the chair for the moment.

I am particularly interested in New York City, and as a matter of fact, I am surprised that when Mr. Christensen asked the question, you did not say immediately New York was the obvious place where the greatest hospitals should exist and be protected. [Laughter.]

It is not that I am parochial or anything like that.

But anyway, getting to the thrust of my question, health care in New York obviously is really dependent upon the Medicare GME payments, probably much more so than the average.

So, you know, people like myself—and I know Mr. Rangel and others—would worry about the impact of this whole reformation in freezing limits and limiting the number of residents, eliminating, foreign medical graduates, limiting payment for the first 3 years, cutting indirect adjustment—a big, big difference, because New York is different than Chicago, Boston, or Houston.

So I hate to see just a scythe go through the whole process and average it out where there is an undue concentration of teaching, research and residency which has to be protected.

Maybe all of you would like to make a comment on that.

Mr. ALTMAN. Well, I have looked quite extensively at the special interests of New York, and there is absolutely no question about it, that for many of these issues there is New York and the rest of the country. It is not even like: Well, there is New York and Chicago or New York and Boston. There is New York.

And it flows in several important dimensions. One is on the direct side. The amount of payments per resident is the highest in the country in New York. New York depends more heavily on the number of foreign-trained residents than any other part of the country. They receive a much larger proportionate share of the indirect teaching and the disproportionate share payments. There is absolutely no question that if you look at the numbers in New York, the impact of Medicare policy has a disproportionate impact on the current delivery system.

I will be glad to share those numbers with you. You probably know them. I am sure the medical——

Mr. HOUGHTON. No, I would like to see them.

Mr. ALTMAN. And how you deal with that is a complicated issue.

I am not a big believer in averaging. I do not think averaging makes sense in this area. I think we ought to decide from a policy point of view where you want the system to go. And, you know, in defense of New York and Boston and Philadelphia, the Nation looks to them to train physicians that go out all over the country.

So I would not average at all. That does not mean that those areas are not going to be affected if you cut back and probably will

be disproportionately affected. But if you average, it will be an absolute disaster for them.

Mr. HOUGHTON. Sure. Dr. Hanft, would you like to make a comment?

Ms. HANFT. Yes. I am quite familiar with New York, particularly the role both the New York Health and Hospitals Corp. plays in both care for the indigent and in their very large role in graduate medical education, institutions like Bellevue and Kings County Hospital.

I agree with Stuart that any of these changes will have a disproportionate effect on New York. But I would also raise the question with New York as to whether they need the number of specialty training programs they have in the city, whether there cannot be more of a collaborative effort across the number of medical schools to share some of those residencies, rather than each one having their own institutional spread of residencies through all the specialties.

So I think there is some effort that could be made by the educational institutions in New York to begin to soften the blow over time.

Mr. HOUGHTON. Well, in order to have that, if I could just interrupt for 1 minute—in order to have that effort made, there has got to be some sort of incentive.

Ms. HANFT. Yes.

Mr. HOUGHTON. So it is either an incentive internally or amongst the hospitals there or something which we do.

How would you suggest going about that?

Ms. HANFT. Well, as you will recall, some of the suggestions made earlier to change graduate medical education was the development of education consortia. And this is one area where New York might be a pioneer by getting the Cornells and the NYUs and the Mount Sinais and SUNY Downstate to really sit down and begin to decide what kind of work force does New York need, and how can they, as effective educational institutions, work together to begin to phase down areas where they may be producing too many specialists and to be able to establish the kind of training sites needed for managed care for the community health centers in New York and for the other service providers in the city and the State.

You could—Rochester has done a very effective job in outpatient training, for example, and in the training of family practitioners.

Mr. HOUGHTON. Yes. That would not have any impact on a disproportionate share of funding or something like that because of the unique nature of the city.

Well, look, the time has gone on, and I really appreciate this, and maybe we can get some other figures from Stuart on that.

Mr. ALTMAN. We will be glad to get them for you.

[The information requested was not received at the time of printing.]

Mr. HOUGHTON. That would be great. And I really appreciate your time.

Mr. ALTMAN. Thank you.

Mr. HOUGHTON. And we will have the next panel. Thank you so much.

Now I would assume that Messrs. Munson, Jacott, Schwartz, and Anderson will come to the table.

Thank you very much, gentlemen, for being with us. I am sorry I am the only one here. There will be others appearing in and out. You know, this is a rather peripatetic place.

But Mr. Munson is the executive director of the University of North Carolina Hospitals and speaking on behalf of the Association of American Medical Colleges.

Maybe you would begin.

STATEMENT OF ERIC B. MUNSON, EXECUTIVE DIRECTOR, UNIVERSITY OF NORTH CAROLINA HOSPITALS, APPEARING ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. MUNSON. Thank you, Mr. Chairman.

As you said, my name is Eric Munson. I am the chief executive officer of UNC Hospitals in Chapel Hill where I am trying to run a hospital that the basketball team can be proud of. [Laughter.]

I am also representing today the Association of Medical Colleges, and I appreciate the opportunity to testify on potential changes in the Medicare program and their effect on our Nation's important teaching hospitals.

Specifically I will comment on two Medicare payments to teaching hospitals, the indirect medical education and the direct graduate medical education payments.

Second, I want to call your attention to an issue of urgent and increasing concern to teaching hospitals, specifically the Medicare average adjusted per capita cost calculation.

Academic medicine and teaching hospitals are in a period of extraordinary and tumultuous change. My colleagues and I have enthusiastically engaged in this revolution in health care delivery. Further, we are part of a national movement to getting costs under control, improving the quality of care, and maintaining an ever-expanding access to care to all Americans.

My written statement includes just a few examples of the strategic initiatives some of us have undertaken to meet these national challenges.

The teaching hospitals are complex institutions. We have additional responsibilities in society that make it harder for us to compete in an environment where price is the only driving force. Teaching hospitals certainly provide patient care, but our care is frequently delivered to the most seriously ill, often using more sophisticated technology, and to the most disadvantaged persons in our society.

Everyone of us has an anecdotal experience of an immediate or extended family member who has benefited from having been referred to one of our country's many great academic medical centers. Your story may involve cancer or organ transplantation or hemophilia or cystic fibrosis or a complicated behavioral problem. We all have our stories, and we must remember these stories when we think about tinkering with the public program which has enabled most of these stories to have happy endings.

Teaching hospitals are also on the cutting edge of research and technology. We provide the environment for the conduct of clinical,

biomedical, and behavioral research and the introduction of new technologies.

To some degree, that is one of the historical purposes of the IME Medicare adjustment. At UNC hospitals, for example, we have a major lung transplantation program, and we may find the cure for cystic fibrosis one day soon.

Our research moves from the lab to the bedside and then into the community. I understand that today's conventional wisdom is that we are too expensive. We also know that in today's scientific age, we are priceless.

Teaching hospitals also serve as sites for the clinical education of all types of health care professionals, from physicians to nurses to allied health professionals. At UNC hospitals we have over 400 residents in 20 specialty and subspecialty training programs. We have 460 more students learning everything from physical therapy to cancer prevention to rehabilitation counseling.

We are working hard to increase the number of primary care physicians we train, and we have decreased the number of specialty positions we offer.

We learned just this week that 59 percent of the 170 UNC graduating medical students have selected residencies in primary care.

We continue to operate the country's finest demonstration of dispersed medical education through our Area Health Education Center. Through the area health education system program, students from all four North Carolina medical schools received training experiences all over the State.

Not only does this program foster exposure to primary care practice models in rural North Carolina, it also sustains the practicing professionals who serve as clinical role models in these remote settings.

All these additional responsibilities define today's teaching hospitals, but they also make our care expensive. Some policymakers and many payers expect teaching hospitals to be able to isolate the costs associated with their academic mission from the costs of providing care. We think that is pretty difficult.

Teaching hospitals finance these additional activities through a complex and delicate system of cross-subsidized revenues derived from patient care including payments from the Medicare program. In particular, teaching hospitals, including UNC hospitals in Chapel Hill, depend on DGME and IME payments.

In 1993, UNC hospitals received about $20 million for these two categories of payment, enabling us to fund, for example, an expanded breast cancer treatment program, losses in the Southeast United States' finest burn center, a new laboratory for gene therapy, a new training program in emergency medical services, construction of ambulatory primary care training sites for our primary care trainees, and placement of clinical work stations in the offices of rural primary care providers.

Increasing competition is making it more difficult to maintain our contract with society. In a marketplace where public and private insurers are not required to support their fair share of these responsibilities, the Medicare program's historical explicit payments to teaching hospitals take on crucial importance. Reduced

Medicare support will make it more difficult for teaching hospitals to sustain their role in society.

On this point, I find it paradoxical and even pathetic that the new crop of publicly held managed care companies are so eager to hire our product, specifically primary care doctors, but they have no interest in talking about the costs of production.

Medicare and Congress, on the other hand, have recognized from the beginning that in order to ensure quality care for the next and expanding generation of seniors, Medicare has a responsibility to help pay for the next generation of caregivers. Now, in my view, is no time to flinch on this contract.

I would like to now end my comments by turning to the Medicare AAPCC methodology, which Representative Stark alluded to earlier on and explain how that poses a threat to the future of teaching hospitals' ability to carry out their responsibilities.

In some areas of the country, as in California, Oregon, Minnesota, and Florida, this threat is real and immediate. In other areas such as mine where Medicare risk-based contracting is not as prevalent, the urgency of addressing this problem is only coming to the attention of teaching hospitals.

One thing is certain. As time passes and Medicare enrollment in risk-based programs grows, this problem will only increase in magnitude and become more difficult to solve. Failure to address the way in which DGME and IME payments and the disproportionate share payments are incorporated in the AAPCC calculation poses a threat to the financial status of teaching hospitals. Modifying this aspect of the calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table.

I urge you to address this issue in the context of the Medicare reform package currently being developed by the subcommittee. The AAMC staff would be happy to work with the committee to remedy this situation.

Before I close, I would like to make a personal biased observation. Our country's teaching hospitals—I have worked at three—are a national treasure. They are also fragile. In this era of competition, greed, and return to shareholders, I believe that those who champion education, research, and public service, the very domain of government, will be smiling when the last chapter is written.

Thank you.

[The prepared statement follows:]

TESTIMONY OF ERIC B. MUNSON
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman and members of the subcommittee, I am Eric Munson, Executive Director of the University of North Carolina Hospitals in Chapel Hill. The Association of American Medical Colleges (AAMC) welcomes the opportunity to testify on the Medicare program's current law and policies relating to Part A payments for graduate medical education. The Association represents all of the nation's 126 accredited medical schools, approximately 300 major teaching hospitals that participate in the Medicare program, the faculty of these institutions through 92 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents. In 1992, nonfederal members of the AAMC's Council of Teaching Hospitals (COTH) accounted for 6 percent of the nation's hospitals, but nearly 2 million, or almost 20 percent, of all Medicare discharges.

Teaching hospitals are among our nation's most complex enterprises. They are important components of the nation's health care system because they:

- provide all levels of patient care-from primary to tertiary services-often to the most disadvantaged members of our society;
- serve as primary sites for the clinical education of health professionals, including physicians, nurses and allied health professionals; and
- provide the environment for the conduct of clinical biomedical and behavioral research and the introduction of new technologies.

The health care delivery system is evolving as both public and private payers struggle to control health care expenditures, and academic medicine is responding positively to the changes in the environment. Teaching hospitals, faculty practice plans and medical schools have recognized the need for change within their own organizations and are actively engaged in helping to reformulate the health service delivery system, find ways to reduce the rate of increase in health care costs, improve accountability, and maintain or improve the quality of clinical service. Teaching hospitals are studying ways to deliver services more efficiently through partnerships with other health care organizations and are seeking new arrangements with payers of services. Medical schools, often in conjunction with teaching hospitals, are working aggressively to: increase the number of generalist physicians; identify new community-based sites for physician education; enhance the curriculum to reflect both new knowledge and new delivery paradigms; and assure the vitality of biomedical and behavioral research.

For example, at the University of North Carolina Hospitals, we are engaged in a number of strategic initiatives which seek to balance our traditional, statutory, public mission with the contemporary, market driven mandate to be an inexpensive provider of health care services. Some of our strategic initiatives include:

- expanding our network of primary care providers, through contracts and acquisition, for both service delivery needs and residency training sites;
- networking with other providers to cast a wider net for various managed care offerings;
- collaborating with our medical school faculty colleagues to "sell" our primary, secondary, tertiary and quaternary services to those purchasers of care with long term commitments to serve our market area; and
- marketing specific product lines such as lung transplantation to regional and national buyers as "Centers of Excellence."

With regard to graduate medical education, we are changing the blend of residency training positions available by increasing primary care opportunities and decreasing the number of specialty slots. We continue to operate the country's finest demonstration of dispersed medical education through our Area Health Education System (AHEC). The AHEC program provides all four of North Carolina's medical school students with training experiences throughout the state. Not only does this program foster exposure to primary care practice models in rural North Carolina, it sustains the practicing professionals who serve as the clinical role models in these remote health care settings.

While pursuing all of these strategic initiatives, we continue to service the people of North Carolina as the "court of last resort"...the place to which the sickest patients are sent...the place to which the poorest patients are sent...the place to where the cure for cystic fibrosis may be found...the place where teenage mothers go for education and health care. We know that today's conventional wisdom says we are too expensive; we know also that in today's scientific age, we are priceless.

In St. Louis, where the market is rapidly changing from one based on fee-for-service to managed care payment arrangements, St. Louis University Health Sciences Center is transforming itself into a more effective institution through structural change. The Health Sciences Center has consolidated the clinical practices of its faculty into a single unit to promote administrative efficiency and allow the faculty to develop and market product lines to health care purchasers. It is also consolidating the newly-reorganized faculty practice group with the hospital into a single provider structure that aligns physician and hospital incentives and permits rapid and coherent responses to changes in the market. Soon, this new entity will merge with other health care providers in the community who have strong primary care bases and broader geographic coverage. This move will provide the Health Sciences Center with access to a sufficient base of covered lives, and to a network of providers who can provide ambulatory training opportunities for both medical students and residents.

In Kansas City, the University of Kansas Medical Center is concentrating not only on restoring health, but keeping people healthy through the formation of community-focused networks. KU has joined with other health systems and two Blue Cross plans to form a corporation that operates a HMO in a two-state area and seeks to find innovative ways to benefit the communities it serves. KU Medical Center also has formed the Jayhawk Health Alliance with seven suburban and rural hospitals within 75 miles of the medical center.

These examples are typical of the actions that teaching hospitals and teaching physicians are taking around the nation to adapt to the new and rapidly changing marketplace. Academic medicine is prepared and willing to meet the delivery

system's new imperatives. But in a competitive environment based on price, teaching hospitals and medical schools face special challenges because these complex organizations have unique missions that, of necessity, add to their costs. The costs of these additional missions are borne in our current system by patient care revenues, including payments from the Medicare program, through a system of cross-subsidization. Patient service revenues have supported graduate medical education and other academic activities, and payments from paying patients have supported charity care patients.

The Prospective Payment Assessment Commission (ProPAC), in its March 1995 report to the Congress, notes that as the competition among health care delivery providers intensifies, the traditional patterns of subsidies across payers and providers will change (page 5). As the overall costs of medical care have risen sharply, private health care payers have adopted payment systems-such as capitation, aggressive contracting and discounting-that restrict their payments to cover only goods and services they believe are necessary and of identifiable, narrowly defined benefit to their enrollees. These types of payment arrangements increasingly do not recognize costs associated with the education and research missions of teaching hospitals.

In the newly price competitive environment, there is pressure on private payers to avoid paying higher patient care rates to fund the additional products of teaching hospitals that go beyond direct patient care. The AAMC believes that teaching hospitals, who are eager and willing to compete in the marketplace, will at some time in the short term future no longer be able to "make up the shortfall" to fund the costs associated with their academic missions through higher charges to patients. Revenue data from hospitals belonging to the AAMC's Council of Teaching Hospitals show that private and some public payers support about two-thirds to four-fifths of these additional costs primarily through increased charges for services. However, as ProPAC notes, ". . . increasing competition in the private sector is making it harder for teaching facilities to obtain the higher payment rates needed to cover the added costs of their graduate medical education programs" (page 7).

In the absence of a marketplace where all insurers or sponsors of patient care programs support their fair share of the academic mission of teaching hospitals and teaching physicians, the Medicare program's historical, explicit payments to teaching hospitals in support of their added responsibilities take on crucial importance. Even though Medicare payments support only a portion, between one-fifth and one-third-of the costs associated with the academic mission, teaching hospitals rely heavily on the two Medicare payments with an educational label: the direct graduate medical education (DGME) payment and the indirect medical education (IME) adjustment. Reduced Medicare support will make it more difficult for teaching hospitals to sustain their additional missions.

The AAMC believes that Congressional decisions on Medicare payment policy should be made in the context of their impact on the entire health care system. As ProPAC indicated in its March 1995 report:

> Medicare's payment policies must be considered in the context of changes occurring in the financing and delivery of health care. Among the most significant of these are the growth of capitated payment methods and managed care techniques in the private insurance market... Important factors contributing to these developments include constraints on payments from private payers and increased competition among providers and payers (page 3).

While the academic medical community understands the Federal government's need and commitment to reducing the budget deficit, and the growth in Medicare and Medicaid expenditures, teaching hospitals and teaching physicians would be particularly harmed by reduced Medicare support just when they are undergoing major change. I am pleased to appear before you today to comment on three issues relating to Medicare Part A payments of crucial importance to teaching hospitals:

- the role of Medicare payments for DGME costs in support of residency training;
- the importance of the Medicare IME adjustment to the financial viability of teaching hospitals; and
- the methodology for calculating the average adjusted per capita cost (AAPCC), the rate that the Medicare program pays to risk contractor HMOs.

Even under normal circumstances these three issues would be important, but they take on especially critical dimensions in the current environment. For example, while many proposals to change Medicare payments would affect both teaching and non-teaching hospitals, substantial reductions in IME and DGME payments would harm teaching hospitals disproportionately, seriously threatening their financial stability and affecting access to care and quality of care received by Medicare beneficiaries and other patients. Additionally, failure to address the way in which DGME and IME payments and the disproportionate share (DSH) payment are incorporated in the AAPCC calculation poses a threat to the financial status of teaching hospitals.

I urge the members of this subcommittee to consider carefully its Medicare payment policy recommendations. Teaching hospitals and teaching physicians play critical roles in our health care delivery system, and they could be damaged severely unless changes are crafted carefully and are based on an extensive understanding of the service, education and research missions of academic medicine.

Direct Graduate Medical Education Payments

Hospitals that train health professionals have multiple functions. In addition to providing medical care to individual patients, these hospitals provide the resources for the clinical education of physicians, nurses, and allied health professionals. To provide this formal, experientially-based clinical training, hospitals incur costs beyond those necessary for patient care. These added direct costs include: salaries and fringe benefits for trainees and the faculty who supervise them; the salaries and benefits of administrative and clerical staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for electricity and maintenance.

The Purpose and History of the Medicare Direct Graduate Medical Education Payment

When Congress established the Medicare program in 1965, it acknowledged that educational activities enhanced the quality of care in institutions and recognized the need to support residency training programs to help meet the public need for fully-trained health professionals. In drafting the initial Medicare legislation, Congress stated:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (House Report, Number 213, 89th Congress, 1st Sess. 32 (1965) and Senate Report, Number 404, Pt. 1, 89th Congress, 1st Sess. 36 (1965)).

Similarly, in the regulations governing the Medicare program, the Secretary of Health, Education and Welfare stated:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities (42 C.F.R. Section 413.85 [formerly Section 405.421(c)]).

Thus, since its inception the Medicare program has assumed some responsibility for graduate medical education costs, making separate payments to teaching hospitals for these costs. If there was ever an assumption that the "community" would take responsibility for its share of these costs, it certainly is not occurring in the current competitive environment.

Until the mid 1980s, Medicare paid for its share of DGME costs based on the hospital's historical and reasonable costs as determined by an audit. Reimbursement was open-ended in that a proportionate share of "reasonable and allowable" DGME costs incurred every year was "passed through" to the Medicare program. DGME payments were also open-ended in that there was no restriction on the number of years that Medicare reimbursement would pay for support a resident's training.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-72), which dramatically altered the DGME payment methodology. The legislation changed the DGME payment methodology from one based on annual historical DGME costs to a prospective per resident amount. The Medicare program now pays its proportionate share of a hospital-specific per resident amount based on audited costs from a base year and updated for inflation rather than on the basis of DGME costs actually incurred. Today, a hospital's DGME payment is calculated by multiplying the hospital's fixed amount per resident by the current number of residents and then multiplying that result by Medicare's share of inpatient days at the hospital. Other legislative and regulatory changes have been made since COBRA, but the basic methodology for calculating the DGME payment remains the same.

In addition to changing the payment methodology, COBRA placed limits on the number of resident trainee years for which full Medicare payment would apply. In a subsequent change, Congress chose to restrict full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. The five-year count would be suspended, however, for a period of up to two years for training in a geriatric residency or fellowship program. Payment for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent.

The change in DGME payment methodology required by COBRA, which the AAMC did not oppose, terminated the previous open-ended commitment to financing graduate medical education. Although COBRA limits DGME payments, it still acknowledges the historical scope of direct graduate medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

Proposals to Change Medicare Payments for DGME Costs

Since the implementation of per resident payments in 1989, policy makers have proposed changes in the methodology to encourage residency training in generalist specialties and in non-hospital-based settings. The Association recognizes that the present system has not produced the number of generalist physicians that society may need in a reconfigured health care system. A 1992 Association policy statement calls for:

> . . . an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The policy document's foundation rests on the implementation of voluntary, private sector initiatives. Among them is creating and maintaining incentive programs aimed at individual medical students, resident trainees, and practicing physicians as the best methods of inducing career choices in certain specialties. The Association's policy statement strongly endorses that private sector organizations and governmental bodies should join together in partnership to eliminate the many barriers that exist to meeting the need for generalist physicians.

With respect to the role of the Federal government, the AAMC policy statement recommends that the Medicare program and other third-party payers should adopt other reforms in physician payment designed to compensate generalist physicians more equitably by reducing the marked disparity in income expectations stemming from our current system of physician payment. A second recommendation is that payment methods for financing the direct costs of graduate medical education should not create nor perpetuate barriers to shifting the balance between generalist and non-generalist training.

Appropriate training experiences in ambulatory, community-based non-hospital settings are essential to produce competent physicians. As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings is needed to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training.

The nation's medical schools have implemented programs to increase the awareness and attractiveness of generalist medicine. New clerkships emphasize more experience in ambulatory settings. Courses with a primary care focus have been added during the pre-clinical years, and new curriculum strategies, such as primary care tracks and competency-based curricula, are being developed and implemented. Role modeling and mentoring opportunities are being provided through classes, formal mentoring programs, or the assignment of advisors and the development of primary care interest groups. Schools have convened primary care task forces, appointed new Associate Deans for Primary Care, and developed new departments of family medicine and divisions of general internal medicine and general pediatrics.

The AAMC is pleased to report that medical schools' efforts, in combination with market forces, have been rewarded as medical students' interest in generalist practice continues to increase. Although data on medical students' career choice from as recently as the graduating class of 1989 show a declining selection of the generalist specialties, more recent data signal that medical school graduates continue to notice the changes in the health care environment. In 1994, the percentage of medical school graduates indicating their intention to pursue certification in one of the generalist disciplines increased again. Of graduating medical students, 22.8 percent indicated an intent to choose a generalist career in 1994 compared to 14.6 percent in 1992 and 19.3 percent in 1993. In addition, results from the National Residency Matching Program (NRMP), released on March 15, 1995, showed that medical students "matched" into family medicine residency programs at the highest rate in the NRMP's 43-year history. Over 2,000 graduating seniors from U.S. medical schools, or 15.4 percent of those seeking first-year residency positions, matched into a family medicine residency. This compares to 14.0 percent of all U.S. seniors in 1994.

Personal incentives such as loan forgiveness, tax benefits, and other inducements, such as narrowing the income gap between generalist and non-generalist physicians, are more likely to result in greater numbers of U.S. medical school graduates entering the generalist disciplines. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs. There are also a variety of federally-sponsored student loan repayment programs that could be bolstered.

Our present system for graduate medical education has much to commend it. The AAMC appreciates the need to study different payment policy options. However, it is important to note that many options are interrelated in sometimes unexpected ways that, if adopted, could result in unintended consequences, such as the need for a regulatory mechanism. The need for re-examination notwithstanding, Congress should carefully consider changes in Medicare payment policy that would reduce the program's current level of support for DGME, and yet fail to encourage the attainment of desirable public policy goals, such as an increase in the number of generalist physicians. This is particularly true in light of diminishing support from other payers and the present unlikelihood of establishing an all-payer fund for graduate medical education.

In addition to proposals to shift the balance of generalist and nongeneralist physicians, policy makers also have expressed interest in limiting the variation in hospital-specific per resident amounts. Many of these proposals are intended to limit the growth in Medicare expenditures. Among the more frequently mentioned proposals which seem to have captured the attention of some policy makers are:

- encouraging the development of non-hospital-based ambulatory training sites by allowing entities other than hospitals to receive Medicare DGME payments and changing payment rules for the IME adjustment;
- weighting payments by specialty to encourage training in the generalist specialties;
- constructing a national average per resident payment methodology that would reduce the variation in hospital-specific per resident payments; and
- limiting payments based on certain types or a defined number of residents.

Each of these proposals and their potential impact on graduate medical education is discussed below.

Encouraging the development of non-hospital-based ambulatory training sites. Increasingly, care that was delivered in a hospital inpatient setting is now being provided in clinics, ambulatory surgery centers, community health centers, and other alternate sites. As health maintenance organizations and other forms of managed care delivery systems command a larger share of the health care delivery market, medical educators have recognized that if physicians are to practice appropriately in these settings, it is important for them to be trained in similar settings.

Changes are needed to ensure that training sites chosen by residency program directors are selected because they offer appropriate educational experiences, not because they are more easily funded. Some changes in Medicare DGME funding should be considered to encourage residency training in non-hospital, ambulatory sites. The law regarding Medicare DGME payments is very explicit in stating that DGME payments may be made only to hospitals. On the other hand, the law and implementing regulations allow hospitals to receive DGME payments for the training of residents in non-hospital, ambulatory settings (subject to certain requirements). Although an ambulatory site may not at present receive a Medicare payment directly for any DGME costs it might incur, nothing in the law prevents it from negotiating for a payment from a hospital for the residents that the non-hospital site accepts.

The AAMC believes that the funding for graduate medical education should support residents and programs in the ambulatory and inpatient training sites that are most appropriate for the educational needs of the residents. The Association believes that Medicare DGME payments should be made to the entity that incurs the cost. Recipients of

payments could be teaching hospitals, medical schools, multi-specialty group practices or other organizations that incur training costs. The AAMC strongly encourages the formation of formal associations, or graduate medical education consortia, to assure the continuity and coordination of medical education and to serve potentially as the fiscal intermediary in distributing payments across various training sites. However, the AAMC does not support payments being awarded directly to training programs, since ultimately the organization of which the program is a part must determine the institutional commitment to graduate medical education.

The AAMC urges Congress to consider modifying the statutory requirement that only hospitals may receive Medicare DGME payments and to permit other entities to receive the payment if they incur the cost of training. A payment methodology would have to be developed based on the costs of training at those sites. To explore the issues inherent in such a change, the AAMC would support an effort to design a research and demonstration project to encourage the development of new integrated training sites and/or GME consortia. Under the project, the Administration could experiment and monitor the impact of allowing non-hospital sites to receive DGME payments if they run the training programs and incur the costs.

However, shifting residency training to non-hospital sites may negatively impact the level of a hospital's IME payment. Many policy makers believe that the IME adjustment in the Medicare inpatient PPS serves as a disincentive to conducting graduate medical education in non-hospital, ambulatory sites. They argue that the current rules governing the count of a hospital's trainees for IME payment purposes provide an incentive to keep residents in certain areas of the hospital. Hospitals are allowed to count only residents in the PPS-related units of the hospital, or its outpatient department. If a teaching hospital sends a resident for a training experience rotation to a nursing home or a clinic in a rural area, for example, the hospital may not count the time that the resident spends in these settings for IME payment purposes.

The AAMC encourages the elimination of barriers to graduate medical training in non-hospital, ambulatory settings and/or inner city and rural sites while maintaining the current institutional PPS payment structure. The Medicare IME adjustment, which compensates teaching hospitals for their higher operating costs due to severity of illness, the provision of a broader scope and greater intensity of services, and the presence of physicians-in-training is inpatient-based. To address this apparent barrier to development of non-hospital, ambulatory training Congress could, for example, allow hospitals to count hospital "sponsored" residents in non-hospital settings for IME payment purposes. To maintain the budget neutrality of such a change in the counting rules, Congress could require a freeze on the number of inpatient residents that the hospital could count for IME payment purposes, setting a limit on the aggregate payment. The AAMC would be pleased to work with the committee staff to develop this proposal further and to formulate other budget-neutral policy options.

Weighting Payments by Specialty. For several years, some policy makers have proposed changes in Medicare payments for DGME costs that are intended to provide incentives to encourage the training of generalist physicians and to eliminate the variation in hospital-specific per resident amounts. Additionally, these proposals would reduce the Medicare program's role in GME funding.

For example, Medicare DGME payments could be based on a per resident amount that would then be weighted based on the specialty area that a resident is pursuing. Thus, the Medicare program would make a higher payment for a resident in a generalist specialty than for a non-generalist resident. Such a proposal, if adopted, would replace the current hospital-specific Medicare payment methodology with a system based on fewer multiple rates. Thus, a hospital's total direct GME payment would be based not on its costs, but on the specialty mix of its trainees. Some policy analysts believe that these types of proposals would not only eliminate the variation in direct GME payments, but also would offer incentives to produce more generalist physicians. The proposal would attempt to accomplish this policy goal by paying relatively favorable amounts for generalist residencies, and substantially less favorable payment amounts for all other residencies.

The Association opposes proposals that are intended to stimulate the production of generalist physicians by weighting DGME payments by specialty. Although the AAMC strongly supports more individuals entering generalist practice, the Association does not believe that this proposal would achieve its intended objective of encouraging the training of more generalist physicians. Proposals to weight Medicare DGME payments by specialty would have a negative effect on most hospitals' DGME payments, depending on the hospital's specialty mix of resident trainees.

Additionally, data on career choices of medical school graduates indicate that medical students' selection of residency training programs is affected not by Medicare payments to hospitals, but by market conditions and personal suitability to a particular specialty. At present, there are more generalist training positions offered to medical school graduates than there are interested students to fill them. The task at hand is not to increase the number of generalist training positions, but to increase the attractiveness of the training positions already available.

In its March 1993 report to the Congress, the Physician Payment Review Commission (PPRC) concluded that weighting DGME payments to hospitals is undesirable. The commission indicated that there was already a sufficient number of existing generalist training slots, and weighting would have little influence on hospital management's and residency program directors' decision making.

Changes in physician manpower supply, pressure from both federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship training programs. At the same time, the Association recognizes the frustration of government policy makers in assuring the public has access to an appropriate specialty mix of physicians. The AAMC supports strategies to develop additional generalist physician manpower, but proposals to weight Medicare DGME payments based on specialty, if enacted, would only contribute to the instability of GME funding. Strong residency programs require continuity of effort and stable

support. If future generations of Americans are to have appropriate access to well-trained physicians, we must maintain and strengthen our medical education system, including its residency training component.

Constructing a National Average Payment Amount for DGME Costs. Last year, during the debate over comprehensive health care reform, some policy makers recommended the development of a national average per resident payment methodology with payment adjustments for regional differences in wages and/or wage-related costs. In some instances, the proposals excluded certain types of costs, such as direct overhead costs or allocated institutional overhead costs. These changes were suggested in the context of a package of proposals for graduate medical education reform, including an all-payer funding mechanism that was to be separate from payments for patient care services.

The AAMC supports the continuation of the current Medicare per resident payment method based on hospital-specific costs. The AAMC believes that a national average payment method would fail to recognize structural factors that legitimately affect a hospital's per resident costs. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty supervisory costs, being borne variably by the medical school or teaching hospital. The diversity of support for the costs of faculty is probably the most important reason for the variation in Medicare per resident payments. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Wide variation in per resident amounts exists among hospitals in the availability and amount of support from non-hospital sources, including faculty practice earnings and state or local government appropriations. While some proposals would adjust the Medicare national average per resident payment for differences in wages and other wage-related costs, these other structural factors would not be reflected in the national average payment methodology, creating inappropriate winners and losers.

Last year, at its January 20, 1994 meeting, ProPAC discussed recommendations on graduate medical education financing for its March 1994 report. Commissioners reviewed a staff analysis of graduate medical education costs and payments and noted the complexity of the distribution of these payments to hospitals. Chairman Stuart H. Altman, Ph.D., cautioned those who prefer moving to a national average payment methodology for residency costs without incorporating a number of adjustments in the payment system. Pointing to the commission's eleven-year experience with the prospective payment system--the first attempt by the federal government to standardize payments based on national averages--Dr. Altman noted how many adjustments had been added to the PPS over the years to achieve payment equity. ProPAC's preliminary analysis of graduate medical education costs found significant relationships between per resident costs and hospital size; its share of full-time equivalent residents in the outpatient setting; its share of costs related to faculty physicians' salaries; geographic region; location in a metropolitan statistical area; and area wages.

The AAMC also supports the current methodology because it recognizes all types of costs, including salaries and fringe benefits of the faculty who supervise the residents, direct overhead costs, such as malpractice costs, and the salaries and benefits of administrative and clerical support staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for maintenance and utilities. The AAMC opposes proposals to exclude certain types of DGME costs, such as faculty supervision costs or overhead costs, from the calculation of the Medicare per resident amount. The AAMC believes the level of payment should recognize all types of costs, including direct overhead costs, such as malpractice costs, and clerical support. The current method recognizes the diversity in how graduate medical education is organized and financed. Further, ample faculty supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing patterns of practice. Graduate medical education in all specialties is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated.

The AAMC believes that, within these policy parameters, consideration should be given to changes that would ensure equitable, economically justified payments among training sites. The AAMC intends to pursue the development of alternative payment proposals that would recognize the significant diversity across institutions that participate in graduate medical education. For example, one suggested alternative has been to develop a methodology that pays hospital-specific costs within a payment corridor, such as within two standard deviations of the average per resident amount. The AAMC would be pleased to share our payment policy proposals with subcommittee members and staff, and with the administration as the policy options are refined.

Limiting Payments Based on Certain Types or a Defined Number of Residents. Education in the practice of medicine includes both undergraduate medical education in a medical school and graduate medical education in a teaching hospital or other clinical site. Because medicine involves a number of different specialties, each specialty area has developed its own residency training period. The AAMC believes that the variable length of training for each specialty area is appropriate and in the national interest, but recognizes that Medicare payment policies must be balanced. Some policy makers have proposed imposing additional limits on the length of time for which the Medicare program should provide its support.

Currently, the Medicare program limits the number of years for which it will provide full support. Congress has restricted full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years.

As noted earlier, the limit is waived for a period of up to two years for training in a geriatric residency or fellowship program. Payment for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent.

The AAMC believes that any further limitation on Medicare support for graduate medical education should not be arbitrary or inconsistent with adequate minimal residency training. For example, some have suggested that the Medicare program should pay only through the period required for initial board certification in a specialty or pay only for a three-year period, regardless of the specialty. Because the initial skills and techniques needed by different specialties require different lengths of training, the AAMC believes that support through initial board eligibility is an essential minimum training period that every patient service payer should help finance.

In its March 1993 report, PPRC also "rejected as unwise the options of paying only for primary care positions or only for the first three years of training" (page 66). While the commission was aware of the need to increase the proportion of generalist physicians, it concluded that the nation would continue to require well-trained physicians in all specialties, and that such a policy would not be "sufficiently flexible" if changes in the health needs of the population called for physicians in specialties that required more than three years of training.

It should be noted that paying only through the period prior to initial board eligibility, or paying for three-years regardless of specialty, would result in a potential interaction with other areas of Medicare payment policy, notably in the Part B component. If Medicare Part A payments were limited to the initial board eligibility required to become a competent practitioner, advanced residents could be thought of as physicians in the early years of practice whose services could be supported from the physician component of Medicare. Consequently, if residents beyond initial board eligibility or beyond three years could not be counted for Part A hospital payments, then individuals in residency years which would not be included in a hospital's payments should or could be allowed to bill under Part B for services rendered.

As long ago as 1976, the Institute of Medicine (IOM), in a study on Medicare and Medicaid reimbursement policies, recommended a similar payment method, called the "unified method of payment," for certain institutions. Under this method, licensed physicians-both teaching physicians and house officers-would be allowed to bill fees for services rendered. The IOM report also maintained that whether the teaching physician or the house officer delivered the service should not affect the level of payment for the service provided. Residents who had not completed the first-year of post-MD/DO training (or the second-year based on state licensure requirements) would be paid on a Part A basis to the hospital. Such proposals raise questions about the role of faculty supervision in graduate medical education. If policy makers consider imposing further restrictions on payments beyond the current five-year or initial board eligibility period, then the potential impact on total Medicare payments, including Part B payments, also should be understood.

Another proposal made by some policy makers is to limit Medicare DGME payments only to graduates of U.S. medical and osteopathic schools. They point to a growing consensus that U.S. medical and osteopathic schools are training an adequate number of physicians for our nation and that an excessive number of foreign-trained physicians are entering residency programs in the U.S. where they are supported by patient service revenues, including Medicare payments.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for international medical graduates (IMGs) would cause substantial access and service problems for Medicare enrollees. One of the issues that policy makers would need to address in enacting such a change would be the implementation of a process and a time table so that patient access to services would not be reduced precipitously. Additionally, a gradual transition period with adequate, permanent replacement funding would be needed to enable hospitals and their medical staff to modify programs, personnel, and services while maintaining access to patient care.

A third proposal advanced by some policy makers would limit Medicare DGME payments to a defined number of residents. One option could be to limit payment to the current number of residents in the training system. More aggressive options might be to place an aggregate limit on the total number of positions, for example the number of U.S. graduates plus some additional percentage. Policy makers should understand that this latter proposal requires the establishment of regulatory mechanisms to allocate the funding among training institutions.

Graduate medical education rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, foregone compensation and personal initiative. It is a system that could be easily damaged unless any changes to it are carefully crafted and are based on an extensive understanding of both the nature of the teaching hospitals in which it is conducted and the nature of graduate medical education itself.

Indirect Medical Education (IME) Adjustment

The Purpose of the IME Adjustment

Since the inception of the Medicare prospective payment system (PPS) in 1983, Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education (IME) adjustment. The AAMC believes that the IME adjustment is an important equity factor that recognizes the additional roles and costs of teaching hospitals. While its label has led many to believe that this adjustment compensates hospitals solely for graduate medical education, its purpose is much broader. Both the House Ways and Means and the Senate Finance Committees specifically identified the rationale behind the adjustment.

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House

Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

The IME adjustment should not be confused with the Medicare payment for DGME costs. Payments for Medicare's share of the direct costs of graduate medical education programs are separate from the PPS.

Since the inception of the PPS, the IME adjustment has been reduced twice from its original level of 11.59 percent (a reduction of 30 percent), and the executive and legislative branches have proposed further reductions in the level of the IME adjustment. These proposals have been based on calculations using a variety of regression models, more current data, and different combinations of variables. In January 1989 the General Accounting Office (GAO) issued a report that estimated the size of the IME adjustment using various regression specifications and called for a reduction in the level of the adjustment. Every year since 1989, ProPAC has recommended a gradual reduction in the level of the adjustment.

In recent years, however, Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, ProPAC has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care, and in making its recommendations has tried to assure "rough justice" among hospital groups. "Rough justice" refers to a policy objective of assuring roughly comparable total margins for teaching and non-teaching hospitals.

While PPS operating margins[1] for teaching hospitals are on average higher than those for non-teaching hospitals, teaching hospitals' total margins have remained consistently lower than non-teaching hospitals' total margins. As analyzed by ProPAC in its June 1994 report and shown in Table A below, data from the ninth-year of PPS (1992-93), the most complete information publicly available, show that average PPS margins for non-teaching hospitals were minus 6.4 percent, but total margins were plus 4.7 percent. Major teaching hospitals, however, posted PPS operating margins of 8.0 percent, but their average total margins were substantially lower at 3.0 percent. The average total margin for all hospitals was 4.1 percent.

Table A
PPS Operating Margins and Total Margins, by Hospital Group, PPS 9

Hospital Group	PPS Margin	Total Margin
Major Teaching	8.0%	3.0%
Other Teaching	-2.2	4.0
Non-teaching	-6.4	4.7

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

A more recent ProPAC analysis of preliminary and unpublished data from the tenth-year of PPS (1993-94) shows the same relationship between financial margins and teaching status. Major teaching hospitals (hospitals with resident-to-bed ratios over .25) which are underrepresented in the incomplete tenth-year database, had PPS margins of plus 11.2 percent, but recorded average total margins of plus 1.8 percent. Other teaching hospitals, those with IRBs of less than 0.25, had average PPS margins of minus 0.8 percent and total margins of plus 4.4 percent. Non-teaching hospitals had the lowest PPS margins at minus 5.9 percent, but posted the highest total margins at plus 4.8 percent.

The AAMC's Impact Analysis of Reducing the IME Adjustment

The AAMC is greatly concerned that some policy makers have concluded that the IME adjustment could be reduced substantially without threatening the financial viability of teaching hospitals. The AAMC does not agree with this perspective and believes that a reduction of the IME adjustment would seriously undermine the financial stability of teaching hospitals. While a review of FY 94 financial data supplied by 91 hospitals belonging to the AAMC's Council of Teaching Hospitals (COTH) suggests that some teaching hospitals are performing well financially, a closer examination reveals that their total margins have been relatively stable for three years and are comparable to the total margins of non-teaching hospitals. Increases in the average PPS margin have contributed to stable aggregate total margins over the period.

PPS margins for this group of 91 teaching hospitals, all but 19 of which are "major teaching" hospitals, increased in 1994. "Major teaching" hospitals are defined as those having resident-to-bed ratios of 0.25 or greater. Average PPS margins increased from 3.70 percent in 1992 to 11.75 percent in 1994. Of the 91 hospitals, 16 (18 percent) reported lower PPS margins in 1994 than in 1993. While 37 hospitals had negative PPS margins in 1992, only 15 hospitals had PPS margins less than zero in 1994. More importantly, however, the average total margin for this group has remained fairly stable (between 4.60 and 5.12 percent) over the three-year period.

[1]The PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, IME payment, outlier and "high End Stage Renal Disease [ESRD] use" payments) less Medicare inpatient operating costs, divided by PPS revenue. The PPS margin definition excludes Medicare revenues and costs associated with capital, direct medical education, PPS exempt patient care units, and some other categories. Because payments for most of these cost components (except capital) are made on a cost reimbursement basis, the margins for these items cannot be positive. Therefore, the margins for Medicare inpatient beneficiaries are less than the PPS margins shown in this analysis.

Any reduction in the IME adjustment would substantially harm teaching hospitals, destroying the "rough justice" that has been achieved with the current level of the IME adjustment. On average, PPS margins calculated without the IME or DSH payment adjustments--but with only DRG, outlier and "high end stage renal disease (ESRD) use" payments--are minus 31.76 percent. The IME adjustment makes a significant contribution to reducing what would have been large losses, increasing the average PPS margin from minus 31.76 to plus 0.96 percent. The addition of the DSH payment to the margin calculation moves the average PPS margin to plus 11.75 percent. If the IME adjustment is reduced from 7.7 to 3.0 percent, as proposed by the Republican House Budget Committee alternative budget for FY 95, the average PPS margin would fall from a positive 11.75 to a negative 1.49 percent, a reduction of 13.24 percentage points.

Most important, if the IME adjustment were reduced to 3.0 percent, the impact on average total margins would be substantial. The average total margin in 1994 would fall from 5.1 percent to 2.8 percent, a decrease of 2.3 percentage points. At 6.7 percent, ProPAC's recommendation for FY 96, and 4.5 percent IME levels, average total margins would be 4.6 and 3.5 percent, respectively. The calculation assumes no change in the hospital's 1994 intern and resident-to-bed ratio and no other changes in Medicare payment policy.

Congressional mandates extending Medicaid coverage to broader populations which previously may have been categorized as indigent patients, combined with favorable changes in Medicaid payment policy, may have contributed to these hospitals' improved total margins during this period. However, recently mandated limits on the amount of Federal funding available for Medicaid disproportionate share payments has moderated or will reverse this pattern. In addition, the continued growth in managed care arrangements, which often do not recognize the training and other special costs incurred by teaching hospitals, and pressure by third-party payers to discount high cost tertiary services, threaten teaching hospitals' financial stability.

The IME payment is an important equity factor in the Medicare PPS, compensating teaching hospitals for the higher patient care costs they incur as a result of the severity of their patients' illnesses, the scope of services provided and the impact of educational programs on hospital operating costs. Last year, some policy makers argued that in a reformed health care system in which more individuals would have health insurance coverage and in which all payers would contribute to a fund for patient care costs associated with the academic mission, a significant reduction in Medicare IME payments would be justified. One year later, at the current level of IME payments, "rough justice" appears to have been achieved, but the number of uninsured and under-insured is growing and prospects for the creation of an all-payer fund for costs associated with the academic mission are dim.

Teaching institutions are vital national and community resources, often taking care of the most disadvantaged members of society. Yet their overall financial viability, on average, tends to be more precarious than non-teaching hospitals. The AAMC has noted repeatedly the purpose of the IME adjustment is to recognize factors that increase costs in teaching hospitals and ensure these hospitals' overall financial viability. Analysis by government and private researchers consistently has shown an empirical basis for a differential payment to teaching hospitals based on their costs. The justification for a special adjustment for these institutions traces back to the Medicare routine cost limits of the late 1970s and the inception of the PPS in 1983. Even if the health care system is reformed to improve access, legitimate cost differences between teaching and non-teaching hospitals will continue to exist. Teaching hospitals continue to have higher inpatient operating costs because of the types of patients they treat, services they offer, biomedical research they conduct, and residents they teach.

The IME adjustment was originally developed to create a "level playing field" for teaching and non-teaching hospitals. It serves as a proxy to adjust for inadequacies in the PPS, including:

- inadequate recognition of differences within a given DRG of the complexity of disease, intensity of care required, and resources utilized by patients in teaching hospitals;
- non-recognition of the teaching hospital's costs of maintaining a broader scope of services, stand-by capacity for episodic needs (e.g. trauma services) and the capacity to provide specialized regional services;
- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- unavoidable decreases in productivity stemming from the presence of physician trainees; and
- additional ancillary services ordered by physician trainees as they learn how to diagnose and treat patients efficiently.

The AAMC strongly supports the importance of considering other factors, such as aggregate financial performance, in addition to an empirical estimate in determining the level of the IME adjustment. Teaching hospitals are under the same budgetary pressures as other hospitals to provide care efficiently; moreover, they must also fulfill their unique educational and service missions, including provision of health care to the poor. The current IME adjustment of 7.7 percent for each 0.1 increase in the number of residents-to-beds represents a substantial reduction of over 30 percent, or nearly 4 percentage points, from the original adjustment of 11.59 percent. Teaching hospitals have coped with the decreased rate, but in the current health services delivery environment, they will not be able to withstand further reductions without making substantial changes in the programs and services that they offer.

A reduction in the IME adjustment would hinder teaching hospitals' capability to support adverse selection within the DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units. The AAMC continues to oppose any reduction in the indirect medical education adjustment and urges the Congress to consider carefully the impact of a reduction in the adjustment on all teaching hospitals.

Average Adjusted Per Capita Cost (AAPCC)

As the delivery system moves toward capitated payments for covered lives, separating the payment for DGME costs and for patient care costs attributable to the special roles of teaching hospitals from patient care revenue becomes necessary. The AAMC believes that the current method of calculating the Medicare AAPCC, the rate that the program pays to risk contractor HMOs, results in a payment system that creates an uneven playing field between teaching and non-teaching hospitals.

The AAPCC calculation includes all Medicare fee-for-service expenditures, specifically the DGME payment, the IME payment and the DSH payment. These payments are intended respectively to compensate hospitals for specific missions (graduate medical education), or for providing services to atypical patients who are severely ill or are of low-income socioeconomic status.

Once these payments have been included in the AAPCC and paid to an HMO, there is no assurance that these dollars are used for the purposes intended by the Congress. Thus, teaching hospitals are at a competitive disadvantage when they attempt to contract with HMOs because the HMOs receive the same AAPCC amount regardless of with whom the HMO has a contract. Teaching hospitals have higher patient care costs associated with their additional missions. The Medicare payment system recognizes these higher costs through the IME and the DSH adjustments and the DGME payment.

ProPAC recently noted this problem in its March 1995 report to the Congress:

> Medicare's capitated payment under its managed care risk contracting program does not appropriately distribute payments for the costs of teaching programs or of caring for a disproportionate share of low-income patients. The capitated rate reflects the extra Medicare payments provided to teaching and disproportionate share hospitals in the fee-for-service sector, regardless of whether Medicare enrollees receive care in those hospitals. The relationship between HMOs and the teaching and disproportionate share hospitals in their service area warrants further evaluation (pages 7-8).

The AAMC believes that the IME, DSH and DGME payments should be excluded from the calculation of the risk payment rates and paid to a teaching hospital directly when the Medicare HMO enrollee actually incurs a bed day in the teaching facility. Simply put, if the teaching hospital provides the service, it should receive the IME, DSH and or DGME payments directly whether the service is provided to Medicare beneficiaries under the prospective payment system or through HMOs with risk contracts.

The AAMC urges the Congress to address this methodological issue in an urgent manner as part of its package of proposals to reform the Medicare program. The Association recognizes that while this problem is more prevalent in some parts of the country than in others, it will be increasingly difficult to resolve as national enrollment in Medicare risk-based HMOs grows. In addition, the Congress should require ProPAC, as part of its analysis, to develop a methodology for removing these costs from the calculation of the AAPCC and for paying them directly to teaching hospitals when services are delivered to Medicare HMO patients. The Association is pleased that ProPAC has started to analyze how the Medicare program pays risk contractors and the deficiencies of the AAPCC methodology. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding HMO use among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Conclusion

The AAMC regrets that the possibility of establishing all-payer funds for the special missions of teaching hospitals and medical schools apparently has diminished in the past year. At the same time, all evidence indicates that the health care delivery system will continue to emphasize price competition, challenging the financial viability of teaching hospitals and teaching physicians. The AAMC is deeply concerned that the fundamental structural changes now occurring in the health delivery system will undermine the ability of academic medicine to adapt to the new environment and to fulfill its unique missions.

Academic medicine consists of a diverse group of highly complex institutions providing the environment and resources for medical education and research for the nation and providing both basic and tertiary patient care services. The current emphasis on re-examining national policies in light of limited public resources places these institutions and their vital activities at risk if their special roles and nature are not appreciated.

National policy on health care delivery and payment must recognize the unique characteristics and diversity of teaching hospitals and teaching physicians so that their fundamental missions can be preserved. Reductions in Medicare payments to teaching hospitals and teaching physicians will undermine the ability of these institutions to fulfill their multiple responsibilities at the same time they are struggling to adapt to a new delivery environment. Academic medicine supports those changes that assure the provision of high quality health care in a cost effective delivery system, a vibrant research capability and the capacity to educate outstanding practitioners. Academic institutions need the understanding and support of society to fulfill their obligations. The AAMC looks forward to working with the members of the committee and their staff to meet these common goals.

Mr. CHRISTENSEN [presiding]. Thank you, Mr. Munson. And Dr. Jacott

STATEMENT OF WILLIAM E. JACOTT, M.D., UNIVERSITY OF MINNESOTA, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. JACOTT. Good afternoon, Mr. Chairman. I am William Jacott. I am a family physician, and I am associate provost for the academic health center at the University of Minnesota in Minneapolis. Today, however, I am speaking as a trustee of the American Medical Association.

As we have learned by the discussion this morning, graduate medical education is really a complex system. Any discussion of GME involves those issues such as the physician work force planning, quality of care, charity care, and specialty choice. I will focus today, however, on financing mechanisms that you, as a committee, will be examining. I want to offer you a structure for analyzing this complex issue. I will discuss several principles that the AMA has endorsed and a suggested first step for implementation. These and other guiding principles are further elaborated in our written testimony.

There are no easy answers here, but there is one overriding goal—for Americans to be confident about the training and education that their physicians receive. But to do this, we must ensure stability and accountability in funding of graduate medical education.

Our first principle, one mentioned earlier and several times, is that all third-party payers should pay their fair share for GME. That is all third-party payers, private as well as public.

You have heard in testimony earlier today about direct and indirect payments to hospitals and especially to those large tertiary care institutions affiliated with medical schools like ours at the University of Minnesota. Right now, Medicare is the single largest payer for GME. It pays about half of the total cost.

Private third-party payers often do not pay their fair share to support graduate medical education, education from which they continue to profit. Hospitals negotiate discount contracts with certain private third-party payers and they do this to maintain their market share. But because these contracts rarely include provision for paying a share of the hospital's GME cost, the costs get shifted. The discount contractor provides no GME support, but benefits from medical resident service.

The AMA believes that there should be some kind of accountability and fairness here. We think that there should be explicit and uniform contributions from all payers for GME. And one way to do this is to require all payers to adopt an approach that is similar to the Medicare methodology for determining their share of the direct costs of GME.

Our second principle: We should continue the current system of linking GME payments to patient care services. Many GME programs are moving to alternative sites for delivery of care and education. We ought to have the payments in those cases follow the patients and the resident physician who is providing that patient's care. And that means if the patient gets his or her care at an am-

bulatory clinic or a nursing home or a rural health clinic, then that facility should receive the payment.

This has the further benefit of encouraging physician training in "nontraditional" sites, a subject that was discussed earlier this morning, with decided emphasis on primary care. Physicians in training benefit because they are better prepared to practice in any evolving health care delivery system. Patients benefit because of the increased availability of care.

The National Resident Matching Program just reported on March 15 that over half of medical student seniors have chosen primary care as their initial training. Some of these students, however, may later choose subspecialty training. But it is clear that student choices are responding to the marketplace. And GME training opportunities ought to support these choices.

The AMA recommends that HCFA revise its regulations governing Medicare direct medical education payments to teaching hospitals. There are some wide variations in claim costs, largely due to the imprecise nature of regulations currently governing what direct costs are allowable. More parity in payment needs to be developed. All payers, including Medicare, should be assured that they are paying legitimate GME costs. This accountability is only fair if we expect all payers to contribute their fair share to the costs.

In conclusion, Mr. Chairman, the AMA believes that the changes I have articulated today are warranted in order to control GME costs. We want to stabilize GME funding so we can assure a quality national physician work force for our patients.

We appreciate, with your approval, Mr. Chairman, the opportunity to supply additional comments for the record, and I would be pleased to answer questions.

Thank you.

Mr. CHRISTENSEN. Thank you, Dr. Jacott. Your full testimony will be submitted for the record.

[The prepared statement follows:]

Statement

of the

American Medical Association

to the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

RE: Financing Graduate Medical Education

William E. Jacott, MD

March 23, 1995

Mr. Chairman and Members of the Subcommittee:

My name is William E. Jacott, MD. I am a family physician, Assistant Vice President for the Academic Health Center at the University of Minnesota, and a member of the Board of Trustees of the American Medical Association (AMA). On behalf of the 300,000 physician and medical student members of the AMA, I'm pleased to have this opportunity to testify regarding issues of graduate medical education (GME) financing and physician workforce planning. My testimony will briefly review how GME is currently financed and some of the problems that have arisen as a result of that financing system. I will then offer guidelines and recommendations developed by the AMA for improving this system while preserving its stability and the essential functions of training medical personnel for future generations.

Background Information

Graduate medical education (GME) is an essential component of the formal education of the physician. Graduates of U.S. medical schools are required to complete at least one year of GME by all jurisdictions before being able to obtain a license to practice, and 2 or 3 years of GME in several jurisdictions. Graduates of foreign medical schools are required to have 3 years of GME by half of the 54 jurisdictions and either 1 or 2 years by the other half. Physicians must successfully complete a GME program accredited by the Accreditation Council for Graduate Medical Education (ACGME) in order to be eligible for certification in one of the specialties of medicine, for which training ranges from a minimum of 3 years to as long as 8 years. Physicians may be licensed, however, without successfully completing all years of an accredited GME program.

During the past two decades, the GME "system" has increased in size and scope. At present, there are some 7,277 individual GME programs conducted in over 1,500 medical facilities. Approximately 1014 institutions, of which 85% are hospitals, sponsor GME programs in one or more of the specialties of medicine. The majority of GME is conducted in large tertiary care hospitals affiliated with the nation's medical schools.

As of 1993, there were 97,300 resident physicians enrolled in ACGME-accredited GME programs in this country. Approximately 74% of those resident physicians were graduates of U.S. or Canadian medical schools accredited by the Liaison Committee on Medical Education (LCME), 3% were graduates of U.S. osteopathic schools, and 23% were graduates of foreign medical schools not accredited by the LCME. Almost one-third of the total resident physicians on duty were enrolled in approved residencies in internal medicine or internal medicine subspecialties. And, as reported as recently as March 15th, 1995, by the National Resident Matching Program, this year more than half of U.S. medical student seniors have signed up for initial residency training in primary care -- that is, in family practice, internal medicine and pediatrics.[1] While some of these students will continue to enter subspecialty training, it is clear that student choices are responding to the changing marketplace.

The responsibility for the oversight of this large and extremely important educational enterprise is widely diffused. GME program directors, hospital service chiefs, medical school department chairs, and the administrators of medical facilities currently have a great deal of autonomy in determining the size and mix of the GME programs sponsored by a given facility. The ACGME is responsible for establishing accreditation standards in the approved residency training programs and accrediting individual GME programs. Individual Residency Review Committees (RRCs), which are comprised of representatives appointed upon nomination by the AMA, the appropriate specialty board, and, in a majority of cases, a specialty society, are responsible for assuring these standards are met.

GME Financing

GME is largely financed from patient care revenues generated by teaching hospitals. Medicare is the only third-party payor that reimburses hospitals separately for GME costs. Although Blue Cross plans and commercial insurance companies generally recognize that GME costs are built into the rates they pay teaching hospitals, they do not require that these costs be explicitly identified for separate reimbursement. Health maintenance organizations (HMOs), preferred provider organizations (PPOs), and self-insured industry or government plans are generally unconcerned about the individual components of provider costs, particularly GME costs, as long as they are able to obtain competitive prices by negotiating discounts from stated charges. With the exception of Medicare, there is no way to document precisely the actual contribution that each payor whose beneficiaries use the services of resident physicians in teaching hospitals makes to the financing of an institution's GME costs. It is reasonable to conclude, in fact, that a significant portion of HMOs, PPOs, and self-insured plans do not contribute to the financing of GME.

The federal government is the single largest contributor to the total costs of GME in the country. The Medicare program pays approximately 30% of the direct costs of GME in non-federal teaching hospitals. The Department of Veterans Affairs (VA) and Armed Forces finance GME programs operated in VA and military hospitals. These federal hospitals sponsor approximately 10% of all GME positions in the country. Through grants provided under Title VII of the Public Health Services Act, the federal government also subsidizes some of the costs of GME programs in family medicine, general internal medicine, and general pediatrics. Finally, the federal government provides an additional contribution to the

[1] The AMA also recognizes Obstetrics-Gynecology as a primary care specialty.

financing of GME costs of non-federal hospitals to the degree that state Medicaid programs actually contribute to the financing of GME costs. Although exact figures are hard to obtain, the federal government, in the aggregate, finances approximately one-half of the total direct costs of GME in the country.

The methods of financing GME largely dictate the current nature of the GME system. As noted above, the great majority of GME costs are financed from hospitals' patient care revenues; thus, programs tend to be hospital-based. Over the years, the allocation of these funds has been heavily influenced by program directors, service chiefs, and department chairs, who have been primarily interested in providing resident physician coverage for increasingly specialized impatient services. As a result, the GME system became heavily oriented toward inpatient-based, highly specialized training in tertiary care institutions. The current methods of financing GME have made it difficult to establish primary care GME programs in settings other than hospitals, such as non-hospital based ambulatory settings and rural health clinics.

Improving GME Financing

During the past decade, government concerns about the long-term financial integrity of the Medicare program and attendant changes in the financing of health care in both the private and public sectors have focused a great deal of attention on the financing of GME. The sequence of events that led to this situation reveals the compelling reasons for reform in GME financing. In 1983, the Congress, prompted by the need to control the rate of growth in Medicare expenditures, reformed Medicare policies governing Part A payment to hospitals and introduced the Diagnostic Related Groups-based Prospective Payment System (PPS). In constructing the DRG payment methodology, the Congress specifically excluded the costs of GME from the calculation of the DRG payments. Under PPS, teaching hospitals received a separate payment, the Direct Medical Education (DME) payment, to cover Medicare's share of the institution's medical education program costs. It should be noted that the DME includes not only the costs of GME, but also the costs of nursing and allied health education programs. With respect to GME, hospitals are allowed to claim costs in three major categories -- the salaries and benefits paid to resident physicians, salaries paid to faculty for supervising resident physicians and administering GME programs, and general overhead allocated to GME programs. There is great variation in the costs claimed by individual teaching institutions for DME, and this is largely attributable to the accounting method used to determine GME costs. Although Medicare's standard cost reporting methodology is still used to calculate an institution's medical education costs and the amount of the DME, the 1985 Comprehensive Omnibus Budget Reconciliation Act (COBRA) modified the payment methodology to limit payment for GME costs. Under these new rules, the GME payment amount cannot exceed, on a resident full-time-equivalent (FTE) basis, an institution's FTE amount for FY 84, corrected for inflation.

In addition to the DME payment, teaching hospitals also receive a second payment --the Indirect Medical Education Adjustment (IMEA)--not received by nonteaching institutions. Although many analysts have treated the IMEA as though it were solely due to the costs of medical education, this is not the case. When introducing the PPS, the Congress stated clearly that the IMEA was intended (1) to serve as a proxy for an intensity-of-illness-factor that could not be incorporated into the DRG payment and (2) to cover the costs of medical education that could not otherwise be identified and included in the DME. The academic

community has acknowledged that the IMEA is not in any way an educational adjustment equivalent to the DME.

Medicare's new payment methodology for physician services, the Resource-Based Relative Value Scale (RBRVS), has had an important impact on discussions of GME financing for several reasons. First, because the IMEA payments were explicitly identified, Congress was able to determine for the first time Medicare's contribution to financing the total costs of medical education conducted in teaching hospitals. Second, by mistakenly identifying the IMEA as though it was dedicated only to medical education costs, Medicare's contribution to financing these costs was exaggerated. As a result, RBRVS has had the effect of making medical education costs, particularly GME costs, a highly visible target for those seeking ways to control Medicare expenditures without seeming to cut services to beneficiaries.

Those interested in decreasing the amount Medicare pays for GME have justified their position by referring to the language of the original Medicare legislation. In the body of the legislation, Congress stated that the costs of the services provided by interns and resident physicians could be claimed by hospitals as a legitimate inpatient expense. However, no mention was made of the many other costs associated with medical education programs. In the Conference Report accompanying the legislation, Congress acknowledged that hospitals incurred additional expenses by sponsoring medical education programs, but stated that Medicare should pay its fair share of those costs only until the community developed an alternative way of paying those costs.

The Social Security Advisory Council (in 1982), the Inspector General of the Department of Health and Human Services (in 1984) and officials of the Health Care Financing Administration (in 1985) have all stated that sufficient time has passed for alternative sources of funds to be identified to cover GME costs. To date, however, Congress has rejected the notion that Medicare should discontinue paying GME costs. At the same time, Congress has expressed concern that the policies governing Medicare payment for GME may be no longer appropriate and should be examined.

Coincident with the introduction of the Prospective Payment System (PPS), major changes also occurred in the financing of health care services in the private sector. Due in large part to the continued growth of aggregate health care costs, businesses and other third party payors have developed more aggressive strategies for controlling their own expenditures for health care. Central to these strategies are efforts to negotiate discounts in the prices providers are paid for delivering services to plan beneficiaries. In order to maintain market share in this increasingly competitive environment, hospital administrators have been willing to provide discounts, even though doing so has clearly eroded their operating margins. Since GME had been largely financed from hospitals' discretionary revenues, the narrowing operating margins have been perceived as a threat to the continued financing of GME costs.

In its report, "The Financial Status of Teaching Hospitals: The Underrepresentation of Minorities in Medicine" (1990), the Council on Graduate Medical Education (COGME) documented the declining operating margins of the nation's teaching hospitals. However, the data presented in the report clearly demonstrate that this decline is due primarily to a decline in non-Medicare revenue margins. The decline in non-Medicare revenue margins is due largely to two factors: (1) deep discounts negotiated with some payors, and (2) the growing uncompensated care burden being borne by teaching hospitals. Nevertheless, and this is particularly important, teaching hospitals have generally done better than non-teaching

hospitals under PPS, primarily because of the Medicare IMEA payments received by teaching institutions which have been used to offset these costs.

Rational reform of GME financing will occur only if there is constructive dialogue on important GME issues among members of the medical profession, government officials, and representatives of business and the insurance industry. The AMA would like to use this opportunity to articulate overall goals for GME financing reform and propose a set of principles that can serve as a framework to guide discussions of GME financing reform.

Goals

The AMA believes that reform should achieve long-term stable funding of GME to ensure that all graduates of U.S. medical schools will be able to obtain, at the very least, GME leading to eligibility for initial board certification and result in increased accountability for the total number and specialty mix of GME positions, the appropriateness of the site of GME training, and the appropriateness of both the content and length of training requirements.

The AMA believes that these goals can best be achieved if discussions of GME financing reform are guided by the following set of principles:

Principle #1 — All third-party payors should participate explicitly and in a uniform way in the financing of GME.

Principle #2 — The financing of GME should continue to be linked to the financing of patient care services and payments should accrue to the actual facility providing those services.

Principle #3 — Efforts to reform GME financing should focus primarily on the methods of financing the direct costs of GME, with any changes in IMEA phased in gradually so that alternate sources of funding can be identified.

Principle #4 — The Health Care Financing Administration should revise the regulations governing Medicare DME payments to eliminate some of the variation in GME costs claimed by teaching hospitals.

Principle #5 — The procedures used by the ACGME RRCs and the Specialty Boards for adding new specialties and those for extending the length of training required for certification in existing specialties should be reviewed.

Discussion

Principle #1

The AMA believes strongly that all third-party payors should participate explicitly in the financing of GME in order to ensure stable funding for GME into the future. We also believe that there should be a uniform system across the country for contributing to GME financing. Medicare is at present the single largest payor for GME and has a methodology in place for identifying an institution's total direct GME costs. Accordingly, the AMA recommends that all payors be required to adopt the Medicare approach for determining their

share of the direct costs of GME. We recognize that an all-payor system for financing GME was a controversial issue argued in the context of comprehensive health system reform last year. But it is equally clear that private payors are not paying their fair share to support a system from which they continue to profit.

It may be virtually impossible to develop mechanisms ensuring that all payors contribute to GME as long as individual teaching hospitals are free to negotiate payments for patient care services with individual payors without any restrictions. As a means of maintaining "market share," teaching hospital executives have demonstrated a willingness to provide discounts to certain payors, with the consequence of diminishing -- sometimes quite significantly -- the institutions' operating margins. Given past experience, it is difficult to believe that teaching hospital executives would be willing to voluntarily negotiate separate GME payments or allow a portion of their negotiated payment to be designated for GME in order to comply with this principle. Accordingly, we believe that a new approach to financing GME is needed.

Medicare could make its participation in GME financing in individual hospitals contingent upon the participation of all payors whose beneficiaries are hospitalized in teaching hospitals. This approach would place on teaching hospital executives the responsibility for obtaining from various payors their agreement to participate in GME financing as a condition of having their beneficiaries use the services of the institution. Since the Medicare methodology would be used to calculate each payor's fair share of the institutions' GME costs, there would be no requirement for prolonged negotiations on the terms of the payment.

Principle #2

Before reaching the conclusion that the financing of GME should continue to be linked to the financing of patient care services, the AMA considered the proposals advanced in recent years that alternative sources of funds should be identified to cover GME costs. The interest in identifying alternative sources of GME funding can be traced directly to concerns about the continued use of Medicare Part A Trust Funds to pay medical education costs. The most frequently mentioned alternative sources of funds that might be available to finance GME include general tax revenues, medical school budgets, and faculty practice plans. The AMA believes strongly that GME costs should continue to be paid from revenues intended to cover the costs of patient care services.

This recommendation is based on the fact that surveys of resident physician activities have shown that resident physicians spend approximately 75% of their time involved in direct patient care activities. Resident physicians undoubtedly provide some services that would otherwise be provided by the patients' attending physicians. In these cases, the resident physician is acting as a surrogate for the supervising attending physician who bills for these services. The attending physician, in return, supervises the resident physician's education. This quid pro quo arrangement is perfectly appropriate as long as the attending physician is not also compensated by the hospital for supervising the resident physician's education (see Principle #4). However, resident physicians also conduct patient care activities that supplement those that would normally be provided by attending physicians. It is appropriate to pay for the services of resident physicians.

Some commentators have suggested that resident physician salaries should be eliminated and that resident physicians, because of the educational nature of their training, should pay tuition

to cover the other direct GME costs. Others have suggested that resident physicians should generate their own income by billing for their services. The AMA also rejects these arguments. Resident physicians act in the capacity of advanced graduate students and should be treated accordingly. Under many circumstances, graduate students receive a stipend and their tuition is waived if they provide services as a teaching or research assistant. Since most resident physicians provide patient care services and teach medical students and other resident physicians, it is appropriate that they receive a stipend and not pay tuition to the teaching institutions with which they are affiliated. Such a mechanism would raise the total costs of medical education, leading to rising debt loads for young physicians entering their practices.

Another important point regarding the patient services nexus for payment is that payments for these services should go directly to the facility where the training takes place and where the patient is provided the service. Given current trends, including the delivery of services in ambulatory and primary care settings, and the consequent emphasis on primary care within the GME system, it is absolutely essential that payment accrue to the facility where the patient receives services. The AMA continues to support initiatives to develop new methodologies for the costs incurred in physician training in "non-traditional" sites and encourages medical education to be provided in settings that will best prepare physicians to practice in any evolving health care delivery system (e.g., nursing homes, outpatient surgery or ambulatory care settings, rural settings, and homeless shelter clinics).

Principle #3

While recommending that GME financing reform focus primarily on the methods of financing direct GME costs, we recognize that this is not the only policy issue related to the topic of GME financing. Certainly, the financial viability of major teaching hospitals, particularly those which serve a disproportionate share of uninsured patients, is a legitimate issue for concern. In this regard, the AMA recognizes that teaching hospitals are particularly concerned that Congress might legislate decreases in Medicare IMEA payments and thus further decrease their operating margins. However, as noted previously, the 1990 COGME report documented that recent decreases in hospital operating margins are rooted primarily in decreases in non-Medicare revenue margins. The AMA therefore believes that it is inappropriate to focus attention solely on the Medicare IMEA. The financial status of teaching hospitals will remain unstable as long as hospital administrators continue to grant discounts to certain private payors who do not contribute their fair share to the financing of GME, and until governments develop a more equitable way to cover the costs of uncompensated care.

The AMA believes that efforts to reform GME financing should not be burdened in the immediate debate by attempts to resolve these very complex issues of uncompensated care and the effect of discount contracting on the financial stability of some teaching hospitals. Such an approach would inevitably lead to prolonged discussion that would effectively derail any attempts to deal with the serious problems facing GME.

Principle #4

The AMA strongly supports the principle that HCFA should revise the regulations governing Medicare DME payments to eliminate the extraordinary variation in DME costs that currently exists among teaching hospitals. The variation in claimed costs -- as much as a

tenfold difference -- can be traced to the imprecise nature of the regulations governing the determination of allowable GME costs. Under existing Medicare regulations, individual teaching hospitals have an inordinate amount of discretion in determining how costs are allocated. Frankly, the degree of variation that exists undermines the credibility of teaching hospitals and the medical profession on GME financing issues. In order to incorporate the Medicare approach for financing GME into an all-payor system, the methodology used for claiming GME costs must be refined so that all payors, including Medicare, can be assured that they are paying only legitimate GME costs. This accountability is a fair expectation if we are to expect all payors to contribute fairly to the costs of GME.

In its first report, COGME noted the results of a Congressional Budget Office survey indicating extreme variation in claimed GME costs by teaching hospitals and recommended that this issue be studied in more detail. Further analysis indicates that the variation in GME costs within this group of institutions can be explained primarily by two factors: (1) variations in faculty salary costs, and (2) allocated overhead costs. Within each of these categories, the degree of variation cannot be explained by variation in the size and scope of the institution's GME programs or the nature of the teaching hospital.

During recent years, discussions aimed at determining ways for controlling the total costs of DME have generally assumed that limitations would be placed on the total number of GME positions available in the country. Although ill-founded, these discussions have created a certain anxiety about the availability of GME positions for all graduating students of U.S. medical schools. Indeed, in order to avoid this situation, several professional organizations recommended in the mid-1980s that graduates of foreign medical schools be denied access to GME in this country as a means of controlling GME costs. It is now apparent that total GME costs can be decreased without cutting positions--provided that steps are taken to eliminate inappropriate differences in faculty salary costs and allocated overhead costs claimed by some teaching hospitals.

In this context, the AMA recommends that HCFA rewrite existing regulations to define more precisely the faculty salary costs and general overhead costs that may be allocated to GME. More specifically, regulations should be promulgated to limit faculty salary costs to the time faculty are directly involved in the administration of GME programs or in the supervision of resident physicians under circumstances in which no separate bill is submitted for professional services either by the physician or the hospital. Similarly, overhead costs should be limited to those associated with direct support of GME program activities. General overhead costs should not be allocated to GME. As noted previously, all payors should then adopt the Medicare regulations in order to ensure consistency in determining and auditing GME costs and to fairly distribute the shared burden.

We also recommend that annual surveys continue to document the level of salaries and benefits paid to resident physicians in order to ensure that unreasonable variation in salaries does not develop among teaching hospitals. Similarly, annual surveys should be conducted in order to document the variation in faculty and overhead costs among teaching hospitals. This should not be construed to imply that variations are not warranted; sites and needs vary and a St. Paul hospital will not pay the same faculty salaries as will a New York City Hospital. The results of these surveys should be made available to payors who are contributing to the financing of GME.

Principle #5

In order to prevent inappropriate growth in the number of GME positions, the AMA feels that revisions must be considered in the procedures for adding new specialties and for extending the length of training required for certification in existing specialties. During the 1980s, the number of resident physicians in GME programs increased by greater than 30%. During the same period, the number of U.S. medical school graduates remained fairly constant. We conclude that the marked increase in GME positions was largely due to the proliferation of new specialty residency programs and positions. This trend has clearly increased the costs of GME in this country.

At present, decisions regarding specialty training issues are controlled, for all practical purposes, by the specialty boards and the ACGME. In some cases, changes in training requirements have been initiated by a specialty board, and in some cases, by an RRC. As a body primarily concerned with GME accreditation issues, the ACGME has not been charged with the responsibility of balancing the interests of the specialty oriented organizations with the concerns of government, business, other interested parties, and the public. As a result, the specialty organizations have been free to increase training requirements, thus increasing the costs of GME, without concern as to the impact of their decisions on the system as a whole.

Voluntary accreditation and certification remain an important feature of the GME system in this country. To maintain this important characteristic, interested parties and the public must be assured that there is accountability for the decisions made by the RRCs and the specialty boards. In its first report (1988), COGME recommended that the parent organizations of the ACGME convene to develop specific ways for dealing with this issue. In addition, COGME recommended that the American Board of Medical Specialties bring this issue to the attention of the individual boards. To date, these boards have not dealt with this problem in a satisfactory manner.

Conclusion

The AMA has considered the issues surrounding financing reform in GME and has developed goals and a set of principles to assist the national debate on this issue. The AMA believes that such reform is warranted in order to control the costs of GME, to stabilize the funding of GME, and to improve the accountability of the GME system to society so that national physician workforce objectives are achieved and maintained.

The AMA offers the above articulated principles as guidance to the Subcommittee and Committee in their evaluation of GME financing. We thank the Subcommittee for soliciting our thoughts and recommendations on this highly complex issue of financing graduate medical education. We look forward to working with other affected organizations and hope that we can be a continuing resource as the Subcommittee and full Committee develop their proposals.

Mr. CHRISTENSEN. Dr. Schwartz.

STATEMENT OF SEYMOUR I. SCHWARTZ, M.D., FACS, CHAIRMAN, BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS

Dr. SCHWARTZ. Thank you, Mr. Christensen.

I am Dr. Seymour Schwartz. I am professor and chair of the department of surgery at the University of Rochester Medical Center in Rochester, N.Y. I am appearing today as chairman of the board of regents of the American College of Surgeons with its constituency of over 60,000 surgeons.

In that regard, we are pleased to have the opportunity to offer this testimony, and we will focus our remarks on the issues of Medicare payments for direct medical education costs, but also on physician work force requirements and controls.

It is our feeling, strongly so, that the Federal financial support for graduate medical education must continue if our Nation is to maintain its preeminence in producing well-trained, highly qualified physicians.

The College strongly believes that all Federal, and as was stated before, all private health care financing programs should participate in the support of this system.

Reductions in Medicare payments to hospitals and physicians have already been implemented. This has been compounded by continuing payment decreases by private third-party payers and an increasing trend to managed care.

As a consequence, teaching programs have become increasingly dependent on Medicare support, because they are less able to compensate for any funding shortfalls through payments they receive for services provided to non-Medicare patients.

This is more of a problem for specialties with longer training programs, such as the surgical specialties, which already receive reduced financial support beyond the first 5 years of training.

Proposals have been made to limit Medicare direct graduate medical education support to the first 3 years of residency. I was pleased to hear from Dr. Heyssel that he modified this proposal with respect to the 5-year surgical program.

The College opposes these proposals. It is felt that the specialties with the longest training programs are just as critical to the health care needs of our Nation as those with a shorter program. Also, the quality of programs that train our medical and surgical specialists are as important as the quality of those that train our primary care physicians.

Recent studies have concluded that the physician work force problem is not so much that of undersupply of certain types of physicians as it is of an oversupply of physicians in general. We agree to that, and would also point out that the larger problem is a poor geographic distribution of all categories of physicians.

The College believes that Congress should focus its attention on policies directly aimed at controlling the size and specialty mix of our Nation's physician work force, rather than on indirect efforts to achieve these goals through mechanisms of program financing. We also feel that such policies hold the promise of reducing total Medicare spending for direct graduate medical education.

We also agree that broad goals should be set regarding the number of generalists and specialists to be trained, but would emphasize that quality should be the major determinant in deciding which residency programs should be funded and in how residency slots should be allocated.

Actually the number of residency positions in surgical programs is determined specifically by patient mix and volume that ensures that training criteria are met. This has limited the number and the size of surgical training programs. The number of physicians trained in surgical specialties has remained relatively constant over the past decade. In the academic year of 1982 to 1983, there were 21,000 residents cumulatively in all surgical specialties. About 10 years later, 1992 to 1993, the most recent year for which data are available, this number is essentially the same.

Now I would like to emphasize that in general surgery for the same period, the number has decreased steadily from 8,683 to 7,788.

There is a growing sentiment in the medical community that the number of residents should be constrained. However, Federal physician work force controls may be viewed by some as not in concert with the current efforts to reduce bureaucracy.

We would submit that a mechanism is in place. That mechanism is the residency review committees for the various specialties. They are encumbered at this time by the feeling that they do not have the authority or the antitrust immunity required to impose limits.

We would suggest Federal endorsement of the residency review committees as the body to address the issue of numbers.

I would point out that even if we accept the physician work force controls as a possible solution, they in no way address the persistent geographic maldistribution of physicians. And as has been pointed out several times already, it seems that current marketplace pressures may be playing a positive role in alleviating or correcting this situation.

In Southern California, for instance, medical and surgical specialists are finding that there are simply not enough patients to maintain their practices, and some of these are relocating to smaller and at times rural communities. Some have even become primary care physicians.

Mr. Chairman, on behalf of the College, I would like to thank you for the opportunity to express our views on these issues. I would be pleased to answer any questions.

[The prepared statement and attachment follow:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS

to the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

presented by

Seymour I. Schwartz, MD, FACS
Chairman, Board of Regents

RE: Graduate Medical Education

March 23, 1995

Mr. Chairman and members of the Subcommittee, I am Seymour I. Schwartz, MD, FACS, Chairman of the Board of Regents of the American College of Surgeons, and Professor and Chairman of the Department of Surgery at the University of Rochester Medical Center in Rochester, NY. I am pleased to appear here today on behalf of the College to provide our views on Medicare funding for graduate medical education. In particular, I intend to focus my remarks on the issues of Medicare payment for direct medical education costs and on physician workforce requirements and controls.

First of all, I want to stress that federal financial support for graduate medical education must continue if our nation is to maintain its world preeminence in producing well trained and highly qualified physicians. Further, the College strongly believes that all federal and private health care financing programs should fully support this system. We are very concerned, for example, about reports that Medicare HMOs may not be passing on to teaching institutions the federal funds they receive to support graduate medical education.

We are aware, of course, of the budgetary pressures that Congress has faced in recent years and the reasons why entitlement programs like Medicare make attractive targets for spending reductions. However, you should be aware that, because of reductions already implemented in Medicare payments to hospitals and physicians, compounded by continuing payment decreases by private third-party payers and the increasing trend toward managed care, teaching programs are becoming even more dependent on Medicare financial support and are less able to compensate for any funding shortfalls through payments they receive for services provided to non-Medicare patients. This a particular problem for those specialties with longer training periods, such as the surgical specialties, which already receive reduced financial support from Medicare beyond the first five years of training.

Proposals have been made that would further limit Medicare direct graduate medical education support to just the first three or four years of residency training. The College opposes such proposals. Generalist physicians can not meet all of our nation's health care needs. Those specialties with the longest training periods -- such as neurosurgery, which typically includes seven years of residency training -- are just as critical to the health care needs of our nation as those with the shortest residency training. Furthermore, the quality of programs that train our nation's medical and surgical specialists is as important as the quality of those that train our primary care physicians; both types of programs should be funded for their full residency periods.

In an effort to increase the supply of primary care physicians, proposals have also been made that would use money saved by limiting Medicare support for specialties with longer training programs to increase the amount provided to primary care residency programs. As we have noted in past testimony, the College has long doubted that paying hospitals more to establish primary care residency positions will do anything to influence the

career choices made by individual medical students. In addition, many residency positions in primary care training programs go unfilled year after year. It makes little sense for a Congress that is concerned about budget savings to increase federal funding to encourage hospitals to establish yet more residency positions that are likely to remain unfilled.

Indeed, recent studies of the nation's physician workforce have concluded that our problem is not so much an undersupply of certain kinds of physicians as it is an oversupply of physicians in general, as well as a poor geographic distribution of physicians. (A paper is attached that more fully outlines some of the issues associated with policies directed at increasing the supply of primary care physicians.) It is the College's view that Congress should focus its attention on policies that are directly aimed at controlling the size and specialty mix of our nation's physician workforce, rather than on indirect efforts to achieve these goals through program financing mechanisms. Such policies also hold promise for reducing total Medicare spending for direct graduate medical education costs.

The College agrees with proposals that have been made that would limit the total number of physicians being trained, perhaps to 110 percent of U.S. medical school graduates. We also agree that broad goals should be set regarding the number of generalists and specialists to be trained. We do believe strongly, however, that quality should be the major factor in determining which residency training programs will be funded and how actual residency slots will be allocated among each specialty.

In the surgical specialties, the number of individuals being trained has been restrained by such quality considerations for many years. No surgical training program can add new residency positions unless patient mix and volume assure that specific training criteria are met. This limits both the number and the size of surgical training programs. In addition, smaller training programs with relatively few residents are held to the same high standards as larger programs.

In fact, the number of physicians trained in the surgical specialties has remained relatively constant for more than a decade. In the 1982-83 academic year, there were 21,133 residents across all the surgical specialties; in 1992-93, the most recent year for which complete data are available, there were 20,976. In general surgery, the number has actually decreased steadily, from 8,683 in 1982-83, to 7,788 in 1992-93. Further, it is worth noting that the total number of surgeons being trained each year in some specialties is actually quite small (e.g., 53 in colon and rectal surgery, 39 in pediatric surgery, and 89 in vascular surgery in 1992-93).

Of course, there is a regulatory overtone to the idea of federal physician workforce controls that may not appeal to some policymakers. However, while there is growing sentiment in the medical community that the number of residents should be constrained in some way, there is also a general belief that antitrust laws preclude physicians from establishing and imposing any limits on their own initiative. The residency review committees for the various specialties and the Accreditation Council on Graduate Medical Education believe that they do not have the authority or the antitrust immunity needed to impose such limits. A federal mandate to do so would address some of these concerns.

It is worth noting that Congress has often established commissions and supported studies of our nation's physician workforce, but it has never given these entities the authority to implement any workforce policies based on their findings.

Of course, while physician workforce controls are a possible solution to problems involving overall physician supply and specialty mix, they do not address the persistent geographic maldistribution of physicians. As you know, federal efforts to address this problem have met with limited success. However, it now appears that market pressures may indeed hold some promise for alleviating, if not completely correcting, this situation. Many medical and surgical specialists located in areas where managed care has become a dominant market force, such as southern California, are finding that there simply are not enough patients available for them to maintain their practices. As a result, we are hearing

that quite a few of these specialists are relocating to smaller communities, often in more rural states. Many of them have also assumed the role of primary care physicians.

Mr. Chairman, thank you again for the opportunity to express our views on these issues. I would be pleased to answer any questions you may have.

American College of Surgeons

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PRIMARY CARE: HAVE POLICY MAKERS GONE TOO FAR?

Issue

Over the last several years, the federal governmental has implemented a number of policies and programs intended to increase the supply of primary care practitioners, including increases in Medicare payments for primary care services, such as physician office visits. In many cases, these initiatives have come at the expense of other programs and other categories of health professionals and services. Some physicians' organizations continue to demand more for primary care. However, there is evidence that further increases in the number of primary care physicians could lead to an oversupply. At the very least, Congress should carefully consider whether it is fair to support any additional primary care initiatives by arbitrarily reducing payments to other physicians or reducing funds for other programs.

Key Things to Keep in Mind

1. **The Potential for "Overkill".** The federal government has adopted Medicare reimbursement policies favoring primary care residency programs. And, there is continuing discussion of adopting policies that would assure that 50 percent or more of all residency positions are allocated to primary care. However, a recent study published in the Journal of the American Medical Association concluded that "a change as great as the 50 percent solution will cause a long-term surplus of primary care physicians and a long-term shortage of specialists."[1]

2. **Medicare Beneficiary Need for Specialty Care.** The federal government has adopted a number of provisions to increase Medicare payments to primary care physicians (e.g., the relative value system, preferential updates, and exemptions from various cost-containment policies). However, it seems likely that Medicare beneficiaries, given their age and health status, may well need greater amounts of specialty care than the non-Medicare population. For example, a recent study published in the New England Journal of Medicine found that "Internists and family practitioners are less aware of or less certain

[1] Richard A. Cooper, "Seeking a Balanced Physician Workforce for the 21st Century," Journal of the American Medical Association, September 7, 1994, pp. 680-686.

about key advances in the treatment of myocardial infarction than are cardiologists."[2] In fiscal year 1993, there were almost 310,000 Medicare hospital admissions for the treatment of myocardial infarctions.

3. **Impact of Non-Physician Primary Care Providers.** The federal government has simultaneously adopted policies to increase the supply of primary care physicians and the supply of non-physician primary care practitioners, including physician assistantsand advanced practice nurses. Those recommending further increases in the supply of primary care physicians generally fail to take into account the capabilities and contributions of a rapidly increasing supply of non-physician primary care providers. Moreover, in determining the number of so-called primary care shortage areas, the government itself fails to take into account the availability of physician assistants, nurse practitioners, and other qualified providers of primary care. This may explain why the Task Force on Human Resources for Health of the Association of Academic Health Centers has recommended that the Secretary of Health and Human Services convene a special Advisory Council to assess, among other things, "whether primary care shortage criteria should take into account the availability of non-physician personnel.[3] In any event, given the fact that past government policies are at least partially responsible for today's oversupply of physicians, it seems quite likely that the government will again overshoot the mark if it continues to adopt programs favoring primary care.

4. **Lessons from Managed Care.** Policymakers have repeatedly been told to use the physician staffing practices of health maintenance organizations (HMOs) and other managed care organizations as a guide to the population's need for specialist and primary care physicians. However, as one study has warned, "HMO patients tend to be younger and healthier" and "HMO physicians provide only a portion of the specialty care."[4] Moreover, another recently published study found that seven Kaiser HMO plans and three other large HMOs had primary care physician-to-population ratios of 53.6 and 35.7 per 100,000 enrollees, respectively, compared to the nation's current primary care physician supply of 65.7 primary care physicians per 100,000 population.[5]

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[2] John Z. Ayanian et al., "Knowledge and Practices of Generalist and Specialist Physicians Regarding Drug Therapy for Acute Myocardial Infarction," New England Journal of Medicine, October 27, 1994, pp. 1136-1141.

[3] Association of Academic Health Centers, Task Force on Human Resources for Health, "Avoiding the Next Crisis in Health Care," 1992, p. 21

[4] Richard A. Cooper, "Seeking a Balanced Physician Workforce for the 21st Century," Journal of the American Medical Association, September 7, 1994, pp. 680-687.

[5] Jonathan Weiner, "Forecasting the Effects of Health Reform on U.S. Physician Workforce Requirement: Evidence From HMO Staffing Patterns," Journal of the American Medical Association, July 20, 1994, pp. 222-230.

5. **International Comparisons.** The average American must, by now, believe that the primary care physician-to-population ratios in the United States are considerably below those in other countries frequently held up as having model health care systems. However, as emphasized in a study by U.S. and British researchers published in the New England Journal of Medicine, the ratio of primary care physicians to the general population is the same in the United States and the United Kingdom. A more recent study notes that "the percentage of physicians in the United States who practice one of the primary care disciplines is 36 percent to 38 percent, values quite similar to those in Europe."[6]

6. **Trends in Surgical Residency Positions.** The tone and temper of recent discussions about physician residency programs might prompt some policymakers to conclude that the number of surgical residencies must be rising dramatically. The fact is the number of surgical residents has been quite stable for many years. For example, in the 1982/83 academic year, there were 21,133 surgical residents while, by 1992/93, the number had actually fallen to 20,976.

7. **Non-Primary Care Shortages.** Some policymakers may have been led to believe that the only physician "supply" problems are in the primary care arena. However, the advisory body charged with reviewing physician supply and demand issues, the Council on Graduate Medical Education, has specifically concluded otherwise. For example, the Council has noted that shortages exist in general surgery and warned that "[a]ging of the U.S. population will increase demand for surgical services, and the number of physicians in general surgery is inadequate to meet a growing need for trauma services and for surgical care in rural areas."[7]

8. **Medicare Support for Surgical Residency Programs.** The American College of Surgeons supports the concept of limiting the number of physician residency positions and setting broad goals regarding the number of generalists to be trained. However, the College insists that any mechanism for addressing physician supply issues must explicitly include a policy of adequate funding for all residency positions through the entire course of the training period. As it stands now, Medicare generally pays less than its share of the costs of training surgical residents, primarily because the program limits funding to a maximum of five years, which is shorter than the amount of time required to train most surgeons.

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[6] Richard A. Cooper, Seeking a Balanced Physician Workforce for the 21st Century," Journal of the American Medical Association, September 7, 1994, pp. 680-687.

[7] Council on Graduate Medical Education, Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century, October 1992, p. 22.

Mrs. JOHNSON OF CONNECTICUT [presiding]. Thank you, Dr. Schwartz.

Dr. Anderson.

STATEMENT OF WILLIAM G. ANDERSON, D.O., PRESIDENT, AMERICAN OSTEOPATHIC ASSOCIATION

Dr. ANDERSON. Madam Chair, thank you very much for the opportunity to appear before the Subcommittee on Health.

My name is William Anderson, and I am president of the American Osteopathic Association. I have been practicing as an osteopathic physician for over 38 years in primary care in Southwest Georgia and in recent years as a surgeon in inner-city Detroit.

I am pleased to be here representing 36,000 osteopathic physicians, the majority of whom are in primary care and, we believe, are playing a very vital role in health care delivery in the United States today.

So we feel as though it is very important that members of the subcommittee take under consideration, when we speak of funding of graduate medical education, preserving this system of training osteopathic physicians that has demonstrated historically that it can produce a higher percentage of primary care physicians. As many as 60 percent of the 36,000 are currently in the primary care specialties.

So before I go to some specific recommendations relative to this matter of training relevant physicians and cost containment in graduate medical education, I wanted to just make a few brief remarks relative to the profession itself.

Osteopathic physicians are trained in many respects the same as allopathic physicians in that we have the same basic training in medicine, surgery, physiology, anatomy, and all the fundamentals. However, osteopathic physicians have the added dimension where emphasis is placed on the musculoskeletal system and the body functioning as a whole with an interrelationship between structure and function.

This philosophy of practice was first initiated by Andrew Taylor Still over 100 years ago, and it permeates our educational process from undergraduate through the graduate levels.

Although a number of osteopathic physicians ultimately go into the specialties and the subspecialties, they all are first trained in primary care. They have that orientation, and it is embedded in them in the rotating internship. We believe that this enables them to practice better even as specialists. So I certainly prevail upon the committee to take under consideration those measures that will be necessary to preserve this system of training.

Now let me go then directly to the matter of how we can achieve savings in graduate medical education while preserving the system and, second, addressing the issues of the physician work force.

First, let me mention the matter of the allocation of the GME positions. We certainly do support the concept that the number of residency positions could be limited to just 110 percent of the total graduates from the osteopathic and allopathic medical schools in the United States.

At the present time, we receive funding from various sources—and the Federal Government through Medicare is the principal

source of that funding—we are funding the equivalent of 140 percent, and we recognize that many of those are the international medical graduates that make up the difference between the 100 percent and the 140 percent.

We feel that if we are in a situation now where we are graduating as many as we need—and there are those who think we are even graduating more than we need—it seems to be just prudent, then, that we should buy what we need to meet the needs of the citizens of this country first.

Then if we have a system that produces enough physicians, it seems to me we should limit our funding to just meeting that need.

So I would strongly recommend that consideration be given to limiting the funding to 110 percent of our graduates.

Now there is a potential for the loss of osteopathic graduate medical education positions if the osteopathic allocation then is buried within a single allopathically dominated pool; therefore, I would prevail upon you to take under consideration the fact that there is a separate system of educating physicians.

Second, GME funding should be equitable for all positions and based on national averages rather than the current system that is hospital-specific, that provides for a wide range of costs in graduate medical education, that may be producing the same end product.

Third, GME funding should be by all third-party payers, and you have heard that repeatedly this morning, and we in the osteopathic profession want to reinforce our position relative to that.

We feel as though all of the third-party payers should participate by funding graduate medical education, recognizing that as managed care now is permeating the medical market and soon will include many of the people who are in the Medicare program, and while the HMOs are receiving 95 percent of that average cost per Medicare patient, and that includes the medical education portion, we feel as though they should bear a portion of that cost, or that portion of the payment to the managed care systems should be removed, so it can go directly to those training institutions.

Fourth, we feel as though there should be a freeze at least on the resident-to-hospital-bed ratio at the current level. This would remove the disincentive to move much of the graduate medical education out of the hospital and into the ambulatory sites. That is less costly than the hospitals. You do not begin to incur as much of an indirect medical cost where training takes place in the ambulatory sites.

If the greater need is for primary care physicians who will practice in ambulatory sites, we feel as though that is where they should receive their training.

In conclusion, osteopathic physicians have provided for many years a vital component in the health care delivery system in America. In order to assist the country in meeting the many challenges in physician work force development and reducing cost, we suggest that the present system of funding graduate medical education be made more equitable. All residents, without regard to the site of their training, should receive the same direct funding. The indirect funds would be based on averaging, utilizing the same national average, not hospital-specific, and based on a more recent

year basis. Most of us now are operating on the basis of a 1984 base year funding methodology adjusted for inflation.

We do believe that this reimbursement system for graduate medical education does not take into account the demands that are now placed on the educational system in the development of consortia and in the process of paying for the educators.

We certainly would encourage you to consider the 110-percent cap. Simply cutting the payments will not facilitate the work force change that is desired.

Thank you, Madam Chair, for giving me the opportunity to present the concerns of the American Osteopathic Association.

[The prepared statement follows:]

TESTIMONY OF WILLIAM G. ANDERSON, D.O.
AMERICAN OSTEOPATHIC ASSOCIATION

OSTEOPATHIC GRADUATE MEDICAL EDUCATION

Mr. Chairman and members of the Committee, thank you for inviting the American Osteopathic Association ("AOA") to appear before this hearing. My name is William G. Anderson, DO, and I am the current president of the AOA. I am appearing before you today as the representative of the 36,000 osteopathic physicians practicing in the United States.

The AOA is the national organization for osteopathic medicine. The AOA is involved in nearly every stage of an osteopathic physician's education. The AOA is recognized by the United States Department of Education and the Commission on Recognition of Postsecondary Accreditation as the accrediting agency for osteopathic medical colleges. The AOA also accredits 136 hospitals and health care facilities in 26 states. Such hospital accreditation is recognized by the Department of Health and Human Services. Additionally, the AOA in conjunction with various affiliated organizations, formulates general requirements for graduate medical education (internships and residencies) leading to specialty certification through the AOA's various specialty boards. The AOA also examines and approves osteopathic internship and residency programs in osteopathic and jointly accredited (DO/MD) hospitals. The AOA conducts examinations for specialty certification following the completion of such training. Finally, the AOA administers an extensive program of continuing medical education which is required to maintain AOA membership, specialty certification and licensure in numerous states.

For nearly 40 years, I have practiced osteopathic medicine -- first, as a family physician in Albany, Georgia and later, as a general surgeon in Detroit, Michigan. At present, I am the Associate Director of Medical Education at Detroit Riverview Hospital.

The Osteopathic Medical Profession

While the subject of my address today is graduate medical education in general and osteopathic graduate medical education in particular, I would like to first provide you with some background information on the osteopathic profession. There are two distinct but parallel branches of medical practice in the United States: osteopathic medicine and allopathic medicine.

Osteopathic medical practice, a reform movement in medical care, grew out of concepts developed in 1874 by Andrew Taylor Still, MD. Dr. Still's philosophy of medical care focused on "wellness," preventive medicine and the body's ability to heal itself. Dr. Still studied the attributes of good health so that he could better understand the process of disease. He devised a philosophy which emphasized the unity of all body parts, particularly that of the musculoskeletal system, as a key element of health. The unique osteopathic manipulative treatment grew out of this philosophy. All of these principles -- "wellness," holistic medicine, osteopathic manipulative treatment and an emphasis on family/generalist practice -- have been essential elements of osteopathic medicine for over 100 years.

Today, the majority of physicians in this country are allopathic physicians (MDs); however, doctors of osteopathic medicine (DOs) constitute more than five percent of all physicians practicing in the United States. After years of struggling for acceptance, osteopathic physicians have

secured broad recognition at law[1] and in the courts[2] as equivalent to our allopathic brethren. The DO and MD degrees are the only recognized degrees leading to the unlimited licensure for the practice of complete medicine and surgery. Despite our success, there still remain some isolated pockets of discrimination against the osteopathic community, and osteopathic physicians must continue to fight for equal treatment.

Significantly, while DOs constitute only 5.5 percent of the nation's physician manpower, they are often the only physicians practicing in many rural and underserved communities. Osteopathic physicians comprise more than 15 percent of all physicians practicing in communities of less than 10,000 people and fully 18 percent of physicians serving communities of 2,500 or less. Additionally, DOs comprise ten percent of all physicians serving in the uniformed services. In all, whether serving in rural or urban areas and in public service or private practice, the nation's osteopathic physicians provide care in nearly one hundred million patient visits each year.

Osteopathic medicine has recently received attention for its production of an appropriate balance of primary care physicians and specialists. More than 60 percent of the profession consists of primary care physicians who provide a complete range of services to patients of all ages. This statistic is no fluke. Throughout its history, the osteopathic profession has consistently been able to exceed the proposed federal recommendations for 50 percent of the nation's physician workforce to be comprised of primary care physicians. Each year, more than half of the osteopathic medical school graduates choose to enter practice in primary care fields. A recent study to determine which medical schools -- allopathic and osteopathic -- produce the largest percentage of primary care physicians revealed that 15 of the top 25 and all of the top ten were colleges of osteopathic medicine.[3] The success of the osteopathic profession in

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[1]For example, Medicare defines physicians as including osteopathic physicians (42 U.S.C § 1395x(r)); Hospital accreditation by the AOA is statutorily recognized (42 U.S.C. § 1395bb(a); and osteopathic physicians are statutorily authorized to practice medicine in the Public Health Service (42 U.S.C. § 209(d)), Medical Corps (10 U.S.C. § 532(b)), Veterans Administration hospitals (31 U.S.C. § 4105(a)(1)), and Federal Health Service (5 U.S.C. § 7901(e)).

[2]See Stern v. Tarrant County Hospital, 778 F.2d 1052, 1060 (5th Cir. 1985), cert. denied, 476 U.S. 1108 (1986) (noting that osteopathic physicians and allopathic physicians have similar training and face identical testing and licensing requirements); Brandwein v. California Board of Osteopathic Examiners, 708 F.2d 1466, 1468 (9th Cir. 1993) ("At the present time the differences between the schools of osteopathy and allopathy are minor"); Weiss v. York Hospital, 745 F.2d 786, 792, 820-22 (3d Cir. 1984), cert. denied, 470 U.S. 1060 (1985) (noting at footnote 4 that an MD had testified as to the fact that there was no difference between graduates of allopathic and osteopathic medical schools in terms of medical training and ability to provide medical care, and, at page 820 that the defendant hospitals did not contend that osteopathic physicians are less qualified, nor did the hospitals offer any "public service or ethical norm rationale for their discriminatory treatment of DOs.").

[3]L. Haspel, DO, Osteopathic Graduate Medical Education: Past, Present & Future (1995) (study completed for the Josiah Macy, Jr. Foundation).

producing community-level primary care medical practices is the result of the profession's carefully crafted educational program that emphasizes primary care and the osteopathic philosophy at all levels of education and training.

Osteopathic physicians start their medical careers by earning the degree of Doctor of Osteopathy or Doctor of Osteopathic Medicine (DO). Presently, there are 16 accredited colleges of osteopathic medicine located in 14 states.[4] The colleges enroll qualified applicants who have completed four-year college degrees and often advanced graduate degrees. Requirements for graduation from osteopathic medical colleges include the successful completion of a four-year curriculum of basic sciences and clinical studies, including the same subject matter taught in allopathic medical schools.

While the education of an osteopathic physician includes the same materials required of allopathic physicians, the education also emphasizes principles of osteopathic care. As the osteopathic philosophy places an emphasis on the musculoskeletal system and holistic care, so too does the curriculum in our medical schools. In addition, osteopathic medical students receive training in the administration of manipulative medicine. In the first two years, the standard osteopathic curriculum includes two to three hundred hours

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[4]Chicago College of Osteopathic Medicine, Midwestern University - Chicago, Illinois

College of Osteopathic Medicine of the Pacific - Pomona, California

Kirksville College of Osteopathic Medicine - Kirksville, Missouri

Lake Erie College of Osteopathic Medicine - Erie, Pennsylvania

Michigan State University, College of Osteopathic Medicine - Lansing, Michigan

New York College of Osteopathic Medicine, New York Institute of Technology - Old Westbury, New York

Nova Southeastern University, Health Professions Division, College of Osteopathic Medicine - North Miami Beach, Florida

Ohio University College of Osteopathic Medicine - Athens, Ohio

Oklahoma State University College of Osteopathic Medicine - Tulsa, Oklahoma

Philadelphia College of Osteopathic Medicine - Philadelphia, Pennsylvania

University of Health Sciences, College of Osteopathic Medicine - Kansas City, Missouri

University of Medicine & Dentistry of New Jersey, School of Osteopathic Medicine - Stratford, New Jersey

University of New England, College of Osteopathic Medicine - Biddeford, Maine

University of North Texas Health Sciences Center at Fort Worth, Texas College of Osteopathic Medicine - Fort Worth, Texas

University of Osteopathic Medicine and Health Sciences, College of Osteopathic Medicine and Surgery - Des Moines, Iowa

West Virginia School of Osteopathic Medicine - Lewisburg, West Virginia

which focus on manual medicine, and the concepts that the body's systems are interrelated, that a dysfunction in one system may be reflected in a dysfunction in another, and that the body has a self-healing capacity.[5] Osteopathic medical schools expose their students to clinical experience at an early stage in their training, typically including a 14-week family medicine clerkship in addition to another 16 weeks in pediatrics and internal medicine.[6] This curriculum is part of a larger process of teaching all students to be primary care physicians first and foremost.

Following graduation, osteopathic physicians generally embark on a course of unique graduate medical education. Just as osteopathic medical education differs from allopathic education, so too do the postdoctoral training programs. The graduate medical educational program is designed to build upon the osteopathic concepts taught during medical school. The internship year of osteopathic graduate medical education required for entry into osteopathic residency training, includes mandatory rotations in primary care areas of internal medicine, obstetrics and gynecology, general pediatrics, family practice and surgery. In addition, the required curriculum for internships states that "Osteopathic principles and practices shall be incorporated throughout the program."[7] Following internships, the physicians progress to residencies in primary care and other specialties. The osteopathic internship with its rotations in areas of primary care is required regardless of whether a physician contemplates a non-primary care specialty, such as anesthesiology or radiology. It is our understanding that such required primary care content is not included in allopathic non-primary programs. Moreover, all of our residency training programs, as with our internships, incorporate osteopathic concepts. The AOA residency training curriculum requirements include "Utilization of osteopathic principles and practices relating to the specialty."[8] The osteopathic system of graduate medical education creates a profession in which all facets of primary care and specialty care are represented. The osteopathic profession has become one in which primary and non-primary specialties are balanced in a way that more properly reflects the needs of our society.

With this explanation of osteopathic medical care and osteopathic medical education in mind, I would now like to address directly the issues of Graduate Medical Education and the AOA's recommendations for this Committee.

1. Allocation of Positions

The program of osteopathic predoctoral and postdoctoral medical education and training produces high quality physicians who practice in primary and specialty care fields. Our program of graduate medical education reflects our belief

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[5]C. D. Meyer, DO, Osteopathic Medicine: Past, Present and Future: What's Distinctive About Osteopathic Medicine (March 1995) (presentation for the Josiah Macy, Jr. Foundation).

[6]Id.

[7]Policies and Procedures for Intern Training, Section VII, D, 1 (American Osteopathic Association, March 1993).

[8]Residency Training Requirements of the American Osteopathic Association, Section II, C, 3, e (American Osteopathic Association, July 1992).

that all properly trained physicians should have knowledge of primary care and specialty care areas in order to be able to provide complete medical care. This unique program has achieved an appropriate balance of primary care physicians and specialists. Among osteopathic physicians currently in practice, more than sixty percent are primary care physicians.

While osteopathic physicians have developed and refined this educational model over the course of time, the federal government plays an essential part in its continued success through funding of graduate medical education. A variety of legislative proposals have attempted to address the significant questions of how many and what type of physicians will be needed in the future.[9] Questions of how best to fund Graduate Medical Education must be considered as part of this process. At present, federal funding is intended to foster development of an appropriate number of physicians in different practice areas.

The AOA supports the government's efforts to encourage more physicians to practice in primary care fields. As policy is developed, we must hope that osteopathic programs receive an appropriate portion of available funds. Without continued support for osteopathic training programs, our graduates will lose the benefit of an osteopathic graduate medical education that has been proven to be very valuable in meeting health manpower needs. For osteopathic practice to survive, the profession must be able to maintain its distinct educational program beyond the medical school level. The simple fact is that osteopathic education requires more than the medical school experience; complete training in the osteopathic approach to medical care requires continued application of osteopathic principles and procedures in osteopathic postdoctoral training programs.

The question of how many graduate medical education positions should be funded is one issue which this committee may consider. Many organizations and individuals have recommended that the total number of funded residency positions be limited to the aggregate number of osteopathic and allopathic medical school graduates. While the AOA generally concurs with this position, we believe that the number of funded GME programs should be designated separately and proportionately for osteopathic and allopathic programs.

DOs comprise a small, but distinct minority of physicians. If funds for allopathic and osteopathic graduate medical education are intermingled, there is some danger that, through either deliberate or inadvertent actions, osteopathic programs would not receive sufficient graduate medical education funds. This would be particularly the case if the osteopathic allocation was buried within a single allopathically dominated allocation formula. However, if the funding is separately earmarked for osteopathic and allopathic use, then there is assurance that the necessary funds will be available for osteopathic programs, which already comply with the federal mandate for primary care.

With a secure and separate source of funds, osteopathic physicians will be able to maintain a complete osteopathic medical education system, which produces an appropriate primary care/specialty balance and physicians who bring primary care to areas which sorely need such care. Of

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[9]See, e.g., the proposals contained in the proposed Health Security Act, H.R. 3600, 103d Cong., 1st Sess. §§ 3001 et. seq. (1993).

course, in order to guarantee sufficient funds, the allocation must be in appropriate proportion to the number of osteopathic medical graduates. We suggest that in a separate allocation system, the number of funded allopathic residency programs would be determined based on the number of graduates of allopathic medical schools, while the number of funded osteopathic postgraduate programs (internships and residencies) would be determined based on the number of graduates from osteopathic medical schools.

The AOA proposed the idea of a separate and proportionate allocation of funds for osteopathic GME to Congress and the Council on Graduate Medical Education ("COGME"). In response, COGME concurred with the AOA's suggestion and recommended that funding for postgraduate training programs be allocated on a separate basis for allopathic and osteopathic physicians.[10] While osteopathic and allopathic educational programs both produce complete practicing physicians, their respective educational models -- from medical school through graduate medical education -- are different. By guaranteeing a separate funding allocation for osteopathic postdoctoral training programs, Congress will help to ensure the continued vitality and viability of osteopathic medical care.

2. Funding for Graduate Medical Education.

I would next like to discuss the criteria for funding respective Graduate Medical Education ("GME") programs and the source of such funds. Currently, there are separate formulas for reimbursment of direct and indirect GME costs incurred by teaching hospitals.

Direct GME costs are reimbursed under a formula which is based on each hospital's 1984 costs per resident, adjusted for inflation.[11] Since 1984 there have been significant changes in graduate medical training, particularly within the osteopathic profession. Non-salaried volunteer faculty has given way in large measure to salaried faculty. Osteopathic programs have grown relative to their allopathic counterparts and have consequently incurred additional costs for additional faculty, such as program directors and clinical supervisors. These costs were already imbedded in the large allopathic programs in 1984 and, therefore, included with their base year measure. Because most of our faculty salary expenses have arisen since 1984, osteopathic programs have lost ground relative to the allopathic programs, despite cost of living adjustments. COGME is aware of the fact that a similar situation exists in the allopathic profession with respect to the large academic health centers versus smaller teaching institutions. Consequently, both COGME and the osteopathic profession are urging that at the very least, the base year for measuring direct costs be changed from 1984 to as current a year as possible in order to take into effect actual changes and thereby create a more level playing field.

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[10]Council on Graduate Medical Education, Recommendations to Improve Access to Health Care Through Physician Workforce Reform, Fourth Report to Congress and Department of Health and Human Services Secretary (1994).

[11]Direct Graduate Medical Education (DGME) payments to each hospital equal the hospital's updated base-year (1984) costs per FTE resident, times the weighted average number of FTE resident, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. GAO/HEHS-94-33 Medicare GME Payment Policy.

COGME has also recognized that the current reimbursement formula for direct costs is skewed heavily in favor of the large academic health centers for a number of reasons, including the ability of the larger institutions to involve a proportionately greater number of staff members in the compensated teaching faculty. COGME, therefore, is advocating that the current formula, which is based on each institution's actual 1984 costs, be replaced by a formula based on a national per resident average cost (possibly with regional adjustments). We join COGME in urging this change. The updating of the base year and the change to a national average will create a fairer and more rational system of determining each institution's level of reimbursement for direct costs of GME programs.

The adjustment in the funding of graduate medical education should not be limited to the means of direct funding. We also believe that the system for reimbursement of indirect costs of GME should be reformed.[12] The present formula is based in significant part upon the training program's resident-to-hospital bed ratio. Again, larger academic health centers have the resources to maintain such ratios at a significantly higher level than their smaller counterparts. Again, we and COGME urge that this method of measuring indirect costs of GME be replaced by a formula employing an updated historic base year experience figure.

Third, the source of funds for reimbursing the direct costs of GME should be addressed. Presently, such funds are provided in large part by Medicare/Medicaid and Blue Cross/Blue Shield. We agree with COGME's Fourth Report that "the direct costs of GME be funded by all third-party payers through the development of a national GME funding pool."[13] With the growth of managed care, it is essential that managed care groups and all insurers in the private sector pay their fair share of GME direct costs.

One last topic with respect to funding involves the fact that osteopathic teaching hospitals are typically smaller, community-oriented facilities. Because of the current funding system's rewards for larger institutions, the osteopathic hospitals have not had the benefit of elaborate resources for payment of faculty and trainees. Yet, osteopathic medicine is developing alternatives. Consortia of hospitals and colleges of osteopathic medicine have emerged in various locations to expand and enhance graduate medical education for training in family medicine, internal medicine and other specialties within the profession.[14]

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[12]Medicare Indirect Medical Education ("IME") payments to each hospital are based on a formula that provides an increase of approximately 7.7 percent in the federal portion of the DRG payment, for each 0.1 increase in the hospital's intern and resident to bed ratio. GAO/HEHS-94-33 Medicare GME Payment Policy.

[13]Council on Graduate Medical Education, Recommendations to Improve Access to Health Care Through Physician Workforce Reform, Fourth Report to Congress and Department of Health and Human Services Secretary (1994).

[14]For example, the COGMET program established by Michigan hospitals and the College of Osteopathic Medicine at Michigan State University in Lansing, Michigan and the Family Practice program established by Ohio hospitals and the College of Osteopathic Medicine at Ohio University in Athens, Ohio have had particular success in developing graduate medical education programs in primary care.

The trend in many cases is for the consortia to make increasing use of ambulatory care settings for teaching purposes. We believe that the funding programs should recognize these consortia on an equal basis and fund them accordingly. With proper funding, these consortia will prove to be extraordinary programs for the training of another generation of osteopathic physicians to provide high quality medical care.

3. Enrollments

The last issue of Graduate Medical Education that I would like to address is the subject of recommended enrollments in medical school. The AOA has advocated that osteopathic graduate medical education programs be funded on a separate but proportional basis with respect to allopathic programs. Certain organizations and individuals have gone on to recommend that the total number of funded residency positions be limited to the aggregate number of osteopathic and allopathic medical school graduates.

As I indicated earlier in my testimony, the AOA generally concurs with this position, but notes one particular reservation. While some parties have urged that the number of residencies should be tied to the aggregate number of students in a particular "base year," we believe that the base year concept is not appropriate insofar as it fails to recognize that the osteopathic profession continues to grow and develop. While the number of residency positions should be tied to the number of graduates, such measure should contain a reasonable provision for growth in such numbers.

Over the past several years, the number of physicians graduating from colleges of osteopathic medicine has regularly increased,[15] in part as a result of federal plans developed in the past to expand primary care capacity in the United States. Use of a base year would not account for enrollment growth in osteopathic medical schools and could deprive the osteopathic profession of funds needed for the education and training of our graduates. With the base year cap, graduate medical education programs would not have the funding to allow for program expansion as the number of graduates of osteopathic medical schools grows. In effect, the use of a base year would punish the profession that is currently producing a proper balance of specialists and primary care physicians, which balance is deemed critical for reform of the health care system.

Some additional clarification is necessary with respect to the growth of osteopathic medical schools. First, we believe that the continuing growth of enrollment in osteopathic medical schools serves the nation's needs. Osteopathic physicians, with their balance of specialists and primary care and practice in underserved communities, are the type of physicians needed in this country. A fair division of federal funds which allocates separate and appropriate amounts to osteopathic graduate medical education will enhance our ability to expand and improve the postdoctoral training component of our educational system.

Finally, it should be noted that the significant growth in numbers of residents is not due to growth in enrollment in U.S. medical schools so much as to the increasing presence of

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[15]Between 1980 and 1995, the number of osteopathic physicians per 100,000 people in the United States increased from 8 to 14.

international medical school graduates in American residency training programs.[16]

Conclusions

Osteopathic medicine provides a vital component of the nation's health care services. As policy makers attempt to encourage more physicians to enter primary care fields of practice and provide services to underserved areas of the nation, we point with pride to our history of serving both these needs.

The osteopathic orientation towards primary care practices supported by a cadre of well-trained specialists and history of providing care in underserved communities are not the result of a statistical aberration. Rather, these goals are fostered through a complete osteopathic educational program. An essential component of osteopathic education is graduate medical education. The present system of funding educational programs has resulted in an inequitable distribution of resources. Osteopathic hospitals are typically smaller, community-based treatment centers. When resources are distributed in accordance with the assumptions present in an outdated base year and without considering factors such as participation in consortia of educational institutions, the osteopathic training sites are not provided with an equitable share of the resources. Without sufficient funding, osteopathic hospitals are not able to improve their educational facilities and expand the number of full time faculty. If the base line measure is replaced with a national average system of funding and consortia are given full consideration, then osteopathic programs will be put onto a level playing field with allopathic graduate medical education programs.

We believe that growth in osteopathic physicians will help to solve current shortages of primary care physicians, maintain an appropriate primary care-specialty distribution and provide physicians for traditionally underserved communities. In order to assist the country in meeting these challenges, we would suggest that Congress and this committee act to correct the current imbalances in funding for graduate medical education. Specifically, we would suggest that osteopathic graduate medical education programs receive a separate and proportionate allocation of the funds devoted to postdoctoral education. Funding criteria should be modified in order to consider the participation of programs in consortia of educational programs rather than looking purely at hospital size. Finally, we recommend that funding allocations be made without reference to any base year in order to allow for funding to change with the population such funding serves. With proper support for osteopathic graduate medical education, osteopathic physicians will be able to continue our history of providing high quality, primary and specialty care medical services.

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[16]Between the 1990-91 and 1993-94 academic years, the total number of residents training increased by 12,737 (from 95,327 to 108,064). However, during the same period of time, the number of United States Medical Graduates training in United States GME programs only increased by 4,996 (from 79,311 to 84,307). Thus, in four years, the percentage of International Medical Graduates training in United States GME programs jumped from 16.8 percent to 21.98 percent. L. Haspel, DO, Osteopathic Graduate Medical Education: Past, Present & Future (1995).

Mrs. JOHNSON OF CONNECTICUT. Thank you very much, Dr. Anderson.

I regret that I was not able to be here for the whole panel. I had an amendment on the floor. Those things end up taking a lot longer than you anticipate.

But I appreciate your testimony, Dr. Anderson. I had not really factored in osteopathic issues, and I do not know whether, when we talk about the number of residencies in America, are we talking about and do we include the osteopathic residencies as well?

Dr. ANDERSON. When I speak of funding 110 percent of the graduates, both osteopathic and allopathic medical schools—and I am saying right now we are talking about a total of about 19,000 physicians that will graduate every year ——

Mrs. JOHNSON OF CONNECTICUT. Does the osteopathic system have its own separate residency program?

Dr. ANDERSON. Yes, it does. Now there are some osteopathic physicians that are in allopathic programs.

Mrs. JOHNSON OF CONNECTICUT. Right.

Dr. ANDERSON. But there is an osteopathic system of training residents, yes.

Mrs. JOHNSON OF CONNECTICUT. So you are saying if we look at caps, it should be across both systems. If we look at residency positions, we should look at residency across both systems.

Dr. ANDERSON. That is correct. It should be proportional in the allocation, recognizing the two separate systems.

Mrs. JOHNSON OF CONNECTICUT. Can you accurately factor out how much of a resident's time is devoted to training and how much is devoted to service? This is to the whole panel.

Dr. ANDERSON. That is very difficult. I would say—and I am a medical educator—it would be very difficult to separate that out.

I could tell you this. The residents themselves would be very eager to tell you how much of it is, "scut work" versus education. But from an educator's perspective it is difficult to separate these two out.

Mrs. JOHNSON OF CONNECTICUT. Also since much of life is scut work, it is hard to determine which is training.

Dr. Jacott.

Dr. JACOTT. I would just like to build on that a little bit. That is a question that has been asked for many, many years, and we have tried to look at it from every angle, and you add a third component, not just service and education, but then you add research as the third piece of the academic mission and try to figure out how they sort out timewise. It is very difficult. I have not seen any studies that clearly split out that time ratio.

Mrs. JOHNSON OF CONNECTICUT. What we are really trying to do in government is exactly what the private sector has tried to do.

What exactly are your cost centers, and how does the money flow? How much is research? How much is training? How much is service? And what is the Medicare premium? How much of the Medicare premium is care for seniors for the patient, and how much is subsidy to training, and how much is subsidy to uncompensated care, and how much is subsidy to the institution, so that they can carry on their academic mission?

This is something that we have never been very good about doing, but it is something that we are going to have to do, because I am sure it was said by others as well, but Dr. Anderson mentioned it most recently. We are going to have to make change, and we are going to have to do that through providing seniors with a lot more options, and to provide them with options, you have to know what the premium is.

So any help you could give us as we try to disentangle the dollars and the missions would be appreciated.

Mr. Munson.

Mr. MUNSON. Thank you for the question. I am also sorry you missed my spellbinding testimony, but that is all right.

To the contrary, I do not believe that government and Medicare are doing just like the private sector. I think you have done a very nice job historically in differentiating the elements of cost that you choose to pay for.

There are five of them: The PPS payment or the DRG payment for the actual service rendered; the IME payment to hospitals like mine, which recognizes the unique severity and comorbidity that the patients bring to our place; the DGME payment, which is a direct cost of house staff stipends and related costs; disproportionate share for those of us that take shares of poor folks; and then outliers for patients, for example, those in our burn unit that stay for 200 days with huge burns.

So on the contrary, I do not think you are doing what the private sector is doing at all. I think you are doing a nice job of identifying, accounting for, and then paying segmented parts of the cost of rendering care to seniors.

On the contrary, as I said in my testimony, the private commercial sector is trying to avoid almost all of that societal responsibility.

Mrs. JOHNSON OF CONNECTICUT. Let my chairman jump in here.

Chairman THOMAS [presiding]. A brief response to that.

Obviously the payment system grew up in part in response to need and part in response to politics. And you are right; the profile fits.

A vision of a teaching hospital, perhaps less so today than earlier, more so earlier than today—and as you are moving out into the community and clinics and stressing—and I came in on the discussion between service and training, and my background is as an educator as well, and you cannot let the students determine when it is happening, because sometimes in a context that you consider to be very educational and useful, they consider it to be drudgery.

And, in fact, we heard earlier testimony, and I believe it to be true, that a lot of the training that is necessary is interpersonal relations, dealing with folks who maybe are not necessarily doctors, and you need to do that, and that is kind of like a work training program, which is almost seamless. You cannot separate it.

But our problem is that I do not want to dictate how much the percentage should be or even get the educational training process into a 60:40, 70:30 game in terms of how we fund it.

Nor do I think that we can continue the current structure based primarily on hospitals running money to those folks on the patient profile through the indirect, which really is, I think, as you more

accurately described it, is a reward for the profile of the patient more than, you know, just the teaching structure.

Then with the disproportionate share, it just makes sense because of the urban locations. As I said in my opening statement, that is where most of them are.

But the hospitals are relatively less significant in the new structure, and perhaps the profile of the patients and what is being done is becoming less significant, so we have got to make it more relevant, and we move that structure, and if that is the case, then the old-fashioned funding mechanism needs to change as well.

To the degree that things remain the same, the funding system makes sense. I think our problem is that they are not remaining the same, and we have got to figure out a way to begin to shift that funding structure that does not produce the Federal Government quotas and divisions in the teaching areas and, in fact, rewarding some beyond what they should have been rewarded and not rewarding others sufficiently because of the location if we change the funding structure.

So I think we are sensitive to the problem. It is just that it is going to be an enormously difficult political problem, which is not partisan, by the way. You heard the gentleman from California. It is not partisan. It gets into some regional aspects—States, teaching hospitals in their States, and the profiles that those hospitals have developed, and that if you change the formula, you change the winners and the losers.

And so all of that will be entering into our decision, notwithstanding the fact that the fundamental basis for funding medical education is eroding because hospitals themselves are becoming less the focal point.

You folks are essential to our coming up with a program that actually is better and actually does solve the problem and does not exacerbate problems that we either know or do not know about.

So I apologize for not hearing your scintillating testimony either, but you need to know that we read all this stuff as well, and I thank you.

Mrs. JOHNSON OF CONNECTICUT. Mr. Munson, I know that we are only giving a minute-and-a-half summary of something that is much more important than that. But your summary does worry me.

Now your comment that the private sector is not taking its societal responsibility, it is true that their premiums are focused primarily on the health costs of the patient they have insured. And then, through taxes, they would maintain that they are taking their societal responsibilities, send the government the money that the government needs to do whatever government thinks is important.

Now it may be that they ought to be paying a premium tax directly, so that we can fund medical education, and that is not a concept that I think is beyond grasp or adoption.

But to then say that the government is doing a better job does worry me terribly, because the disproportionate share thing, we guess at that.

Outliers? Finally after you bent our arms, we did acknowledge that if someone is in the hospital way beyond what the DRG ex-

pected, you might need additional reimbursement. There is still a lot of question about whether it is fair to have the outlier kick in at day 90 or day 80, but the outlier controversy is real.

DRGs? You can hardly believe what my constituents think about DRGs when they get it. When they come into my office with a Medicare bill that shows that their costs—and I am making up the figures—were $1,000, and the hospital got paid $2,500, and they have to pay 20 percent of the $2,500 or fix the numbers so that the 20 percent comes out bigger than the actual payment, this does not strike them as rational, as fair, or as real.

So while the DRG system was a sort of desperate response to desperate circumstances on the part of the government, and the concept of reimbursing on average did help us through a crisis, this is not a model that interests me for the future.

I think for the future we have to get much tougher in the public sector. We have to figure out what care is being given and how it is being given, or we have to move public recipients of every type into the choices the private sector offers. If we do the latter, then we have to think about how do we cover those who do not have any insurance? How do we pay for medical education?

But it is that latter debate that really interests me a lot more. The current reimbursement structure I consider to be of the same ilk of public policymaking that decided that under Superfund we were going to charge people to clean up things that they did that were completely legal at the time they did them, regardless of whether or not they have the money to clean it up now or regardless of whether or not we are going to take all their pension savings, their home, their mortgage, their everything else.

I mean, I do not see the public reimbursement fund structure as any model on which to base the future. So it troubles me that you would make the comment that the private sector is offbase and the public sector is onbase, when I think the reverse is actually my reality.

Mr. MUNSON. OK. You have said a lot, and you have left a lot to respond to.

I did not mean to suggest that the Medicare reimbursement system is perfect or that all the regulations and formulae are perfect.

On the contrary, what I did mean to imply is that the various elements of reimbursement contemplate important societal contributions that teaching hospitals make—education, care for the severely ill and injured, and then the disproportionate share program for poor people.

Mrs. JOHNSON OF CONNECTICUT. Right.

Mr. MUNSON. So all I was saying is that the program, in its entirety, contemplates some things that are very important to society and to teaching hospitals.

I do not believe that the commercial managed care HMO products, albeit, yes, they do pay taxes, but that does not help offset their portion of direct medical education which occurs in our places.

During my remarks, I mentioned the paradox of these same companies who want to hire one of our products, namely primary care doctors. We produce a lot of those. They want to buy them, but they do not want to pay the cost of production. Medicare histori-

cally has wanted to pay the cost of production. That is the kind of difference I was alluding to.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Just to follow that up, we heard testimony earlier that, in fact, the product—it sounds like most of the products coming out of most schools—the product of primary care physicians are, in fact, not equipped to deal with the new world of medicine under managed care. It seems to me that if they are getting a product which they cannot use immediately, schools should plug them in in an efficient way and have them deal with additional training or working on their interpersonal skills with health professionals who are not doctors. They might be interested in contributing a portion of the education cost to get a product that they can use immediately and who has been trained along the lines that they believe to be appropriate.

So I guess as we pursue this, I think you are going to find that the marketplace in terms of what it asks for, to the degree it asks for a product different than is being produced today, is going to be asked to pay for the changes in that product.

And we have begun discussions, and we will continue discussions in terms of a fair share pay.

The easiest way, obviously, is to get a different funding system that is broader based. But we discussed that. It is very difficult to do politically, and it is very difficult to create a different system because of the way in which this one fits circumstances that have not completely changed but are changing.

So we are going to try to do two things, keep the best of what we have had and anticipate how we can get those folks who may not be paying their fair share or who are complaining about the product coming out of the structure, to say: OK, you know, put your money where your mouth is, and let us talk about bringing about changes.

It will be not as perfect as we would like, but there are going to be changes made. And I believe you will find that it will be a broader-based support for the costs with an expectation that the product coming out of it will be more relevant to the needs of the marketplace.

Dr. Jacott.

Dr. JACOTT. I am really delighted, Mr. Chairman, to hear you saying that, because we do—those of us in academic health centers and in education programs—and my background is family practice—and we do hear a lot from the managed care entities that we are not training the kind of person that they want to come out into practice.

On the other hand, we need to look at what their expectations are. If we are just training a triage officer or a gatekeeper, that is really not satisfactory either, to provide the kind of care.

On the other hand, many of our educational institutions have developed within their training programs the kind of information and experience that the residents need to get out and practice in a managed care environment.

At the University of Minnesota, in our Department of Family Practice, we have our own HMO, and it is basically run by the resi-

dents, and the residents have come out and they are marvelous in managed care, if that is what the managed care people are looking for.

But I cannot agree with you more that if they want to say something about the product, then they ought to be paying for the product.

Chairman THOMAS. Well, but beyond that, I think we need to focus on medical training and education in terms of producing the complete product for the marketplace. And we are going to have a panel following you folk, who will be focusing on other aspects of health care professionals. And clearly as managed care utilizes more and more other health professionals who are not doctors, there needs to be a coordination between them.

It makes sense to do more of that during the education and training process rather than on the job. So I think if we are realistic, the profile of who is going to be trained in these centers is going to change as well.

And to the degree that we have too many doctors not of the right type and that we need more folks who are not doctors, you can be doing the right thing with a shrinking universe, or you can be doing the right thing with a larger universe of all of the kinds of people that we prepare and work with.

That is another thing I think we need to try to do, and that is direct the funding, one, to the environment in which it needs to go and, two, to the broader population universe which will be necessary in the future.

That is all uncomfortable for everybody, because it is a significant change, foremost in terms of the impact of the changes on the doctors themselves.

So this is a challenge for all of us. But to the degree that the Federal Government is going to fund medical education for the rationale being a societal good, then we are going to make sure that the product is not misplaced in terms of its emphasis and its need in the marketplace.

It is changing. And we appreciate your testimony. And we are going to move in the direction of trying to provide more realistic funding in realistic ways that allow you to produce realistic folk to serve in the realistic structure of tomorrow.

Dr. ANDERSON. Could I make just a comment?

Chairman THOMAS. Certainly, doctor.

Dr. ANDERSON. I would certainly hope that the managed care organizations would take note of what you have said relative to the responsibilities that they should assume. As long as they have the strong bottom line orientation that they have, and there is no demand placed on them—that is, there is a sufficient pool out there that they can weed out the doctors that do not have that training in managed care—I would like to see a requirement made of those who benefit to participate in graduate medical education. That certainly would include the HMOs.

Chairman THOMAS. If they are not listening, we will deliver the message anyway.

Dr. ANDERSON. Thank you. I hope you do that.

Second, I think to attempt to dissect out now what portion of a resident's time is spent in training, we know the elements that go

into making up the total amount of the payments; I think we should look more at the finished product.

Are we producing—and you made that observation, Mr. Thomas—we should look at the product to determine whether or not we are producing the kind of physician that we need to meet societal needs.

If we are not doing that, without regard to how much it costs, we should stop. We should stop.

So when I say look at 110 percent funding, 110 percent of the positions for our graduates, if that meets the needs, that is where the funding needs to stop.

Chairman THOMAS. Yes. And a lot of times it is not what, it is where. And more and more it is where they are getting it. And I would much rather emphasize an open structure, so that you folks can get them trained where they need to be trained in terms of reflecting what tomorrow looks like, rather than getting into percentages that may or may not be education versus training.

I thank the panel very much.

Dr. ANDERSON. Thank you.

[Pause.]

Chairman THOMAS. The last panel can now take their place, and we have got: Gwendylon Johnson, Kenneth Kalkwarf, and Charles Jones.

As I indicated to the other panels, your written testimony will be made a part of the record without objection, and you may proceed to educate and inform us as you see fit in the time that you have.

Ms. Johnson, if you will start, then we will move across to Mr. Kalkwarf and then on to Mr. Jones, if you will begin.

STATEMENT OF GWENDYLON E. JOHNSON, M.A., R.N., C., MEMBER, BOARD OF DIRECTORS, AMERICAN NURSES ASSOCIATION

Ms. JOHNSON. Thank you, Mr. Chairman, and members of the subcommittee.

I am Gwendylon Johnson. I am a member of the board of directors of the American Nurses Association. Thank you for the opportunity to discuss graduate nurse education.

The American Nurses Association is the only full service professional organization representing the Nation's 2.2 million registered nurses.

We are also testifying today on behalf of the American College of Nurse Practitioners, the Association of Operating Room Nurses, the Emergency Nurses Association, and the National Association of Nurse Practitioners in Reproductive Health.

America's registered nurses deliver many essential health care services in the United States today in a variety of settings—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings.

Because we are there 24 hours a day, 7 days a week, we know all too well how the system succeeds so masterfully for some, yet continues to fail so shamefully for all too many others.

Nursing commends Congress for its increased focus on nurse education issues. It is clear that the U.S. health care system has an increasingly urgent need for primary care providers.

Funding must be made available to strengthen advanced practice nurse programs and to establish new programs to prepare those primary care providers so urgently needed.

Nurses are well positioned to fill many of the gaps in the availability of primary health care services. Advanced practice nurses are trained to provide from 80 to 90 percent of the necessary primary care services of the Nation. Advanced practice nurse education includes the preparation of nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified nurse anesthetists. These advanced practice nurses are prepared as expert clinicians to deliver primary care and other services vital to the Nation's health care needs.

Since its inception, the Medicare program has paid a portion of the cost of training health professionals. Graduate medical education expenditures for nursing education are intended to reimburse a portion of the cost of nurse education to promote quality inpatient care for Medicare beneficiaries.

Thus, Medicare has traditionally made payments to hospitals for the training of nurses in hospital-based nurse education programs. A majority of these programs are hospital-based programs that grant a diploma, rather than a bachelor of science degree that is granted by most university-based nursing education programs, or an associate degree granted by community colleges.

As the need increases for community-based and primary care providers, nursing will be forced to expand the number and capacity of its graduate level education programs. These programs do not currently receive Medicare funding.

In order to quickly expand the number of these expert clinicians, there must be an increased Federal commitment to graduate nurse education, a commitment not subject to the uncertainties of the annual appropriations process.

We urge this committee to redirect a portion of the annual Medicare funds currently being used to reimburse diploma nursing education over a 3-year phase-in period to graduate nurse education programs.

However, since there is also a continuing need for 4-year BSN-prepared nurses to play a variety of critical roles in the evolving health care system, we believe that the current Medicare funds reimbursing hospitals for those programs must be maintained.

We also believe that funding must be available to the 72 existing programs offering what is termed an "RN to MSN" program. In essence, these are accelerated nursing education programs that enable diploma and associate degree nurses to become master's prepared and hence, better able to meet the primary health care needs of the Nation. These programs allow for a readily available pool of skilled health care professionals to become educated as advanced practice nurses in a short period of time.

A graduate nurse education program would help many graduate nursing students who are currently attending school part time due to financial constraints to become full-time students.

The current cost of obtaining a nurse practitioner education is similar to students pursuing master's degrees in other subjects. A division of nursing study estimated that the average cost is about $34,000 per graduate. A large portion of graduate nursing student programs are in clinical practice. Some certifying exams require that the nurse spend one-third of his or her education in the classroom and two-thirds in clinical practice.

Advanced practice nurses currently train in a variety of settings—hospitals, skilled nursing facilities, home health agencies, nurse managed care centers, ambulatory care facilities, HMOs, public health departments, and community health centers.

Therefore, even as advanced practice nurses are training for their degrees, their services are being utilized in providing much needed health care services to patients. However, nursing programs and students currently incur the cost of the support of the clinical training in the advanced practice nurse education, despite the fact that these students are providing direct health care similar to many medical residents.

Funds should be available to nurses to help them defray tuition and fees and provide student stipends, as well as reimburse the costs for faculty supervision at the clinical site.

Mr. Chairman, we commend you and the other members of the subcommittee for holding this hearing on graduate medical and nurse education and for working so diligently to find solutions to the health care crisis. We appreciate this opportunity to share our views with you and look forward to continuing to work with you as you develop solutions to this critical problem.

Again, thank you very much.

[The prepared statement follows:]

TESTIMONY OF GWENDYLON E. JOHNSON
AMERICAN NURSES ASSOCIATION

Good morning, Mr. Chairman and Members of the Subcommittee. I am Gwendylon Johnson, RN, a member of the Board of Directors of the American Nurses Association.I am here today on behalf of the American Nurses Association (ANA), the only full-service professional organization representing the nation's 2.2 million registered nurses, including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives, nurse educators, nurse managers and certified registered nurse anesthetists through its 53 state and territorial nurse associations.

I am also testifying today on behalf of the: American College of Nurse Practitioners, a group of nurse practitioner organizations who advocate for universal access to basic health care and the removal of barriers to consumer access to nurse practitioner care; Association of Operating Room Nurses, Inc., the professional association of perioperative nurses representing 47,600 members who are all registered nurses specializing in care of the patient undergoing surgical and other invasive procedures; Emergency Nurses Association, a voluntary membership association of nearly 21,000 professional nurses committed to the advancement of emergency nurse practice; and the National Association of Nurse Practitioners in Reproductive Health, a national non-profit membership association representing nurse practitioners who practice in obstetrics, gynecology, family planning, reproductive endocrinology and infertility whose purpose is to assure the availability of quality reproductive health services.

We appreciate the opportunity to testify on graduate nurse education. We have long advocated for high quality, affordable health care for everyone in this nation. America's registered nurses deliver many of these essential health care services in the United States in a variety of settings -- hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice, and in managed care settings. As the health care delivery system continues to evolve rapidly in the coming years, it is crucial that all available health care professionals be fully prepared to deliver essential primary care services. To meet the increasing demands on our health care system, funding must be guaranteed to strengthen existing advanced practice nurse education programs and to establish new programs to ensure an adequate supply of these primary care providers.

BACKGROUND

Nurses are well-positioned to fill many of the current gaps in availability of and access to primary and preventive health care services. Advanced practice nurses are registered nurses who are nurse practitioners, clinical nurse specialists, nurse mid-wives or nurse anesthetists who have obtained specialized formal education and training beyond the education that prepared them to initially become a registered nurses (beyond the four year Bachelor of Science degree). In most cases, advanced practice nurse education results in a master's degree.

Advanced practice nurses are trained to provide from 80 to 90 percent of the necessary primary care services of the nation. Primary care services include: preventive care and screening, physical examinations, health histories, basic diagnostic testing, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutrition issues, minor surgery or assisting at surgery, prenatal care and delivery of normal pregnancies, well-baby care, continuing care and management of chronic conditions, as well as referral to and coordination with specialty caregivers.

Of the 2.2 million registered nurses in the United States, approximately 139,117 are considered advanced practice nurses with this type of advanced education and most are trained to provide primary care services. Some advanced practice nurses are specialized in tasks that are complimentary to primary care, (i.e., certified registered nurse

anesthetists administer anesthetics for patients, including intravenous sedations and some clinic nurse specialists (CNS) specialize in such clinical areas as cardiology, oncology, stoma care, although other CNSs provide direct patient primary care services such as mental health counseling and gerontological care. With this advanced education, many State legislatures have expanded the scope of practice of advanced practice nurses to include such things as prescriptive authority. Furthermore, Federal health insurance programs [i.e., Medicare and Medicaid in certain cases, Federal Employees Health Benefits Program (FEHBP) and CHAMPUS in all cases] directly reimburse advanced practice nurses for their services.

CURRENT NURSING EDUCATION FUNDS UNDER MEDICARE

Since its inception in 1965, the Medicare program has paid a portion of the costs of training health professionals. Graduate Medical Education (GME) expenditures for nursing education are intended to reimburse a portion of the costs of nurse education to promote quality inpatient care for Medicare beneficiaries. Thus, Medicare has traditionally made payments to hospitals for the "training" of nurses in hospital-based nurse education programs. A majority of these programs are hospital-based programs that grant a diploma rather than a Bachelor of Science degree that is granted by most university-based nursing education programs, or an associate degree granted by community colleges. Medicare reimburses hospitals based on a formula payment for a portion of the cost of these hospital operated nurses education programs including classroom and clinical training. In cases where the hospital acts as the training site, but the educational program or institution is separate (but with a written joint venture agreement with the hospital), only the clinical training costs are reimbursed under Medicare. As of 1989, no new jointly operated programs have been eligible for Medicare reimbursement. In 1991, Medicare provided approximately $174 million to hospitals in support of nursing education costs, and these payments were estimated to increase to $248 million last year. In 1991, 144 hospital diploma programs received the majority of this Medicare graduate medical education (GME) funding. Despite this funding source, diploma nursing programs are rapidly disappearing. In 1965, they numbered over 800, but in 1994 only 112 programs remained. The numbers are even more dramatic when examining the relative numbers of total nurses educated through the diploma program. In 1965, 77 percent of all registered nurses were trained in hospital operated diploma programs; by 1990, less than eight percent of all nurses were trained in this manner. Nurse education has shifted almost entirely away from the hospital-based settings to community colleges and universities.

Medicare reimbursement for nursing diploma programs is also centralized in certain regions of the country -- six states (Pennsylvania, Illinois, Ohio, New Jersey, New York, and Massachusetts) received 50 percent of the available funding.

Since the enactment of Medicare, dramatic changes have occurred in the field of nurse education. For example, the financing of nurse education has shifted away from hospital-based diploma programs sponsoring students to the students and their families bearing the brunt of the cost of a higher education nursing program. Furthermore, the locus of educational control has shifted from the hospitals to the educational institutions granting four and six year degrees. For the most part, hospital based nursing programs do not produce primary care providers, but rather these primary care practitioners graduate from four-year BSN programs and advanced nursing educational programs. Advanced practice programs for nurses has increased dramatically in the past decade. Therefore, nursing finds that the primary Federal support for nurse education is based on an outmoded payment system reimbursing those nurse education programs that are least likely to be able to help meet the growing need for more primary care and community-based health are providers.

Furthermore, Medicare funds for nurse education are not routinely targeted for this intended purpose, but can be diverted to a hospital's general revenue pool and distributed in a variety of manners based on the institution's internal budgeting processes.

THE NEED FOR A GRADUATE NURSING EDUCATION PROGRAM

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

We also believe that funding must be available to the 72 existing programs offering what is termed an "RN to MSN" program. In essence, these are accelerated nursing education programs for diploma or associate degree nurses to become master's prepared and hence, better able to meet the primary health care needs of the nation. These programs allow for a readily-available pool of skilled experienced health care professionals to become educated as advanced practice nurses in a shorter amount of time.

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

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

THE NEED FOR RN's

Recent research by Linda Aiken, PhD, RN, FAAN demonstrates that hospitals have not increased employment of nurses enough to offset the increase in acuity, so nurses are working under greater pressure to provide critical health care services to acutely ill patients. While employment in the hospital sector increased 33 percent during the 1980s and positions for nurses also increased by over 200,000 FTEs between 1980 and 1992, RNs and LPNs exhibited the slowest growth of any occupational category in the hospital workforce. Further, many of the new RN positions were in administrative or other non-clinical roles. Consequently, nurses represented a smaller share of the hospital workforce at the same time that patients in the hospitals were sicker than in previous years; this increasing need for acute health care services fell mostly on the nursing personnel.

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

THE EVOLUTION OF MANAGED CARE

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

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

HOW THE PROGRAM WOULD WORK

Medicare funding should be used to meet the health care needs of the future by retargeting the eligible entities for this funding to be educational programs rather than health service providers. ANA proposes that Medicare funds under the Graduate Medical Education program which are currently used to reimburse diploma nursing education be re-directed to graduate nurse education programs that are post-baccalaureate, advanced practice programs accredited by a national accrediting body and linked by a written agreement to an academic institution that is accredited by a national, state, and/or regional accrediting body. A formula- driven payment would be established for the training of the clinical training of advanced practice nurses taking into account the number of annual full-time equivalent participants in the program and the national average of costs of such programs in educating such a participant. Advanced practice nurses currently train in a variety of settings including hospitals, skilled nursing facilities, home health agencies, nurse managed care centers, ambulatory care facilities, health maintenance organizations public health departments and community health centers. Nursing programs and students currently incur the costs for the support of the clinical training of the advanced practice nurse education. Yet, these students are providing direct health care in a manner similar to medical residents. Funds should be available

to nurses in graduate nurse education programs to help them defray tuition and fees and provide student stipends, as well as the costs of faculty supervision at the provider site, and program expenses.

ANA also believes that the classroom costs incurred by rural and urban underserved providers should be considered for reimbursement. It has been demonstrated that nurses often provide care in underserved inner city or rural areas where no other provider is available. Thirty-one percent of all nurse practitioners report that greater than half of their patients are Medicaid recipients and eight percent of all nurse practitioners report that 50 percent of their clients are Medicare beneficiaries. Furthermore, 20 percent of all nurse practitioners report that more than 50 percent of their patients have no source of payments. Nurse practitioners also report that special populations comprised more than 25 percent of their patients in practice including the homeless, victims of abuse, culturally diverse patients with a non-Western orientation to health care, and substance abusers. Many clinical nurse specialists provide psychiatric services. Over 25 percent of all clinical nurse specialists report that greater than half of their patients are Medicaid recipients. Overall greater proposals of nurse practitioners and certified nurse midwives were found in urban undeserved and high poverty areas. Near 19 percent of all certified nurse midwives provide care in high poverty areas compared to 10 percent of all obstetricians/gynecologists. In high poverty areas, nurse practitioners and certified nurse midwives work predominantly in clinics and in rural undeserved areas, more than one third of these practitioners work in rural health centers.

Medicare beneficiaries in inner cities or rural areas are known to be able to access the health care delivery system less than their counterparts in other geographic areas despite the fact that they have a single payer system available to them. As managed care continues to grow and the Medicare system looks toward managed care as the cost saving salvation additional steps will be needed to allow this population to access their services. Advanced practice nurses play a critical role in providing care to the nation's elderly population.

THE NEED FOR RESEARCH

There is a need for additional data on the relationship between the workforce trends and advanced practice nurses. We request that Members of this Committee take the lead in establishing a graduate nurse education council to track workforce trends as they relate to the advanced practice nurse. In tracking such trends, the supply and demand for physicians and other health professionals should be assessed.

CONCLUSION

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

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Chairman THOMAS. Thank you very much, Ms. Johnson.
Dr. Kalkwarf.

STATEMENT OF KENNETH KALKWARF, D.D.S, DEAN, DENTAL SCHOOL AT THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO, TEX., ON BEHALF OF THE AMERICAN DENTAL ASSOCIATION AND THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

Mr. KALKWARF. Thank you very much for the opportunity to testify today.

My name is Ken Kalkwarf. I am dean of the Dental School at the University of Texas Health Science Center at San Antonio, and I am here today on behalf of the American Dental Association and also the American Association of Dental Schools.

It is my pleasure to discuss the need for continued and expanded Medicare support for graduate dental education. For almost 30 years, Medicare payments for graduate medical education have been vital to meeting the dental health personnel needs and enhancing the quality of care for Medicare beneficiaries.

The Association's first recommendation is for the continuation of GME funding for hospital-based graduate dental education programs.

Dental residents trained in hospitals have always been counted in GME funding. It is critical that this support continues. GME funding for dental residents is essential to meet the oral health needs of Medicare beneficiaries.

There are many oral health conditions that must be addressed prior to medical treatment of the elderly, the disabled, or the medically compromised. Bacteria from untreated oral infections complicate management of systemic disease and compromise success of medical therapy.

The hospital-based dental programs at my institution train residents in general dentistry, pediatric dentistry, and oral and maxillofacial surgery. The residents within these programs provide consultations for and treatment of patients receiving chemotherapy, head and neck radiation, organ transplants, joint replacement, and cardiovascular surgery, as well as providing consultations for patients with infections or chronic diseases.

In these GME-supported programs, dental and medical residents learn to work together as primary team providers.

The Association's second recommendation is that dental residents be included in direct GME inflationary updates. This would correct a current inequity. In the direct GME formula, primary care dental residency programs do not receive inflationary updates. Without these updates, it becomes difficult to sustain primary care dental residency programs.

Dentistry has few alternative sources of revenue. Many dental residents pay tuition for their postdoctoral primary care training. As a result, primary care dental residents may have educational debts greater than their medical colleagues. The excessive debt burden discourages some students from even applying for postdoctoral training.

The Association's third recommendation is that GME funding be extended to cover nonhospital graduate dental programs. Only

graduate dental programs located in teaching hospitals currently receive Medicare, direct GME, and IME support. This ignores the fact that substantial training takes place outside of the hospital. Dental residents at outpatient clinics provide a significant amount of uncompensated care to elderly and low-income patients, but these programs do not receive GME funding.

We urge the committee to consider providing Federal support to all accredited postdoctoral dental education programs, including those providing only outpatient care.

Mr. Chairman, we want to emphasize that oral health is an integral part of total health, and oral health care is an integral part of comprehensive primary health care. Therefore, graduate dental programs are a vital part of meeting the Nation's health care needs.

However, hospital dental programs and dental school clinics have unique financial problems which make delivering this care difficult. Federal reimbursement for dental services is extremely limited. As a result, hospital dental programs and dental school clinics have become a "safety net" for patients without insurance or resources to pay.

Unfortunately the increasing amount of unreimbursed dental care provided by these training programs puts them at serious financial risk.

A recent Institute of Medicine report recognized the valuable role of graduate dental training and its perilous financial situation. Medicare, DME, and IME are sources of ongoing support for these residency programs. Any significant reduction in direct GME or IME support will cripple the Nation's dental training infrastructure. In fact, without Medicare GME support, many hospital-based dental residency programs would close due to the high cost of training, unreimbursed care costs, and the lack of other funding mechanisms.

In summary, we recommend: First, continuation of GME funding for hospital-based dental education programs; second, inclusion of dental residency programs in the direct GME inflationary updates; and last, extending GME coverage to nonhospital graduate dental programs.

Through such a partnership with Medicare, these programs can continue to play their vital role in meeting the Nation's primary health care needs.

Thank you.

[The prepared statement follows:]

TESTIMONY OF KENNETH KALKWARF, D.D.S.
AMERICAN DENTAL ASSOCIATION

Thank you Mr. Chairman and Members of the Committee for the opportunity to testify today on behalf of the American Dental Association and its 140,000 members. I am Dr. Kenneth Kalkwarf, Dean of the Dental School at the University of Texas Health Science Center at San Antonio.

Introduction

The ADA endorses the goal of the Committee to develop a relevant and long-term policy on the role of Medicare in the support of health professions education. For almost thirty years, Medicare payments for graduate medical education have been vital to meeting the health manpower needs of our country while enhancing the quality of care for Medicare beneficiaries. Since the beginning of Medicare, dental residency training has been part of this funding mechanism. It is essential, we believe, that this assistance be continued. Our views on this important issue are based upon three fundamental propositions:

1) A direct link exists between a financially sound graduate dental education system and the provision of oral health care to the elderly, disabled, medically compromised and other special need populations;

2) Graduate dental education rests upon a fragile economic base;

3) Alternative sources of financing do not exist.

These factors compel, we believe, an adequate and predictable level of federal support through Medicare direct and indirect graduate medical education funding.

Before addressing more specific issues and recommendations with regard to Medicare and Graduate Medical Education payments, I would like to briefly describe the nature of oral health care provided to patients in these dental residency training programs.

Treatment of dental caries (decay) in children was the predominate concern of dentists in the past. Today, as a result of advances made in preventive oral health care over the last four decades, an increasing number of people are retaining their teeth for a lifetime. This change in the nature of dental disease requires today's dentists to master a broader range of treatments and to understand the implications of an ever-increasing number of medical conditions and prescription drugs on the oral health of patients, especially the elderly. Further, there is growing recognition of the importance of providing medically necessary oral health care.

Dental caries and periodontal diseases are bacterial infections which, like pneumonia and other bacterial diseases, require treatment. Oral cancer is more common than most people realize and kills more people each year than cervical cancer. Untreated dental diseases cause millions of hours of lost productivity and impede employability. Oral health affects general health and treatment of dental diseases is often a medical necessity.

For adults without dental coverage or the means to pay for care, teaching hospitals and dental school clinics serve as a dental "safety net". As in medicine, the hospital emergency room is often the major source of oral health care for the poor. The dentists and dental residents in hospitals serve this safety net function, and unless there is a dentist available, patients with dental problems will be given only temporary relief -- the underlying problem, still untreated, will resurface at a later time. Dental staff in these hospitals also provide numerous

consultations, mostly unreimbursed, on medically necessary oral health care needs.

Medically Necessary Oral Health Care

For the **Medicare population**, there are many oral health conditions that must be addressed prior to medical treatment. Medically necessary oral health care is a direct result of, or has direct impact on, an underlying medical condition. It includes care directed toward control and/or elimination of pain, infection, and reestablishment of function. There are a variety of serious diseases and conditions that can be complicated where oral health is not properly attended to.

- For those receiving radiation therapy, a dental abscess or infection frequently becomes uncontrolled and destroys the surrounding bone or even the jaw itself, leading to mutilation and sometimes death. Rampant decay is a common complication due to the destruction of the salivary glands.

- Bacteria from oral infections can spread through the blood stream and attach to heart valves of those with congenital or acquired heart defects and to other prosthetic replacements in patients. This results in death fifty percent of the time.

- For diabetics, any infection can be life threatening, because the infection exacerbates the diabetes and precludes control of elevated blood sugar levels. In this context, it is important to remember that periodontal diseases and dental caries are the most common infections in adults.

- **For** those with a blood disorder, gingival (gum) **bleeding** can be life threatening. Persons at risk **include** hemophiliacs and those with HIV disease.

- **Renal** transplant patients, those on chemotherapy, and anyone with an immune deficiency are vulnerable to the uncontrolled progression of the herpes simplex virus (fever blisters). The virus can spread to the brain and spinal cord in those who are immunosuppressed. When uncontrolled, this often results in death.

- For patients on chemotherapy, oral infections can spread unchecked through the blood stream because of the absence of natural defenses. Mouth infections are the most common infections in chemotherapy patients and are therefore a major cause of life threatening disease in these patients.

Unfortunately, many of the above services are provided without reimbursements from federal fundings or any other sources. Because Medicaid dental services for adults are optional rather than mandated, some states provide no dental coverage for adults and most of the remainder provide only emergency treatment or very limited restorative services. In addition, more states are considering eliminating adult dental services as the country's economic situation continues to strain state budgets. New York State would be an example.

Under Medicare part B, the dental care covered is extremely limited (essentially limited to treatment of traumatic injuries, oral pathology, and jaw surgery). Hospital dental programs cannot rely on Medicare patient revenues to support the programs. As a result, dental residency programs, which serve both the training function and a necessary patient care function, often provide free care because oral health services are not reimbursed.

Dental Residency Training: An Overview

Training for dental school graduates at the postdoctoral level (after dental school graduation) takes place at both dental school clinics and teaching hospitals. The programs that are relevant for discussion of Medicare DGME and IME are the eight recognized dental specialty programs and General Dentistry residency training programs. In 1993, the first year enrollment for all of these programs was 2,447, representing sixty five percent of the dental school graduates for that year. Unlike medicine, there are not enough dental residency positions for all dental school graduates.

The postdoctoral programs and their first year enrollment figures for 1993 are as follows:

Type of Program*	1st Yr. Enrollees (1993)	Length of Training (years)
Dental Public Health	17	1 or 2
Endodontics	155	2
Oral Pathology	8	3
Oral Surgery	213	4
Orthodontics	266	2
Pediatric Dentistry	173	2
Periodontics	188	3
Prosthodontics	201	3-4
General Dentistry	1,224	1-2

* A description of the various residency programs is appended.

General Dentistry training programs provide a one to two year clinical and scientific experience which provides residents with additional expertise in various dental specialties and hospital dentistry. General Dentistry residents learn to care for the oral health needs of those requiring specialized or complex care, such as the handicapped, developmentally disabled individuals, high risk medical patients, and those with infectious diseases. As a result, graduates of these programs refer to specialists less often, which is critically important in rural and underserved areas. Eighty seven percent of those trained in General Dentistry residencies remain in primary care practice. In 1993, there were 1,224 first year enrollees in these programs, but demand remains high as twenty five percent of the applicants were turned away.

Dental residency training also differs from physician training in that approximately one half of all positions are located in dental schools; the other half are in hospitals. Dental school clinics are not eligible for Medicare DGME funding. Of hospital dental training sites, only non-VA, non-DOD teaching hospitals receive DGME support. In 1993 approximately forty four percent of all postdoctoral dental residency training positions took place in hospitals supported by Medicare DGME and IME funding.

What does this mean in terms of federal support? One of the recommendations of the Institute of Medicine's recent study of dental education ("Dental Education at the Crossroads", released

January 17, 1995) directly addresses postdoctoral dental training policy:

> "The Committee recommends that postdoctoral education in a general dentistry or specialty program be available for every dental graduate, and that the goal be to achieve this within five to ten years, and that the emphasis be on creating new positions in advanced general dentistry ..." (Recommendation 7)

The Association would support the establishment of additional positions sufficient to meet need or demand.

Because Medicare DGME and IME funding provides for ongoing maintenance of these programs, continued inclusion of dental training in these formulae helps to maintain the hospital-based postdoctoral training positions that currently are provided. The Association also supports funding for start-up costs of such programs. This is critically important in assuring comprehensive care to patients and to the availability of a workforce able to meet the broad spectrum of patient needs.

Medicare DGME and IME: Impact on Dental Education and Needed Improvements

Given limitations in oral health care coverage described earlier, it is clear that patient care revenue is not sufficient to support dental residency training programs. Significant support from a host institution is required, and even the Medicare GME and IME that teaching hospitals receive can only meet a portion of the total costs.

While Medicare DGME and IME funding streams currently flow to the teaching hospital administration rather than directly to residency training programs, their continuance is vitally important to dental programs. If the dental residency training position "counts in the formula", there is less financial pressure from the hospital administration or threat of program closure. Often, directors of dental residency programs can point to such offsetting funds in making the case for continuation of their programs. These programs are often in a deficit situation absent such DGME/IME support, due to the indigent unreimbursed oral health care that is provided.

A 1994 survey of Medicare GME and IME's impact on 235 hospital dental training found that thirty percent have been threatened with closure due to financial hardship. These Medicare funds help the programs to continue despite an average thirty two percent shortfall in revenues to expenses.

Medicare Direct GME (DGME): DGME payments are based on a formula of full-time equivalent (FTE) residents multiplied by a per resident dollar amount and then multiplied by the proportion of hospital inpatient days used by Medicare patients in the particular hospital. Since the beginning of Medicare, hospital dental training has been part of this funding mechanism.

Under HCFA regulations, the GME formula counts a full-time resident for the time spent in a basic training period plus one year (basic training period means the time required to be eligible for board certification). The regulations make an exception for General Dentistry residencies, so these primary care residents are counted in the formula even though the training is not required for board certification (Federal Register, September 29, 1989, p. 40294). The other basic training periods (plus one year) for dental residencies are: Endo-3 years, Oral Path-4, OMFS-5, Ortho-3, Pediatric-3, Perio-4,

Prosth-4, Prosth Max- 5.[1] Only hospital-supported dental education programs receive this Medicare payment. Dental school-based residencies are not part of this reimbursement formula. Offsite residents can also be counted if the hospital incurs all or substantially all of the costs of such training.

Medicare Indirect Medical Education (IME): As the Committee is aware, the IME adjustment is provided to teaching hospitals to compensate for factors that increase their costs, such as a more severely ill patient population, severity of cases and weakness of the DRG system in recognizing this, and operating costs associated with education programs. As with Direct GME, IME payments are only made to teaching hospitals, and dental residents in hospitals count in the formula.[2]

There is movement toward having more training take place in outpatient or other ambulatory care settings. Innovative dental programs have been established at some hospitals, where dental residents rotate through community health centers. OBRA '93 allows residents in community health centers to be counted under IME if the residents are under the hospital's ownership or control and the hospital incurs all or substantially all of the costs of services furnished by interns and residents. Therefore, it is important for dental residents to continue to count in this formula. The ADA encourages expansions of General Dentistry training sites. These sites provide primary dental care to the unserved and underserved population. It is not possible to promote training in the ambulatory care setting without dental residents in the formula.

Problems and Recommendations:

While continuation of current Medicare DGME and IME funding is vitally important for dental education, there are two additional issues of concern that should be addressed:

(1) Dental programs do not receive an inflationary update under DGME; and

(2) Dental school-based residency programs receive no DGME support.

The Budget Reconciliation law of 1993 (OBRA 1993) defined primary care residencies as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. This medical-only definition reflected a goal to steer more physicians into primary care. The law provided that only these primary care residency positions would receive an annual inflationary update of the per residency amount in the Direct GME formula.

Unfortunately, this completely overlooks the critical primary health care role played by dental residents. For most Americans, the primary care team includes a physician and a dentist. If either is unavailable, the patient has an access problem, as treatment of the entire body must include the oral cavity. The incomplete definition of primary care used for the inflation update was taken from a Public Health Service training definition explicitly limited to a medical loan program. In fact,

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[1]The citation for inclusion of hospital dental residents in Medicare DGME is: 42 CFR (Code of Federal Regulations) § 413.86, referencing § 405.522 (a).

[2]The citation is 42 CFR § 412.105 (g)(i)(A), referencing § 405.522 (a).

contemporaneous report language accompanying the 1992 reauthorization of health professions programs shows that the committee recognized dentistry as a primary care component of practice:

> "The Conferees have tied receipt of Federal scholarship funds to the completion of primary care training programs and the practice of primary care . . . After graduation from allopathic or osteopathic schools of medicine or dental school, the individual must enter general dentistry practice, or will have five years to complete a residency program in either family medicine, general pediatrics, general internal medicine, or general dentistry."

The recent IOM report on dental education specifically states, under the first of eight "Policy and Strategic Principles" that **"[o]ral health is an integral part of total health, and oral health care is an integral part of comprehensive health care, including primary care."**

Further, if GME policy is further modified to "weight" or re-direct DGME funds toward "primary" care, **use of this same definition would cripple the dental residency training infrastructure of this country.**

While policymakers may be pleased to know that dental education does not have such a specialty oversaturation problem as in medicine, we urge that Congress not adopt policies that might disrupt the balance that has been maintained, and we urge support for development of generalists.

At the very least, General Dentistry and Pediatric Dentistry residency training should be included in any primary care funding preference because they are the dental parallel to family medicine and pediatric medicine. Oral and maxillofacial surgeons also play a primary care role when they are the only dental residents in a hospital, and their training programs should be supported.

We would like to work with the committee to correct the inflation update problem, and with regard to any other funding preferences that may be proposed.[3]

Our second recommendation is to correct the inequity that has long existed under Medicare DGME, by extending support to dental school-based residency programs. This would recognize the role that dental school-based residents play in treating underserved populations, including low income and elderly patients. A recent preliminary study of dental school clinics prepared for the American Association of Dental Schools (AADS) found that the median household income of clinic patients was $13,800 -15,600 per year, with two-thirds reporting a household income of $20,000 or less. Eighteen percent of the patients were age 65 and over. AADS estimates that over 600,000 Medicare eligible individuals are treated each year in dental school clinics. It is sensible federal policy for Medicare to pay its fair share of these training costs.

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[3] If the statute is amended this year there should also be a technical correction to delete references to programs that are "approved by the Council on Dental Education of the American Dental Association" (existing language from the Medicare statute and regulations (42 CFR § 405.522 (a)). The Council on Dental Education no longer "approves" programs. In 1975 the Commission on Dental Accreditation (CDA) became the accrediting agency for dental, most postdoctoral, and allied dental education programs.

For federal health professions training policy, the ADA recommends that Medicare's DGME support be expanded to all accredited postdoctoral dental programs.

Thank you Mr. Chairman for your consideration of the Association's recommendations. I would be pleased to answer any questions at this time.

Chairman THOMAS. Thank you very much, doctor.

Dr. Jones, if you would allow us to catch this vote and then come back, we would be pressed if we gave you the full time for your testimony, and I want to, so if you would allow us, the subcommittee will stand in recess until we hurry back.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene. And, Dr. Jones, you may proceed.

STATEMENT OF CHARLES L. JONES, D.P.M., PRESIDENT, AMERICAN PODIATRIC MEDICAL ASSOCIATION

Mr. JONES. Thank you. Mr. Chairman, members of the subcommittee, I am Charles Jones, president of the American Podiatric Medical Association.

As one who has devoted much of his professional life in postdoctoral podiatric medical education, I welcome this opportunity to appear before this subcommittee today on the subject of graduate medical education, a vision for the future.

It is my purpose, Mr. Chairman, to acquaint the subcommittee with podiatric's role in GME and why continued Federal participation in graduate medical education is vital if high-quality health and medical services are to be maintained and strengthened.

Since January 1, 1973, following the Social Security amendments of 1972, postdoctoral residency programs in podiatric medicine and surgery have benefited from both direct and indirect GME payments under Medicare. Based on our best available information, we estimate that as of November 1994, 210 teaching hospitals with 800 residency slots in 29 States and the District of Columbia received Medicare payments for the direct costs of these programs.

Additionally, 46 VA hospitals and 3 military hospitals additionally train 160 podiatric medical residents, although these training programs are funded by those Federal agencies, not Medicare.

Suffice it to say that we believe very strongly that podiatric medical residency programs must continue to have access to funding, including access to any new funding mechanisms that ultimately replace or supplement that currently in effect under Medicare.

Among other things, completion of an approved residency program is now seen as an essential component of training of a doctor of podiatric medicine. A 1992 resolution adopted by the American Podiatric Medical Association house of delegates, for example, makes clear that colleges of podiatric medicine should prepare their graduates for entry-level postgraduate study, not for entry-level practice.

Equally important, an increasing number of States have begun to require a minimum of 1 year postgraduate education or residency for licensure as a doctor of podiatric medicine. As of 1994, 35 States imposed such a requirement.

The basis for any change in GME financing schemes begins with the well-known fact that there are considerably more allopathic medical residency positions than there are graduates of U.S. schools of medicine with these excess positions being filled by foreign medical graduates.

For example, the Council on Graduate Medical Education has suggested limiting the number of residency positions to 110 percent of the number of allopathic medical school graduates.

In the case of podiatric medicine, however, there are no foreign medical graduates. Since to practice in the United States one must have had to successfully complete a course of study at one of the seven U.S. colleges of podiatric medicine.

Hence, the profession's longstanding goal has simply been to provide an adequate number of residency positions to accommodate all graduates of its colleges. This goal was finally achieved in 1991.

But as recently as 1988, there were only enough residency training positions to meet the needs of about 69 percent of the podiatric medical college graduates. And this year we again expect to fall short of being able to fulfill about 10 percent of our postdoctoral training program needs.

Thus, unlike allopathic medicine, there are no excess residency positions, and the positions which do exist are filled by graduates of U.S. colleges of podiatric medicine.

A second premise some employ in debating the need to alter graduate medical education payment schemes is that there are too many allopathic and osteopathic physicians.

The Council on Graduate Medical Education has spent considerable time and effort attempting to document physician supply and demand and identifying the types of allopathic and osteopathic physicians expecting to be in an oversupply in the coming years.

In contrast, the Council on Graduate Medical Education has not examined the supply of and demand for podiatric physicians. In fact, no government body has determined that an excess supply of doctors of podiatric medicine is in the offing.

In 1981, the U.S. Department of Health and Human Services established an ideal ratio of 6.2 podiatric physicians per 100,000 population.

Much more recently the Bureau of Health Professions of the U.S. Public Health Service contracted with the National Center for Health Statistics to obtain baseline data on foot care needs in the general population. This was done as part of a 1990 national health interview survey.

In comparison, podiatric physicians accounted for 4.5 percent of all medical and surgical services provided to Medicare patients by all physicians in 1991. Doctors of podiatric medicine, in fact, provided the majority of foot care services needed by Medicare beneficiaries, and this population continues to increase about 2 percent per year.

In conclusion, Mr. Chairman, the Association does not envy the difficult but necessary task this committee, indeed, has. The Congress faces encountering the Nation's enormous debt and its mounting annual deficits. Sacrifices, we know, will be required of each of us if these larger issues are to be successfully addressed.

But if future generations of Americans are to be guaranteed appropriate access to well-trained physicians, it is absolutely essential that we maintain and strengthen our medical education system, including its residency training component. Postdoctoral residency training, including its supervisory component, requires substantial time and commitment and must be compensated.

The American Podiatric Medical Association believes that all third-party payers, including Medicare, should proportionally share the cost of supervision and related educational costs. This is absolutely essential to help ensure high-quality patient care and to preserve high-quality postdoctoral training.

Thank you.

[The prepared statement follows:]

TESTIMONY OF CHARLES L. JONES, DPM
AMERICAN PODIATRIC MEDICAL ASSOCIATION

Mr. Chairman, Members of the Subcommittee:

I am Dr. Charles Jones, President of the American Podiatric Medical Association, and a private practicing podiatric physician in Chicago, Illinois. As one who has devoted much of his professional life in post doctoral podiatric medical education, I welcome this opportunity to appear before this subcommittee today on the subject of Graduate Medical Education (GME) -- A Vision for the Future. It is my purpose, Mr. Chairman, to acquaint the subcommittee with podiatric medicine's role in GME and why continued Federal participation in graduate medical education is vital if high quality health and medical care services are to be maintained and strengthened.

Podiatric Medicine and GME

As you noted in the press release announcing today's hearing, Medicare has since its inception reimbursed teaching hospitals for the program's share of costs for the training of physicians and other health professionals. But it was not until the Social Security Amendments of 1972 that podiatric physicians became eligible for Medicare's GME benefit. Since January 1, 1973, post doctoral residency programs in podiatric medicine and surgery have benefited from both direct and indirect GME payments stemming from Title XVIII. Based on our best available information, we estimate that as of November, 1994, 210 teaching hospitals with 800 residency slots in 29 states and the District of Columbia received Medicare payments for the direct costs of these programs. Additionally, forty-six Veterans Administration hospitals and three military hospitals additionally train 160 podiatric medical residents, though these training programs are funded by those Federal agencies, not Medicare.

Suffice it to say that we believe very strongly that podiatric medical residency programs must continue to have access to funding,

including access to any new funding mechanism that might ultimately replace or supplement that currently in effect under Medicare. Among other things, completion of an approved residency program is now seen as an essential component of the training of a doctor of podiatric medicine. For example, a special consensus panel convened in March, 1992, by the Liaison Committee on Podiatric Medical Education and Practice concluded that "One year of 'postgraduate' training is necessary to enter either the private practice of or advanced specialty training in podiatric medicine." Further, a 1992 resolution adopted by the APMA House of Delegates makes clear that colleges of podiatric medicine should prepare their graduates for entry level postgraduate study, not for entry level practice. Finally, an increasing number of States have begun to require a minimum of one year postgraduate education or residency training for licensure as a doctor of podiatric medicine (DPM). As of 1994, 35 States imposed such a requirement.

Restructuring GME Financing

The basis for any change in GME financing schemes begins with the well known fact that there are considerably more allopathic medical residency positions than there are graduates of U.S. schools of medicine, with these "excess" positions being filled by foreign medical graduates. For example, the Council on Graduate Medical Education (COGME) has suggested limiting the number of residency positions to 110 percent of the number of allopathic medical school graduates.

In the case of podiatric medicine, however, there are no foreign podiatric medical graduates, since to practice in the United States one must have successfully completed a course of study at one of the seven U.S. colleges of podiatric medicine. Hence, the profession's longstanding goal has simply been to provide an adequate number of residency positions to accommodate all graduates of its colleges. This goal was finally achieved in 1991; but, as recently as 1988, there were only enough residency

training positions to meet the needs of about 69 percent of podiatric medical college graduates. But this year we again expect to fall short of being able to fulfill about 10% of our post doctoral training program needs. Thus, unlike allopathic medicine, there are no "excess" residency positions; and the positions which do exist are filled by graduates of U.S. colleges of podiatric medicine.

Assuring a match between the number of residency positions and the number of podiatric medical college graduates has been complicated somewhat, due to a decline in the applicant pool, by relatively recent fluctuations in first year enrollments in the nation's podiatric medical colleges. For example, while first year enrollments gradually rose throughout the first half of the 1980's to peak at 815 in 1986, the number of such students had declined to 561 by 1990. Of note, the Seventh Report to the President and the Congress on the Status of Health Personnel in the United States, March 1990, argued that one reason for the declining enrollments was "applicant awareness of an insufficient number of residency slots to accommodate graduates."

A second premise some employ in debating the need to alter graduate medical education payment schemes is that there are too many allopathic and osteopathic physicians. The Council on Graduate Medical Education has spent considerable time and effort attempting to document physician supply and demand, and identify the types of allopathic and osteopathic physicians expected to be in under - or oversupply in the coming years.

In contrast, the Council on Graduate Medical Education has not examined the supply of, and demand for, podiatric physicians. In fact, no government body has determined that an excess supply of doctors of podiatric medicine is in the offing. In 1981, the U.S. Department of Health and Human Services established an ideal ratio of 6.2 podiatric physicians per 100,000 population. This ratio was

developed as part of the Health Professions Requirement Model, a Federal econometric study. In comparison, the actual 1991 ratio was about 5.0 podiatric physicians per 100,000 population.

Much more recently, the Bureau of Health Professions of the U.S. Public Health Service contracted with the National Center for Health Statistics to obtain baseline data on foot care needs in the general population. This was done as part of the 1990 National Health Interview Survey. This survey of 46,476 households, comprising 119,631 individuals, found that one of every six Americans suffered from foot problems in the twelve months preceding their interview and one of every sixteen Americans deemed their problem serious enough to consider getting professional care. However, more significantly, only 55 percent of those who considered their foot problem serious enough to warrant professional care actually received such care. Of these, 47 percent were seen by a doctor of podiatric medicine for an estimated total of more that 14.5 million patient visits.

In comparison, podiatric physicians accounted for 4.5 percent of all the medical and surgical services provided to Medicare patients by all physicians in 1991. Doctors of podiatric medicine, in fact, provide the majority of footcare services needed by Medicare beneficiaries, and this population continues to increase by about 2 percent each year. For example, in 1991, doctors of podiatric medicine performed 98.5 percent of nail debridements, 82.3 percent of hammertoe operations, 72.5 percent of bunionectomies, and 55.4 percent of rearfoot surgery required by Medicare beneficiaries.

The third premise underlying proposed changes in graduate medical education financing and related initiatives is that there are too many specialists and not enough primary care practitioners. While podiatric medicine is not included in the list of primary care specialties cited in a variety of Federal statutes, the

reality is that doctors of podiatric medicine "often serve as the entry point into the health care system for patients with systemic diseases that manifest themselves by symptoms in the feet," as emphasized most recently in the Eighth Report to Congress on Health Personnel in the United States, published September, 1992, by the U.S. Department of Health and Human Services. Doctors of podiatric medicine also provide a large number of primary care services (as defined in section 1842(i) (4) of the Social Security Act). In fact, evaluation and management services accounted for about 24 percent of the Medicare allowed dollars paid to doctors of podiatric medicine in 1991. Further, the Health Professions Education Assistance Act, when reauthorized in November, 1988, specifically included support for new primary care residency training programs in podiatric medicine. Ten such programs were initially funded, under which about 44 residents are being trained each year. Finally, among the three recognized specialty boards in podiatric medicine is the American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

In short, it would appear that two of the premises underlying proposed changes in graduate medical education financing--excess number of residency positions and practitioner oversupply--do not apply to podiatric medicine. The third--the need for more primary care practitioners--may have unique implications in the case of doctors of podiatric medicine. We believe that policymakers should be mindful of these distinctions as they weigh the need to alter support for graduate medical education.

CONCLUSION

To conclude my testimony, Mr. Chairman, the Association does not envy the difficult but necessary task this committee, indeed, the Congress, faces in countering the Nation's enormous debt and its mounting annual deficits. Sacrifices, we know, will be required of each of us if those larger issues are ever to be

successfully addressed. But if future generations of American are to be guaranteed appropriate access to well trained physicians, it is absolutely essential that we maintain and strengthen our medical education system, including its residency training component. Post doctoral residency training, including its supervisory component, requires substantial time and commitment and must be compensated. The APMA believes that all third party payers, including Medicare, should proportionately share the costs of supervision and related educational costs. This is absolutely essential to help ensure high quality patient care and to preserve high quality post doctoral training programs.

Chairman THOMAS. Thank you, Dr. Jones. You indicated that podiatric doctors receive their training in other Federal funded programs other than obviously through the graduate medical education structure?

Mr. JONES. In the V.A. hospitals and the military.

Chairman THOMAS. And, Dr. Kalkwarf, I assume dentists are involved in that as well?

Mr. KALKWARF. Yes. We have some individuals who do train through DOD funding or VA funding.

Chairman THOMAS. A rough percentage?

Mr. KALKWARF. Approximately half of dental residents will be provided training through some sort of Federal support, about 44 percent through GME funding, a small percentage of DOD and VA, and then the other half are funded privately.

Chairman THOMAS. OK. So about, well, less than 10 percent of those that get to Federal funding come into those other programs.

Ms. JOHNSON. Approximately.

Chairman THOMAS. So the bulk come from GME funding.

We have been supplying this graduate medical education funding obviously since—well, for more than a decade, more than two decades actually.

Is the thrust of your statement that there are not enough residency slots for you folk and that we should give more money so that there would be more slots?

Mr. JONES. There are not enough podiatric residency slots for all the current graduates. And, of course, then you fall into quality of program. We have, the profession——

Chairman THOMAS. But if we put more money into it, does that then produce more slots? If someone is controlling the determination of who gets what slots, and there are not enough slots now, why is adding more money going to produce the slots?

Mr. JONES. It would not necessarily do that. We have spent the last 10 years educating the hospitals to the direct and indirect costs through Medicare, and that is how we have increased the number.

Chairman THOMAS. That is my connection. We have got to work on the folks who are writing programs——

Mr. JONES. That is right.

Chairman THOMAS [continuing]. In terms of the importance both of the dentistry and the——

Mr. JONES. That is correct.

Chairman THOMAS. Now in relation to that, where do you folks fall in this movement toward managed care? Is there—is dentistry being incorporated as part of that?

It would seem to me that if you have a managed care program with a decent preventive care program, dentistry is going to be a key part of that. Am I wrong?

Mr. KALKWARF. No. In certain parts of the country, managed care is starting to play a role. In other parts, it is not. It is lagging behind the medicine managed care model that we are seeing progressing throughout the country.

You know, it is our premise that we need to train individuals in dental education and the general practice programs and the dental specialty programs to be able to function within a managed care market, as well as the private market also, because we are going to have a mix in the future obviously.

[The following was subsequently received:]

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Dental
Association

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April 10, 1995

The Honorable William Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Thomas:

The American Dental Association appreciates the recent opportunity to testify before the Subcommittee concerning future support for Graduate Medical Education.

During the course of the March 23 hearing, you asked several important questions regarding dentistry and managed care. The issues raised are timely and relevant to the debate on health system reform. Your inquiry is particularly appropriate as individual States seek to convert their Medicaid programs into capitated systems.

The purpose of this letter is to briefly expand upon our responses provided at the hearing. We hope the following, additional information will be of value to the deliberations of the Subcommittee.

Dentistry and Managed Care

The Association believes that Congress must understand and accommodate the significant differences between medicine and dentistry as it addresses the issue of managed care. Dental disease is chronic, progressive and destructive. It is also almost entirely preventable through regular examinations and early interception. Americans saved nearly $100 billion in dental care costs during the 1980's through the profession's emphasis on preventive oral health measures. Managed care in the capitated model is designed to respond to and treat medical diseases; conditions which are generally episodic, but also potentially life-threatening and catastrophic in cost.

A basic element of managed care is the gatekeeper. This concept is designed in part to "guide" the patient through the maze of physician specialty and subspecialty care. By contrast, 80% of dental services are provided at one site by one primary care practitioner.

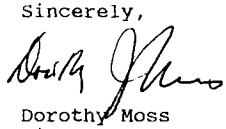
Dentists, of whom over 80% are primary care providers, already serve as gatekeepers for the patient when referrals are necessary.

Most telling, however, is the underlying incentives in the managed care model to limit utilization. This is a consequence of a financing system which--absent deductibles, copayments and other out-of-pocket expenses--often insulates the patient from economic decisions regarding health care services. Gatekeepers, limited choice of practitioners, designated sites for care and lower, capitated reimbursement rates for participating providers can serve as the cost-containment mechanism by creating barriers to patient care.

In contrast, the traditional fee-for-service dental model is cost-effective because it (1) encourages patient visits to prevent oral disease and allow early therapeutic intervention, and (2) involves consumers directly in the cost of dental care. Today's patients pay almost 53 percent of the national dental bill out-of-pocket. The result is, at once, a dramatic rise in the oral health status of those who receive regular dental care and a steady decline in expenditures for dental services as a percent of total health care spending.

The American Dental Association respectfully requests the inclusion of this letter in the formal hearing record of March 23, 1995.

Sincerely,



Dorothy Moss
Director
Washington Office

DM:SK:klp

Chairman THOMAS. And do you think you would be helped if there was a clear focus on a bank of specialists available to back up the gatekeepers in their decisions as to which path an individual should take in terms of whether or not it is, first of all, mental, physical, and then whether or not dental would assist?

I would assume that to the degree we have the opportunity to fall back on—in fact, rely on—second opinions, if you will, within the managed care structure, that you folks would then be seen to be more valuable than you would otherwise.

Mr. KALKWARF. One thing we have to remember is that in dentistry, as compared to medicine, the majority of our practitioners are general practitioners; 80 percent of them are general practitioners. So we do not see the same type of mix in the relationship on the dental side that we do on the medical side at this point in time.

Chairman THOMAS. But when I say "specialty," I really mean specialty as dentists versus others, and that perhaps some of that dental work might be necessary to deal with, you know, symptomatic relief rather than others.

What about podiatric medicine? How is that fitting in in managed care?

Mr. JONES. Throughout the United States, there are quite a few podiatrists on panels and in managed care. But proportionally, they are really squeezed out. And they are especially squeezed out if the managed care organization has financial incentives to the primary care physician, because they do not refer, no matter what.

I have attended several meetings where now the primary care physician is expected to treat most of the common medical conditions—I am not talking about just feet—for at least two or three or four visits until they are assured that they need other triage.

Well, if you are going to keep the patient for three or four visits, the average practitioner outside is not going to get that patient at all.

Another thing that they are doing, another wrinkle that is coming, is that the family practice people are hiring physician assistants and nurse practitioners to administer the more common care, billing at a lower service code, and that lowers the cost.

So there are many factors out there that are affecting the ability of the ordinary practitioner to participate in managed care.

Chairman THOMAS. But you are not opposed, are you, to someone who is adequately professionally trained to perform a service, that if it is not necessary to have a medical degree to perform, that they ought to be allowed to perform it, are you?

Mr. JONES. As long as it is quality work and you are not, you know, going to endanger the patient.

Chairman THOMAS. Of course.

Mr. JONES. I think there are concerns now, and I think some of the panelists this morning said that the primary care physician is not trained in all the conditions. And the managed care organization is suggesting that they go back for a mini-residency, so that they are more adept at treating these things.

And I think you will see that medically, legally, they are going to make some mistakes, which would be normal, and as soon as they lose—as far as podiatry, as soon as they lose a couple of legs—and a leg now is worth about $1 million here in the States—I think

there will be, you know, really some concerns about what they are doing.

Chairman THOMAS. OK. I was going to try to move, then, over to Ms. Johnson, because clearly their concern is that there are a number of things that can be done by professionals in the health care industry that are not allowed to be done or historically have not allowed it to be done because of the historical role of the doctor.

But I guess, Ms. Johnson, my question to you is: Why should we elevate the training of these folk when we have in certain areas—and I guess anesthesiologists would be my best example—why should we take some of these folk and give them advanced training in anesthesia when we already have anesthesiologists who are out of work?

And it seems to me that in moving this structure, you move this way, you have got folks who are getting better training if you had room for those folks who move up. But you do not; they are out of a job.

Why should you not just as easily move in this direction and have doctors performing functions that historically doctors tend not to perform, because they would not have a job otherwise?

And frankly my goal is to push ends this way and provide more folk in that edging between doctors and health professionals in more of that managed care setting that can perform more.

And I think your goal is similar to theirs in terms of finding slots and educational positions for these people who can pursue this advanced training.

In the Medicare area, what percentage—ballpark, if you do not have it fairly precisely—or give me some general feeling of the proportion or percentage of Medicare patients that receive their care from these advanced practice nurses. Do we know?

Ms. JOHNSON. In terms of percentages, it would be difficult for me to even "guesstimate."

I will tell you a large percentage of advanced practice nurses provide gerontological care. We focus a lot in terms of our primary care—our transition to managed care has probably been easier in some aspects because we have always focused on prevention and health maintenance, so-called wellness care, as opposed to always focusing on illness care.

So when you talk about the fact that, for example, with registered nurse anesthetists, someone mentioned earlier that the largest percentage, somewhere in the neighborhood of about 80 percent of anesthetic services in rural areas where there is a great need for care, is provided by nurse anesthetists.

I think there is enough work, enough care needs, given our Nation's status related to health care at this point, that a collaborative approach that involves all of us—and I think you mentioned this a while ago—is the most effective way of approaching it, as opposed to saying one discipline needs to do it all, and others do none.

Chairman THOMAS. Then if you have got doctors who are out of work, but they choose not to move where the work is, and the nurses do, that is a decision in the marketplace.

What about home health care? Is that an area that looks to you folks as a really growth market?

Ms. JOHNSON. As a matter of fact, one of the things that we are focusing on in nursing is the fact that a lot of health care is moving from the hospital into the community.

In listening to the comments of nurses, one of the reasons that the BSN-prepared nurse and the advanced practice nurse are such critical pieces to health care delivery is that a lot of their focus is on moving that health care from the hospital into the community and into home health, into the workplace, into familiar community settings that make it easier to ensure access to health care.

Chairman THOMAS. And not only the traditional caring and supportive role, but the manipulation of various devices, infusion and others, which I think is a kind of a natural fitting. If you are going to have somebody drop by the home, they are going to have to have a degree of that training.

Ms. JOHNSON. It certainly is more cost effective, yes.

Chairman THOMAS. Yes, yes. Does the gentlewoman from Connecticut have anything?

Mrs. JOHNSON OF CONNECTICUT. I appreciate your testimony.

And hearing in the context of our responsibility to better fund medical education the spectrum of training situations that we have to be certain that the new system will meet, I think your testimony is evidence of how hard it has been to break into the existing system, and really at what risk, your training where it has broken in—to what degree it still is at risk, particularly in a period in a change.

So I think your testimony will be very useful to us and is further proof that we need to have a more uniform systemic approach to fostering the development of medical knowledge amongst practitioners and enabling the system thereafter to better integrate skilled practitioners into systems of care that can deliver appropriate and affordable care.

And I appreciate your testimony today.

Chairman THOMAS. With that, I want to thank the panel for your patience as well. The information was very, very helpful to us.

And the subcommittee stands adjourned.

[Whereupon at 1:35 p.m., the subcommittee was adjourned.]

[Submissions for the record follow:]

AMERICAN OSTEOPATHIC HEALTHCARE ASSOCIATION

Statement of
THE AMERICAN OSTEOPATHIC HEALTHCARE ASSOCIATION
For the Record of the March 23, 1995 Hearing
on Graduate Medical Education
Subcommittee on Health, Committee on Ways and Means
U.S. House of Representatives

The American Osteopathic Healthcare Association represents osteopathic hospitals and related institutions nationwide. Seventy percent of our member hospitals sponsor one or more graduate medical education (GME) programs. We are vitally concerned with GME training and believe it is essential that Medicare continue to support it as competitive pressures drive third-party payments downward, thus virtually eliminating whatever support the private sector has heretofore implicitly provided for graduate medical education.

We believe that osteopathic GME programs are especially worthy of support and that harm to them would be a loss to the Nation. Most of these programs are community-hospital based. They train generalist (as well as specialty) physicians in the type of environment in which they will eventually set up practice rather than in a distant tertiary-care medical complex. Our programs turn out a high proportion of primary care physicians. Nearly 60 percent of osteopathic physicians practice in primary care fields. And osteopathic physicians are more likely than their MD counterparts to practice in underserved areas.

We believe that, ideally, all those who pay for health care services should explicitly contribute toward the cost of graduate medical education, but we recognize that an all-payer approach is not likely to be part of whatever incremental health care reform the Congress will adopt in the near future. Therefore, we assume that the issue now is what Medicare's policy toward GME will be during a period when it is necessary to make significant reductions in Medicare program cost.

Recognizing that the area of graduate medical education will not escape budget cuts, we believe that the cuts should respond to physician workforce concerns. A major problem is an overall excess supply of physicians. From the standpoint of both workforce policy and Medicare cost control, there is cause for concern regarding the continuing increase in the total number of residency positions that Medicare is supporting. The Council on Graduate Medical Education (COGME) has recommended an annual limit on the number of first-year residency positions equal to 110 percent of the number of medical school graduates (allopathic and osteopathic). If this recommendation were applied to Medicare funding, it would produce significant savings over present policy, which provides financial support for whatever residency positions are actually filled.

It is important to recognize that international medical graduates (IMGs) make up a major part of the increased number of residents-in-training. For 1993-94, IMGs were about 39 percent of residents. For 1990-91, they were about 30 percent. It is time to recognize specifically that the large numbers of international medical graduates is a problem for physician workforce policy and for Medicare payment policy. One way to respond would be to limit Medicare support to 110 percent of medical school graduates and to specify that the additional 10 percent is for IMGs. Room would be provided for 100 percent of American graduates. Without this specification, limiting the overall number of supported positions might mean depriving some American graduates of training positions while providing them to IMGs. There is little reason to do that, since we know that the quality of American medical school training and its graduates is universally high, which can not be said with the same confidence regarding IMGs and their training. In imposing a 110 percent limit, Medicare would be acting as a prudent purchaser and would be doing so in a way that is consistent with the physician workforce needs of the Nation.

We also encourage the Subcommittee to consider three GME policy changes that make sense and that can be accomplished within an overall policy of spending reduction.

- **Indirect medical education adjustment:** Consider redesigning the adjustment to eliminate the tie to inpatient beds, a tie which seems inappropriate as both the appropriate site of care, and the training needs of residents, move to outpatient settings.

- **Adjusted average per-capita cost (AAPCC):** Redefine the adjustment, used to calculate payments to Medicare risk-basis HMOs, to remove from the area cost figures the cost of graduate medical education. By and large, HMOs are not supporting GME programs and assuming that they do produces excessive payment.

- **Direct medical education base year:** Per-resident amounts derived from the costs each institution had in 1984 are becoming increasingly outdated and inappropriate. For osteopathic training programs, the 1984 base year produces serious inequities. Osteopathic hospitals in 1984 relied much more heavily on volunteer faculty than they do today. Now they need to make much greater use of paid faculty and they need to provide competitive stipends for physician trainees. Use of the 1984 base period makes this difficult, since it takes no account of the relatively greater expenses that osteopathic GME programs now incur. We have consistently urged, in testimony before public bodies such as COGME and the Physician Payment Review Commission, that this problem be addressed and we again recommend that per-resident amounts be based on an adjusted national average of per-resident costs.

Thank you for the opportunity to present the views of the American Osteopathic Healthcare Association.

TESTIMONY OF AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychologists as Health Professionals

The American Psychological Association (APA) is the largest scientific and professional organization representing psychology in the world. APA's membership includes more than 132,000 researchers, educators, clinicians, consultants, and advanced students. APA's mission is to advance psychology as a science and profession and also as a means of promoting human health and welfare. Psychologists study human behavior and experience and apply that knowledge to solving human problems. As an association, APA has a long history of involvement in social policy related to human behavior and human welfare. Beyond their historic role in basic research on human behavior, psychologists represent a significant force in the provision of health care services to the public:

- Psychologists provide outpatient services for mental health conditions, and for general health conditions with a significant behavioral component, in community agencies, health maintenance organizations, school systems, mental health centers, counseling centers, and independent individual and group practices.

- Psychologists provide inpatient services in municipal settings such as federal, state, county, and city hospitals, as well as at private mental hospitals.

- Psychologists also serve on the staff of psychiatric units in general hospitals.
- Psychologists provide liaison services to medical units in general hospitals, since many physical conditions are stress related, have a significant behavioral component, or benefit from assistance with psychological interventions.

- Psychologists work in residential treatment centers and in rehabilitation centers, as well as in many corporate settings that provide mental health or drug and alcohol services to employees.

Consumers of psychological services include individuals, families, public and private organizations, employers, institutions, and third party payers.

The purpose of this testimony is to describe how psychologists function as primary care providers and to explain why psychologists are essential to the provision of quality comprehensive health care throughout our nation. Accordingly, it is critical that psychologists be included in the Medicare Graduate Medical Education (GME) program.

Psychologists as Primary Care Providers

Psychology, as the science of human behavior, serves a critical role in promoting health, preventing disease and assessing and treating illness. Not only do psychologists diagnose and treat recognized mental health problems, they are essential in treating the cognitive, emotional and behavioral aspects of many general health problems.

Many patients who visit a physician do so because of symptoms they have developed as an expression of psychological distress (Sobel, 1993). Symptoms such as depression, anxiety, headache, and exhaustion, are among the most common reasons for a visit to the doctor -- and all of these conditions are responsive to behavioral health interventions. Indeed, in clinical practice, at least 30% of patients who see a physician may have conditions for which no physiological or organic cause is found after routine investigation (Wilson, 1995).

Most major health problems -- heart disease, cancer, high blood pressure, stroke, and diabetics -- are caused by factors which require biopsychosocial interventions (CMHS, 1994). Successful health care requires intervention at both the biological and the behavioral aspects. Both the Surgeon General and the Institute of Medicine have observed that 6 of the 10 leading causes of death in the United States which account for 50% of all mortality, are, in part, behaviorally determined. Psychology, as the science of behavior and behavior change, is uniquely positioned to contribute to the solutions of these chronic health problems (Olmedo, 1994).

A number of researchers have shown that psychological intervention can contribute significantly to both psychological and physical health outcomes in patients with cancer (Fawzy, 1995). Aware of the benefits of these psychosocial therapeutic interventions, today's patients often specifically request such services. Interventions that are designed to help the person feel less helpless and hopeless have the added benefit of encouraging more responsibility to get well and comply with medical regimens. Further, as survival rates have improved with advances in

medical care, the importance of psychological interventions designed to assist cancer patients in dealing with diagnosis and treatment has increased (Fawzy, 1995).

Interventions developed by psychologists have proven effective in the management of different health problems, including: asthmatic episodes, irritable bowel syndrome, vasospasms associated with Raynaud's Disease, dyspnea with chronic obstructive pulmonary disease, severe headaches, and muscle spasms, insomnia and other sleep disorders, gastrointestinal ulcers, post-mastectomy and heart attack. These services have developed in conjunction with the shift in medicine from the treatment of infectious disease to the management of chronic disease. They are health care services provided daily by clinical health psychologists, and fundamental to the provision of quality, cost effective health care. Belar (1994) has argued convincingly that these services relate to the emotional and behavioral aspects of many medical problems, including:

(a) coping with illness and stressful medical procedures,
(b) the impact of stress on disease,
(c) compliance with medical regimens,
(d) the management of pain
(e) the regulation of psychophysiological symptoms,
(f) the physician-patient relationship, and
(g) the prevention of disease (through behavior change such as smoking cessation, weight management and safe sex)

Coronary heart disease is the major cause of death and disability in the Western world. One of the most comprehensive studies of behavioral interventions in severe heart disease patients has now demonstrated significant and clinically meaningful decreases in LDL cholesterol (37%), systolic blood pressure (134 to 127 mmHg), angina pain (90%), and vessel blockage on angiogram in 18 of 22 patients. Over the same year, the control group receiving standard medical treatment experienced a 165% increase in angina pain, and angiograms revealed that nearly half of the patients had increased artery blockage (Ornish, 1990).

Research related to asthma, the major cause of disability in children, is also illustrative. Research has demonstrated that a course of family therapy focused on the behavioral management of symptoms, plus systematic relaxation training, resulted in improved pulmonary functioning, increased compliance with medication, decreased use of steroid medications and decreased number of days impaired by illness in comparison to children not provided family treatment (Gustafsson, 1986). Other controlled research (Wilson, 1994) has demonstrated a 49% decrease in medical office visits for acute asthma two years after a group behavioral treatment. The systematic group treatment was also significantly more effective than individual education and information alone (Belar, 1993).

Case Study: Jack W. Finney, Ph.D., a psychologist at the Virginia Polytechnic Institute and State University, has developed a model of health care based on the recognition that parents first discuss the health and the mental health problems of their children with primary care providers. A small group of children often use a disproportionate amount of medical services without discernible benefit, usually because care seeking is related to unrecognized and untreated psychosocial problems. Therefore, early detection of, and intervention with, these problems should provide better care for the children and an alleviation of strain on the resources of the health care system. A psychological intervention service was established within a large Health Maintenance Organization. Brief targeted therapy was provided for parents and children with common difficulties such as behavior problems, school problems, toileting difficulties, and psychosomatic problems. The treatment was successful for a majority of the children and high parent satisfaction was reported. Of greatest interest, children in this program decreased their overall use of medical services. This offset effect (a reduction in the use of medical care after mental health treatment) also has been reported in studies with adults, and clearly documents the value of psychological services in a comprehensive primary care program.

Behavioral Medicine: The Role of Psychologists in Interdisciplinary Teams

Psychologists are found at every step of the primary care ladder, from primary prevention through health education, to secondary prevention with outpatient services, to tertiary prevention in inpatient programs with medical as well as psychiatric patients. They are accepted and used widely throughout the country by physicians, nurses, and other members of the health care team

(Linton, 1995). Further, with health care reform, there is a growing trend for joint practices between primary care physicians and psychologists to address the psychological aspects of medical problems seen by primary care physicians (Wiggins, 1995).

Psychologists currently participate on multidisciplinary teams in clinics and hospitals providing primary health care services including assessment, consultation and treatment in behavioral health. Psychologists are also found in medical settings such as pain programs and rehabilitation settings, providing services to patients recovering from a wide variety of impairments from cardiac to neurological to muscular to physical trauma, all as an integral part of a primary health care team. Psychologists perform as part of the primary care team in Veterans Administration hospitals, and the National Health Service Corps includes psychologists as part of their multidisciplinary teams in the national network of community health centers in underserved areas. Psychologists also work with family physicians in rural areas as part of primary care teams for the purpose of treating those suffering from alcoholism and substance abuse (APA, 1993).

Like other health care providers, psychologists provide evaluation, diagnosis and assessment services for both mental and general health concerns. Thus, psychologists are an integral part of a network of health care providers available to respond to the most pressing health and community problems of this nation.

> **Case Study:** Dr. Robert Allan Ph.D., a psychologist at the New York Hospital, Cornell Medical Center, has worked with physicians in treating post-coronary patients. Since Coronary Heart Disease (CHD) is the leading cause of death in Western countries. The primary risk factors for CHD are cigarette smoking, elevated serum cholesterol, and hypertension; each of the three factors have major behavioral components in most cases. Behavioral interventions with CHD patients have resulted in a reversal of coronary atherosclerosis, a reduction in angina, and an increase in life expectancy. Among the behavioral interventions that have been employed successfully are stress management, group therapy, dietary changes, smoking cessation, and increased social support. The positive effects of the incorporation of behavioral counseling in treatment for a CHD patient are supported by research, and represent a valuable addition to the treatment regimen for coronary patients.

Role of Psychologists in Training Hospitals and Academic Health Centers

Psychologists provide a substantial share of the teaching, training, clinical supervision and direct service in Departments of Family Medicine programs that train future primary care physicians. They contribute similarly in departments of pediatrics, internal medicine and community medicine.

> **Case Study:** The Medical Psychology Residency Program at the Oregon Health Sciences University (OHSU) is one of many residency programs administered through the Graduate Medical Education (GME) office in the OHSU School of Medicine. Three residents in Medical Psychology are appointed each year for a one-year program with residents an option to add a second year to the program. Residents in Medical Psychology interact with residents from most of the other specialties around patient care issues, as referred to Medical Psychology from one of the other specialties, usually from one of the primary care provider specialties. Patient referrals to Medical Psychology have been increasing each of the past several years because psychological assessment and intervention effectively assist in the diagnosis and treatment of many patients in the health care setting. The setting for the psychology residency program is the Medical Psychology Outpatient Clinic (MPOC). This clinic is one of many in the OHSU Ambulatory Care Department. Stipends for the psychology residents are paid in part from funds provided by the University Hospital from revenues generated from patient care in the MPOC. In every way Medical Psychology patient care and residency training has become an accepted and integral part of health care and residency education at OHSU." (Wiens, 1995)

Psychologists' Role in Health Maintenance Organizations

Psychologists provide services in a variety of settings including community health and/or mental health centers, rehabilitation facilities, hospitals and health clinics, public schools, health maintenance organizations (HMOs), and office-based private practices. In multidisciplinary

arrangements such as HMOs, psychologists play a critical role because they understand the issues of individual and family dynamics which contribute to the over and under use of medical services. HMOs and other managed care plans have an economic incentive to develop prevention programs that reduce unhealthy behaviors and compliance programs that encourage adherence to prescribed medical regimens.

Psychologists are uniquely trained to provide necessary services to the external and internal clients of HMOs. Approximately 35% of the U.S. population now utilize HMOs and the enrollment in HMOs is increasing rapidly. Psychologists in HMOs work with multiple disciplines (i.e. doctors, nurses, and administrative officers). HMOs rely on psychologists to train other health professionals on how to communicate effectively, especially with individuals who have different language or cultural backgrounds, and to identify organizational problems within and between departments. The psychologist in an HMO ensures that individuals are receiving appropriate treatment and that the HMO is working efficiently to deliver these services (Tulkin, 1985).

In HMOs and other settings, psychologists work side by side with pediatricians in primary care: (a) providing psychodiagnostic assessment services required to accurately diagnose learning disabilities;(b) providing consultations regarding child behavior and developmental issues (e.g., behavior management, toilet training, sibling rivalry), and (c) providing identification of high risk situations (e.g., child abuse) and the design of appropriate interventions. Indeed, one study has demonstrated a 63% reduction in utilization of pediatric medical services after psychological intervention with parents (Belar, 1994).

> **Case Study:** Dr. Gregory Hafen works in a large multi-specialty group of 450-plus physicians and psychologists with a capitated population of 350,000 patients in Southern and Northern California. Psychologists have been partners of the medical staff and part of the primary treatment team since 1988. The HMO has instituted open access to behavioral health which has developed its own internal utilization review (UR) and quality assurance (QA) procedures. Psychologists are treated as equals within the medical center and have responsibility for being the gatekeepers to more and less restrictive levels of care. In the new managed care health care market, psychologists' make a significant contribution to the integration of all medical care. Dr. Hafen notes that his organization is committed to the belief that the treatment of mind and body should be integrated. Accordingly, multi-disciplinary treatment teams for medical conditions such as pain management have been instituted. The integration of the behavioral and medical disciplines creates a more balanced and efficient treatment process in the primary care setting. Because patients get the interventions they need instead of inappropriate medical treatments (e.g., drugs in wrong dosages, and combinations), such interdisciplinary treatment is more cost-effective in the long run.

Psychological Services are Cost-Effective

Over the past several decades psychologists have assumed an increasingly greater role in the provision of mental health services. The most extensive research to date on the cost-effectiveness of mental health and substance abuse services involves the study on Hawaii's medicaid population. An analysis of 16,000 medicaid recipients showed that patients with mental health needs were higher utilizers of the medical system by 200-250%. This study also found that over a three-year period medical costs increased by 15% for medicaid patients who never used mental health services and relative to this baseline, targeted, focused mental health treatment reduced medical costs by 25-36%, depending on the comparison group (Pallak, 1991).

A study of the entire Georgia medicaid population revealed a substantial offset savings from mental health treatment. Patients receiving physical and mental health services realized a savings of $1500 over 2 1/2 years. The cost of the mental health services were entirely paid for by these savings (Feidler, 1989). Similarly, the CHAMPUS Program, which provides health care to dependents of military personnel has demonstrated that unlimited outpatient mental health services resulted in a net saving of $200 million between 1989 and 1992 (GAO, 1992).

Data from Kaiser Permanente and the Harvard Community Health Plan reveals that 50-75% of patients seen by general practitioners have complaints of physical illness that are influenced by psychological factors (e.g., indigestion, hypertension, headache, diarrhea, sleep problems, shortness of breath), and that these patients tend to use the health care system twice as often as other health plan members. Short term psychological intervention has resulted in a 47% decrease

in medical utilization in these patients during follow-up (Belar, 1993).

Untreated alcoholism and substance abuse illustrate the consequences of failing to provide mental health services. Cummings found that individuals suffering from alcoholism and substance abuse who sought medical services rather than mental health services resulted in a rapid escalation of medical utilization with costs skyrocketing by 91% (1990). In another study, Luckey found that 1/2 the cost of treating individuals with alcoholism is offset in one year by reductions in medical costs (1987). SAMHSA has reported that the economic and social costs of untreated addictive and mental disorders were $314 billion in 1990 -- more than cancer, respiratory disease, or heart disease (Greenberg, 1993).

With respect to surgical patients, an analysis of 191 studies revealed that brief presurgical psychological intervention has been consistently associated with fewer postsurgical complications, less medication usage and an average of 1.5 fewer hospital days (Devine, 1992). Sturm and Wells have found that the reduction of one functional limitation (e.g., depression) is associated with an increase of $2,000 to $3,000 in annual earned family income. "From a public finance perspective, the increase in employment and earnings is associated with better care is likely to increase tax revenue and lower unemployment and welfare payments." (Sturm, 1995)

Psychological interventions developed for health care problems tend to be short-term and focused in nature, involving techniques as diverse as family therapy, cognitive behavioral therapy, relaxation training, and other psychophysiological techniques such as biofeedback. Numerous follow-up studies have demonstrated not only significant improvement in symptoms and quality of life, but also reductions in subsequent hospitalizations, medical office visits, medication usage and visits to the emergency room. Studies have shown that patients of physicians who received such psychological interventions reported significantly increased physical functioning, an improvement that remained stable during the year after the intervention. Such interventions reduced annual medical care charges by $289 in 1990 constant dollars, which equates to a 32.9% reduction in the annual median cost of their medical care (Smith, 1995).

Finally, researchers have noted that a large percentage of subjects with depressive disorders and panic disorders reported a disability day owing to emotional reasons (44% each). The mean days missed from work for an emotional reason ranged from 3.2 to 9.4 days, and the mean for depression was greater than that attributed to all conditions except cancer and cardiovascular problems (Kouzis, 1994). In addition, the absenteeism rate was from 10 to 33% for high risk employees compared without risks costing a total of $70.8 million annually in illness costs (Wiggins, 1995).

The Value of Including Psychologists in Medicare GME

The public, managed care organizations, and the government are calling for tight, cost-effective, widely available, integrated health care teams to provide human and comprehensive services to our citizens. Psychologists play a major role in training (over 3000 currently on faculties of medical schools and residencies), research (a massive health psychology literature used every day in the primary care field), and direct service (Linton 1995).

It is widely known that the available pool of trainees in psychiatry is diminishing. At the same time, the number of students completing graduate training in professional psychology remains stable. Indeed, within the Association of American Medical Colleges, the premier organization in medical education, there are a large number of psychologist members in the Association for the Behavioral Sciences in Medical Education, along with physician members who come from specialties such as pediatrics and internal medicine. Yet, there is very little federal support for psychology education and training (Linton, 1995).

Due to the extensiveness of scientific preparation and clinical supervision necessary for independent research and practice, an average of 7.5 years beyond the bachelor's degree is required to obtain a Ph.D. in psychology. During this time, however, students contribute to the ever-growing body of knowledge, and provide direct services to patients and their families. Clearly, financial support plays a major role in attracting individuals to a particular discipline. Indeed, it is critical in attracting minorities and the financially disadvantaged (Belar, 1994).

Psychologists frequently serve as the behavioral scientist member of multidisciplinary research teams and are often the principal investigators in these projects. In addition, psychologists work with physicians and other health care providers on multidisciplinary teams in training hospitals and Academic Health Centers and in Health Maintenance Organizations. Federal support for

training psychology interns in health care facilities will allow them greater exposure to primary care, and afford them opportunities to prepare to teach, evaluate and provide services even more effectively as partners in the health delivery system (Linton 1995).

Despite the important role that psychologists play in the delivery of health care services as members of interdisciplinary teams, there has been almost no federal support for students of psychology, including minority students. Compared with assistance to the medical profession, federal assistance to psychology is minuscule (Dumvin, 1994). There is, in fact, a critical need for more psychologists, especially minorities, to work in public settings and in particular in underserved areas. Yet, without federal financial aid programs, it is nearly impossible for those who otherwise could not afford the seven years of graduate school to become a professional psychologists.

Currently, hospitals do not receive any GME funding to support psychology internship programs. This lack of reimbursement, coupled with the loss of income due to health care reforms, has forced many hospitals to reduce financial support to train psychologists. Moreover, current inequities in GME funding have lead to cutbacks in positions of hospital staff psychologists who provide training to interns, in addition to providing diagnostic, assessment, preventive, and therapeutic services to hospital patients. Linton (1995) notes that while it is unusual to find administrators who are antagonistic *per se* to the notion of training psychologists in their facilities, because they receive no GME pass-through funds, a burden is placed on them to differentially support certain elements of the health care team.

The link between financially sound training and competent health care delivery is well known. Further, a growing number of studies have shown that the provision of psychological services reduces medical utilization and cost. Indeed, psychological services produce quality health care that generates better health for the recipients of the services and, in turn, more wealth for society at large. Clearly now is time to recognize the important and critical role psychology plays in health care and to ensure that psychology students participate in the Medicare GME program for the benefit of all Americans.

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STATEMENT OF

AMERICAN SOCIETY OF PLASTIC
AND RECONSTRUCTIVE SURGEONS

to the

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

April 3, 1995

RE: Graduate Medical Education

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

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

In 1994, ASPRS commissioned a study of the plastic surgery market and workforce. The study was performed by RRC, Inc. of Bryan, Texas. Among the study's findings, we learned that substantial increases in provider workforce are expected in the next 20 years, although many underserved areas will require a long time to attract a plastic surgeon.

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

1. Continue Federal Support for Graduate Medical Education

Federal support for graduate medical education must continue to ensure that the United States will maintain a well-trained and highly qualified physician workforce. In recent years, we have observed a trend toward lower payments by third-party payers to physicians and hospitals. As a result, teaching programs have become even more dependent on Medicare financial support and are less able to compensate for any funding shortfalls through payments they receive for services provided to non-Medicare patients. This is

problem is especially acute for specialties with longer training periods, such as plastic surgery, which already receives reduced financial support from Medicare beyond the first five years of training.

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

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

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

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

3. Provide Antitrust Relief for Workforce Planning

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

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

4. Conduct Workforce Planning on National Basis

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

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

This position is consistent with the views of the Physician Payment Review Commission and the federal Council on Graduate Medical Education, and has been included in a number of previous legislative initiatives, most recently the Rockefeller/Durenberger bill introduced in the 103rd Congress. Given the emerging problem of physician oversupply, Congress should strongly consider reducing the number of medical graduates who enter, train, and practice, while taking into account and accommodating the impact of any reductions on medical services to urban and underserved populations.

6. Allot Residency Positions Based on Program Quality

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

Conclusion

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

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

April 3, 1995

STATEMENT OF THE MAYO FOUNDATION

COMMITTEE ON WAYS AND MEANS, HEALTH SUBCOMMITTEE

MARCH 23, 1995

The Mayo Foundation is an integrated health care system, with clinics, hospitals, and other health care entities located in five states. These include Mayo Clinic Rochester, Saint Marys Hospital, and Rochester Methodist Hospital, in Rochester, Minnesota; Mayo Clinic Jacksonville and St. Luke's Hospital, in Jacksonville, Florida; and Mayo Clinic Scottsdale, in Scottsdale, Arizona. We have also merged with Mayo regional practices and hospitals in Minnesota, Iowa, and Wisconsin. We serve patients from all fifty states and many foreign countries. We are engaged in research and education, with over one thousand residents in training at multiple locations.

As the Congress develops policies for graduate medical education, we believe that serious attention must be given to separating funding for education from patient care revenue. In the past, teaching institutions were able to cross subsidize education programs from patient care revenues. In today's world of managed care and market competition, this ability is severely limited. We strongly support a market-based health care delivery system, and see many efficiencies coming from this competition. However, for competition to work there must be a level playing field. In order to create such a level playing field, societal goods, such as research and education, should be funded by all the participants in the health care system.

In the long run, a separate funding pool must be created for graduate medical education. This pool could be funded by a surcharge on all health premiums, and distributed on a per resident basis to the programs that incur the costs of the education. In the short run, it is imperative that the government maintain a fair level of Medicare funding for graduate medical education through the DGME and IME payments.

We suggest that the DGME payment system be simplified and made fairer by making several changes. First, a uniform payment level should be established. There is neither fairness nor good policy sense in the tremendous variation in per resident payment levels that exists today. Second, the payments should be made on a per resident basis, regardless of the type of setting in which the resident is training. Good education policy requires that residents receive more of their training in non-hospital settings, yet the payment mechanism is limited to hospital-based training. Moreover, integrated health care systems are working to make sure patients are treated in the most efficient setting, and the lines between hospital and clinic are often not clear.

We also urge you not to establish graduate medical education funding on a state basis. Mayo participates in a national and international education market. We recruit residents and students from all parts of the country, and train them to meet national needs. Any attempt to apportion residency training funds on a state-by-state basis will seriously disrupt this market. The Mayo Graduate School of Medicine (our residency training program) is one of the largest, and we believe one of the best, training programs in the country. However, it is based in Rochester, Minnesota, a city of less than 75,000 population. If residency funding were to be distributed by state or region based on population, we would have to shut down most of our programs. In this arena, we believe that a working market will allow the best training programs to survive, and poorer programs will shut down for lack of trainees.

STATEMENT OF THE SOCIETY OF GENERAL INTERNAL MEDICINE

The Society of General Internal Medicine (SGIM) was founded in 1978 to promote improved patient care, teaching and research in primary care general internal medicine. There are approximately 2,700 members of SGIM. The importance of generalists to the nation's health care system and the critical role they play in effecting reform in health care delivery has long been recognized by the profession, by the nation's policymakers, and by society. Recent efforts to reform the nation's health care delivery system reaffirmed the role of the generalist physician in providing universal access and controlling costs. The unique contribution of generalist physicians to health care delivery is their ability to provide comprehensive high quality primary care in a variety of settings, to people with a broad array of health-related conditions. Generalist physicians are specially trained to deliver primary care. Primary care is characterized by first-contact care for patients with undifferentiated health concerns; patient-centered comprehensive care that is not organ or problem specific; continuous, longitudinal patient care; and coordination of necessary medical, social, mental, and other services through appropriate consultation and referral. General internists provide this type of primary care to men and women from adolescence through old age.

We commend Chairman Thomas in addressing current graduate medical education (GME) and teaching hospital policy. In examining alternative policies regarding the training of future health professionals, the needs of the health provider in the evolving health care system, and the financing of teaching hospitals, the committee must also consider the series of disincentives related to the generalist disciplines from undergraduate medical training through practice:

1. Financial and other incentives have pushed an increasing number of international and U. S. medical graduates into specialist careers. Despite one of the highest physician to population ratios, the U. S. has shortages in important areas of its health care providers.

2. Federal funding of training after medical school (graduate medical education) promotes hospital-based training of specialists who provide expensive services at low cost to the hospitals.

3. Medical students have strong incentives to choose specialist careers because of increasing indebtedness from medical school and the higher income potential of specialty as opposed to primary care practice.

4. There has been continued and increased demand for specialty services, despite concerns that many procedures and specialty services are overutilized.

Market forces alone will not correct for the low proportion of primary care physicians; the Federal Government must reevaluate and establish specific goals in the financing of medical education and medical practice. The outcome of these goals should be to achieve at least 50 percent of U. S. physicians practicing the generalist disciplines of general internal medicine, general pediatrics and family medicine.

Among the various mechanisms which have been proposed to shift graduate medical education payments to support the training of generalist physicians, we believe that the most effective short-term approach will be to modify payments to hospitals. In July, 1994, the Department of Health and Human Services Office of the Inspector General (OIG) issued a final audit report, "A Study of Graduate Medical Education Costs." The report analyzes hospital graduate medical education costs during the first 5 years of Medicare's prospective payment system, which began October 1, 1983. The report concludes that, in the absence of changes to GME through health system reform legislation, the Health Care Financing Administration (HCFA) should reevaluate Medicare's policy of paying GME costs for all physician specialties. As part of this reevaluation, the OIG recommended that HCFA consider submitting legislation to reduce or even possible eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians.

Our comments address several issues related to policy reform concerning funding graduate medical education:

All Payer System

The Federal Government's financing of medical education should support training that ensures generalist physicians as the primary providers of medical services. SGIM strongly supports the reform of funding of residency training to include contributions from all payers. The per resident amount must be sufficient to cover the costs of training. Funding must also cover the costs of educating residents in all outpatient settings, not just those limited to hospital ambulatory sites. This is necessary to improve primary care training, which should include more time in ambulatory settings, training in managed care, and geriatric training. Funds for medical education should be allocated directly to training programs approved for residency training positions, rather than teaching hospitals. This will encourage the use of residency training funds for ambulatory care.

Limit Residency Training/Payments to Residency Programs

SGIM supports the following approaches to encourage primary care residencies:

1. Limit the number of years covered by direct medical education and indirect medical education payments to residency training.

2. Increased medical education payments should be allocated to general internal medicine and general pediatric residency programs which develop a primary care curriculum and establish appropriate ambulatory training sites.

3. In addition to limiting Medicare payments for residency training, the total number of first-year residency positions should be limited by capping slots at 110% of the number of U. S. medical school graduates.

4. Establish higher weighting for primary care per-resident amounts.

5. Graduate medical education funds saved through reductions in specialty residency support should be made available to primary care directors to support loan forgiveness.

Transition Payments

Transition payments should be provided to teaching hospitals which are required to reduce their residency training programs. The GME payment plan should ensure that institutions that care for disproportionate numbers of disadvantaged patients are funded adequately to ensure that the necessary replacement staff are hired. Also, we recognize that non-physician practitioners may be required to replace residents in some inpatient services at teaching hospitals. Mechanisms should be considered to provide temporary funding to support the introduction of some non-physician practitioners on certain specialized services. This would provide incentives to promote the shift to fewer specialty training positions in teaching hospitals during this time of transition.

Support for Training Primary Care Teachers

There is an increasing demand to train more primary care generalist physicians, however, there are not enough teachers to train these generalists.

Current Medicare policy limits direct GME funding to the number of years required to become board eligible in a particular specialty, or five years, whichever is shorter. General internal medicine, general pediatrics and family medicine each require three years of residency training.

Graduates of the three year residency programs typically spend two years in generalist fellowships in order to pursue careers as faculty in general internal medicine. Generalist fellowships are structured to provide the trainee with teaching and primary care research skills. Since the fellowships are not directed at training subspecialists and no board examination is

administered following completion of the generalist fellowship, institutions which train generalists for academic positions are not eligible for GME funding. Medicare GME policy currently supports only those fellowships which result in specialization and/or additional board certification.

Medicare policy should allow payment of direct GME funding for training generalist teachers. Guidelines for program funding should be established by the Secretary of Health and Human Services. Enclosed is proposed language to amend the Social Security Act in order to allow payments for fellowship training in a generalist discipline.

Proposed Changes to the Social Security Law to Support Training for Primary Care Teachers

42 USC and 1395 ww (h)

Sec. 1886 (h) Payment for Direct Graduate Medical Education Costs

(5)(A) Approved Medical Residency Training Program -- The term "approved medical residency training program" means a residency or other postgraduate training program, participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary and formal postgraduate training programs that provide fellowship training in general internal medicine, general pediatrics or family medicine approved by the Secretary, participation in which leads to a faculty position in general internal medicine, general pediatrics or family medicine.

(5)(F) Initial Residency Period -- The term "initial residency period" means the period of Board eligibility, except that --

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period, and

(iii) a period, of not more than two years, during which an individual is in a fellowship program in general internal medicine, general pediatrics, or family medicine which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, even though these fellowship years do not count towards Board eligibility or certification.

(suggested language underlined)

Conclusion

A reconfiguration of our nation's health care delivery and financing systems is necessary in order to achieve a more balanced system with expanded preventive and primary care services. We commend the committee for their efforts to restructure graduate medical education funding. The Society of General Internal Medicine is committed to working with you in further developing our policy recommendations and ensuring budget neutrality.

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April 6, 1995

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

Dear Chairman Thomas:

Thank you for the opportunity to submit for the record these remarks to expand on the American Medical Association's Statement filed at the March 23, 1995 hearing on graduate medical education (GME) financing. We believe these comments will be useful in better understanding our positions regarding the critically important GME financing and physician workforce planning issues.

Our Statement declared that "Health maintenance organizations (HMOs), preferred provider organizations (PPOs), and self-insured industry or government plans are generally unconcerned about the individual components of provider costs, particularly GME costs, as long as they are able to obtain competitive prices by negotiating discounts from stated charges." The intent of our comment is that HMOs, PPOs, and self-insured industry or government plans are concerned about the price they pay for services and the outcome to the patient. We are well aware that managed care plans track individual components of provider costs in an effort to curtail overall costs. While benefitting from GME programs, these plans have not evidenced a willingness to assume explicitly their fair share of GME costs.

Our discussion of some of the problems that have resulted from the evolution of GME financing noted that "the current methods of financing GME have made it difficult to establish primary care GME programs in settings other than hospitals, such as non-hospital based ambulatory settings and rural health clinics." While it is true that the current methods of financing GME have created obstacles to the establishment of GME programs in non-hospital settings, nevertheless, a number of residency training programs, chiefly in family medicine, have been established in such settings (despite a lack of easy access to a source of funding). Progress has been made in this regard, but there still exists the need to emphasize and encourage the development of and adequate funding for primary care GME programs in non-hospital settings.

We would like to clarify our statement regarding the effect of the Prospective Payment System (PPS) on GME, that "...teaching hospitals have generally done better than non-teaching hospitals under PPS ...." While this is true in general, we would like to point out that it is <u>not</u> so in the case of each and every teaching hospital, especially many public hospitals serving predominantly indigent patients. Furthermore, even though some teaching hospitals may have benefitted under PPS (as compared to non-teaching hospitals), such hospitals carry additional costs related to education and patient mix. Clearly, both PPS and RBRVS (the Resource Based Relative Value Scale) have had an important impact on GME financing. In any future design of GME reimbursement, these significant differences between teaching and non-teaching hospitals must be taken into consideration.

Our Statement, in the section entitled "Goals," declared that "the AMA believes that reform should achieve long-term stable funding of GME to ensure that all graduates of U.S. medical schools will be able to obtain, at the very least, GME leading to eligibility for initial board certification and result in increased accountability for the total number and specialty mix of GME positions, the appropriateness of the site of GME training, and the appropriateness of both the content and length of training requirements." Our use of the word "reform" here (and throughout the document) should not in any way be construed to indicate a preference for government based reform. Change is needed, but it ideally should continue to emanate from private sector initiatives with significant input from the medical profession. We would like to make it perfectly clear that the AMA is not advocating here the involvement of government in mandating how medical residency training programs should operate.

In our discussion of "Principle #1," we recommended that "all payors be required to adopt the Medicare approach for determining their share of the direct costs of GME." While the Medicare methodology for determining GME cost sharing is currently the only complete and tested model we have to look to, the AMA does not mean to imply that it should be adopted without question. Rather, we believe that an approach could be designed that is similar to Medicare's approach,

which may offer an improvement in methodology.

We also discussed, under "Principle #1," an option whereby Medicare could make its participation in GME financing contingent on individual hospitals requiring the participation of all payors with beneficiaries hospitalized in each institution. Such an approach might be less viable, depending on the sophistication of a given market. Our point is that teaching hospitals will have to find innovative ways to negotiate with these payors.

In our discussion of "Principle #3," we stated that "the AMA believes that efforts to reform GME financing should not be burdened in the immediate debate by attempts to resolve these very complex issues of uncompensated care and the effect of discount contracting on the financial stability of some teaching hospitals." Our intent here was to express the opinion that such complicated issues as these will continue to adversely affect the financial stability of teaching hospitals. In the meantime, there is added urgency to appropriately develop a reasonable and fair method for GME financing.

"Principle #4" discussion remarked that "the AMA recommends that HCFA rewrite existing regulations to define more precisely the faculty salary costs and general overhead costs that may be allocated to GME. More specifically, regulations should be promulgated to limit faculty salary costs to the time faculty are directly involved in the administration of GME programs or in the supervision of resident physicians under circumstances in which no separate bill is submitted for professional services either by the physician or the hospital." Our intent here was to point out a subject matter in need of attention (i.e., variations in faculty salary costs) and one example of a manner by which to address the subject. Actually, the preferred way to address the issue, in our view, would be to do so administratively through the individual health care institutions, rather than through the promulgation of regulations. The point we were trying to express here relates to the goal of achieving uniformity in reimbursement methodology for GME.

In addition, under "Principle #4," we commented that "at present, decisions regarding specialty training issues are controlled, for all practical purposes, by the specialty boards and the ACGME." It should be added here that the individual residency training program directors also have wide latitude in making decisions on residency positions and on other specialty training issues. Also, as a footnote to our recommendation that annual surveys should be conducted to document variations in faculty and overhead costs among teaching hospitals, the Subcommittee should note the fact that the American Association of Medical Colleges (AAMC) currently conducts similar such surveys.

Our conclusion stated that: "The AMA has considered the issues surrounding financing reform in GME and has developed goals and a set of principles to assist the national debate on this issue. The AMA believes that such reform is warranted in order to control the costs of GME, to stabilize the funding of GME, and to improve the accountability of the GME system to society so that national physician workforce objectives are achieved and maintained." Our intent here was that such national physician workforce objectives be achieved and maintained primarily through private sector initiatives.

In closing, again, we are very appreciative of the opportunity afforded us by the Subcommittee to submit these comments. As was expressed in our March 23rd Statement, we thank the Subcommittee for soliciting our thoughts and recommendations on this highly complex issue of financing graduate medical education. We look forward to working with other affected organizations and hope that we can be a continuing resource as the Subcommittee and full Committee develop their proposals.

Sincerely,

William E. Jacoby MD

William E. Jacoby, MD
Member, AMA Board of Trustees
Associate Provost, Academic Health Center,
University of Minnesota

cc: Members of the Subcommittee on Health, Committee on Ways and Means

PHYSICIAN PAYMENT REVIEW COMMISSION RECOMMENDATIONS ON PHYSICIAN PAYMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

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PHYSICIAN PAYMENT REVIEW COMMISSION RECOMMENDATIONS ON PHYSICIAN PAYMENTS

THURSDAY, MARCH 30, 1995

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

The subcommittee met, pursuant to notice, at 10:35 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

The press release announcing the hearing follows:

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 22, 1995
No. HL-7

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARING ON THE PHYSICIAN PAYMENT REVIEW COMMISSION RECOMMENDATIONS ON PHYSICIAN PAYMENTS

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will hold a hearing on the physician payment recommendations included in Physician Payment Review Commission (PPRC) 1995 Annual Report to Congress. **The hearing will take place on Thursday, March 30, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 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 John M. Eisenberg, M.D., Chairman of the PPRC and physician groups. 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:

In 1986, the Congress established the Physician Payment Review Commission to advise the Congress on issues regarding physician payment under Medicare. Each year, the PPRC has provided Congress with specific recommendations on ways to improve the program.

In announcing the hearing, Chairman Thomas said: "The 1995 recommendations of the PPRC are extremely important, especially in light of the Administration's refusal to deal seriously with the problems facings the Medicare program. The recommendations included in their annual report will help us to lay the foundation for reform to preserve the Medicare program."

FOCUS OF THE HEARING:

This hearing will review the formal recommendations of the PPRC regarding physician payment under the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, April 13, 1995, 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 advsories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'House Committee Information'.

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Chairman THOMAS. The subcommittee will come to order. This morning the subcommittee will review the 1995 annual recommendations of the Physician Payment Review Commission regarding physician payment. The Commission's 1995 recommendations will provide direction for the subcommittee as we consider further perfections of the Medicare fee schedule. These recommendations and the comments of groups from the physician community will help the subcommittee meet its responsibilities to set policy for physician payment.

The fee schedule has clearly had a positive influence on distribution of physician payment between primary and specialty services. It has also served as a vehicle for regulating payment increases for physicians. However, it does not provide real incentives for cost conscious purchasing of medical services for beneficiaries and, as we will learn today, has the flaws inherent with any government price regulatory scheme.

We should continue to examine and refine payment policy in the old-fashioned Medicare program, but we should also spend most of our energy over the next few months looking for the best means to transform Medicare coverage and bring to it the advantages of the experience in the private market. Cost conscious purchasing of quality care is the theme in the private market, and it is the goal of this subcommittee to look at the private sector to discover the structural reforms we need to bring both Medicare costs in line as well as ensure Medicare beneficiaries the same choices most employed Americans and their dependents now enjoy.

We particularly look forward to hearing from the PPRC, and I personally want to thank the outgoing Commission Chairman John Eisenberg for the contribution he has made in trying to improve the physician payment policies which have been developed by the Commission over time.

I yield to my colleague from California.

Mr. STARK. Thank you, Mr. Chairman. I am pleased to join with you in welcoming Dr. Eisenberg to the subcommittee. His work as Chairman of the Physician Payment Review Commission has been exemplary. As this year's report again demonstrates, the PPRC continues to be the best source of objective analysis about physician payment and related issues. I believe it is no accident that this standard of objective excellence has continued under Dr. Eisenberg's leadership.

Given this record of achievement, I am mystified, Mr. Chairman, by reports that my Republican colleagues intend to replace Dr. Eisenberg as Chairman of the PPRC. Perhaps someone from your side will be able to clear up this mystery today, given that, as far as I know, there is nothing in the work of the PPRC or Dr. Eisenberg which would suggest that he should be replaced.

There is no evidence, for example, that he has indulged in partisan activities or favored one point of view over another in the great debate on health reform. Previous chairs of PPRC and the Prospective Payment Assessment Commission have been allowed to continue essentially indefinitely, and I am just curious as to why a different standard has been imposed in Dr. Eisenberg's case. Since he is here and since I am sure that he too is wondering about why he is not even being given the opportunity to serve a complete

term as Chairman, might it not be appropriate for us to clear up for him the mystery of why the majority members of this committee believe he should not be reappointed?

Mr. Chairman, I would very much appreciate it, and for the courtesy of Dr. Eisenberg, who has long and faithfully served the Commission, if you could shed some light on this enigma.

Chairman THOMAS. The gentleman is asking me to respond to his comment. I do not know whether it is about the fact that Dr. Eisenberg replaced Dr. Lee, and has filled out the portion of that term, and that term has expired, or whether the gentleman from California is concerned about potential new appointees to the position or both? Which is it he is concerned about?

Mr. STARK. The tradition of the Physician Payment Review Commission and ProPAC has been since its inception that the chair has stayed as long as the chair has chosen to serve and not been forced out. And I just wonder what it is about Dr. Eisenberg's service which would cause a change?

Chairman THOMAS. The term has expired, and I guess the gentleman from California is concerned the Clinton administration has now offered Dr. Eisenberg the job as the previous chairman was offered.

Mr. STARK. I just repeat that it has been the policy to allow the chair to stay as long as he chooses, both ProPAC and PPRC.

Chairman THOMAS. And as a presidential appointment.

Mr. STARK. Until they decide for whatever reason to retire or resign.

Chairman THOMAS. Well, I guess maybe there ought to be traditions that are followed and some traditions that are not necessarily followed. And then patterns develop over time that do not lock us into an absolute requirement that a chairman stay in a position until the chairman decides whether or not they want to leave. I believe we have the ability to appoint people to the position and that it ought to be the elected officials who make the determination at the end of the term. Dr. Eisenberg is not being removed in the middle of the term. The term has expired. And if the gentleman wishes to have the chairmen of these commissions determine how long they are going to remain, perhaps he really fully does not understand the structure and relationship between the Members of Congress and the commissions themselves.

Mr. STARK. Well, Mr. Chairman, I bow to your superior knowledge and intelligence and perspicuity in these matters and that you have exhibited over a number of years. I thank the Chair for his comments.

Chairman THOMAS. I appreciate the gentleman from California's comments including the really earnest and honest way in which they were delivered. I am sure there was no hidden agenda in the way in which he described the Chairman, and I appreciate the kind words.

With that, Dr. Eisenberg, your written statement will be made a part of the record, and you may proceed in any way that you wish.

STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY DAVID COLBY, STAFF, PHYSICIAN PAYMENT REVIEW COMMISSION

Dr. EISENBERG. You do have the written record. The Commission's report, the March report, will be released tomorrow, and will be made available to the subcommittee, to the full committee, to both Houses of the Congress. What I would like to do today is to try to briefly summarize what this report recommends, particularly the part of the report that deals with the Medicare system.

As you mentioned, Mr. Chairman, many of the goals that were set out by the Congress in the Omnibus Budget Reconciliation Act of 1989 in reforming the Medicare system are being achieved, and most would consider those reforms to be successful. There are problems, we believe, and we would like to help the Congress address those problems. I do want to emphasize that this system, which was designed by the Congress and implemented by HCFA, is being adopted by a large number of managed care organizations and States in their own Medicaid plans so that many of the issues that we will address today go far beyond Medicare and whether Medicare pays fee-for-service or not, whether Medicare moves to managed care or not. The system which Medicare uses, the resource-based relative value scale (RBRVS), has profound implications in the private sector, and decisions that the Congress makes in changing the RBRVS system will have major impacts on managed care programs who pay fee-for-service to the physicians as well as Medicaid plans.

Let me talk for a moment then about the Medicare RBRVS and the impact that has taken place because of the way the volume performance standard was established. In the Omnibus Budget Reconciliation Act of 1989, Congress decided to have two separate performance standards, one for surgery and one for nonsurgery. In the Omnibus Budget Reconciliation Act of 1993, we added a third, a separate category for primary care. The PPRC has suggested that there ought to be one standard.

The result of having three standards is we believe a distortion in the pattern of relative payments. And we have data in the report that give you specific numbers about how that distortion has taken place, but, in general, there has been a 9-percent relative increase for surgical fees compared with other fees beyond what would have happened had there been a single standard.

Now one of the problems here is that there was very high growth in Medicare in the eighties on the physician expenditure side. But that annual growth in physician expenditures has slowed, maybe as a result of Congress' actions, maybe because of things happening in the marketplace. We suspect because of both. But the fact is that from 1991 to 1993, the average annual growth in physician expenditures has decreased to 3.8 percent, average annual increase. Now, that has resulted in a larger update than would have otherwise been the case, a larger update in physician fees than inflation because of the fact that the volume increases were kept to a level below that which had existed before.

There was embedded in the formula for calculating how the update would be determined a 4-percentage point reduction from the

standard, from the performance standard, which has caused there to be a potential for a reduction in physician fees that we believe was unintended, dramatic, and we think risky for the Medicare program. We provide you in our report in chapter 3 an analysis of what would happen if we do not change the current mechanism for calculating the Medicare volume performance standard, and what it boils down to basically is that within 10 years, Medicare would be paying less, not corrected for inflation, less than Medicare paid at the beginning of the resource based relative value scale system, and we do not think that the Congress intended that, but it is embedded now in the law, this 4-percentage point reduction, and we suggest that Congress reconsider this.

So we have five recommendations on the Medicare volume performance standards. The first is that we replace the historical trends that are used in the volume and intensity calculations and this 4-percentage point deduction with real gross domestic product growth plus 1 to 2 percentage points that would allow for expansion of the Medicare program's payment for increased access to technical services and other advances in medical care.

Second, we recommend that there be a single conversion factor and a single performance standard, and if there must be a separate standard for the three areas that currently exist, we would suggest that they be based on their own trends rather than on a common baseline trend in volume growth, and that if there is going to be a differential, that differential is in effect for only 1 year.

Third, we would like to suggest that the conversion factor reflect the difference between the actual expenditures and targeted expenditures that are accumulated since a base year rather than on a year-to-year basis. We would also like to suggest that we develop a mechanism for shortening the delay between the calculation of what the increase in volume has been and the determination of what the update will be. Right now it is like being in a shower where the lag time between your twisting the dial and the water being hot or cold is long, and you know what happens when you're in a shower like that. You twist it a little to the left and you get scalded. You twist it a little to the right and you are frozen, and you cannot quite get the dial fixed.

What we are suggesting is that we shorten that lag time so that the lag time between our understanding of what the rate of increase has been and our twisting this dial is shorter so that we do not have these wild fluctuations that we think we will have if we do not shorten that lag time.

And third, we would like to suggest that we recognize the fact that these fee increases that physicians have had during the past 2 years are because of the fact that the performance standard was met and performance was better than expected, and, therefore, that the increases that are greater than the Medicare economic index be recognized as a part of what has been described as a deal with physicians. If physicians kept the volume and intensity growth lower, the fee increases would be increased, and physicians should not be penalized for that as we look at rates of increase and expenditures in the future.

And I want to make one more comment about the Medicare fee-for-service system, and I also want to let you know that David

Colby has joined me. David is one of the senior members of the PPRC staff and will be available to help me respond to your questions. On the Medicare fee-for-service system, we have always been worried that if the gap between Medicare's payment levels and payment levels in the private sector widened too much or for any other reason physicians decided not to participate or to provide care to Medicare beneficiaries that there would be a problem in access.

It does not seem that this has happened. Now, the first piece of information that we want to let you know is this: That the Medicare payment rate compared to the payment rate for private insurers seems to have increased. It has increased for two reasons. One is that Medicare has been paying more because of this recent increase in the performance standard-based conversion factor. Second, the private sector has increased its payment levels less than it did in the past. In addition, there is a technical adjustment that we did to last year's estimate. So now Medicare is paying 68 percent of what the private insurers are paying. That is the first fact.

The second fact that we think is important is that overall access to Medicare is pretty good. Only 0.3 percent of Medicare beneficiaries said they could not get care because they could not find a doctor who would accept Medicare. Ninety-three percent of charges are on assignment. Eighty-six percent of charges are from participating physicians, and 65 percent of physicians participate. But it is still of concern to the Commission that Medicare beneficiaries who are African-American, who live in areas that are medically underserved, and people who live in areas of poverty, urban poverty, seem to have a lower use of primary care and a higher use of emergency rooms, and, in fact, higher mortality rates, not all of which can be attributed to the Medicare payment scheme. But we are worried that there is a signal that a problem could be brewing if payment rates do not allow those individuals to find physicians able to provide care to them.

Now let me turn to managed care. The PPRC, like the Congress, is interested in seeing Medicare take advantage of what has been happening in the private sector, including in the managed care component of the private sector. We believe, though, that the current way of paying Medicare, the way in which Medicare pays HMOs, needs to be fixed. The current so-called AAPCC system provides payments which in many areas discourage HMOs from taking care of Medicare beneficiaries, and in other areas probably provide profits that are higher than they need to be.

We would suggest that the Congress think about a system of competitive pricing whereby HMOs would offer a bid to the government and based upon those bids, which would be their minimal acceptable rates for which they would care for Medicare beneficiaries, a rate would be determined, not necessarily the lowest rate, but in order to encourage HMOs who want to provide risk contracts for Medicare beneficiaries to offer competitive bids. We believe that those who do not come in at or below the accepted bid need to be penalized in some fashion by, for example, having to offer the price that they put in as their bid rather than the bid that was agreed upon by Medicare.

Second, we suggest that we blend national and local per capita costs if the AAPCC is going to be used rather than having simply local per capita costs. We also would like to suggest that there are some innovative ways of paying for Medicare beneficiaries and HMOs that we ought to consider. One of those is something called partial capitation whereby the Medicare program pays the HMO not on a fully fee-for-service basis and not on a fully capitated basis but some amalgam of the two. It could work in one of two ways.

For example, it might work as a blended payment. A certain percentage of the payment would be capitated, but then a certain percentage of it would be on a fee-for-service basis so that the incentives for underservice and overservice could be offset. Another way to deal with this proposal is to have a risk corridor so that HMOs would be protected against having too much risk that they would assume for the Medicare beneficiaries.

We believe that these models of partial capitation would help to make Medicare's access to the managed care advances more positive than they would have otherwise been. Now there is a problem with moving toward managed care with Medicare, having to do with the way in which the Congress through HCFA pays for graduate medical education. We have suggested that, because of the fact that graduate education payments are embedded in the AAPCC because the direct and indirect medical education costs are a part of the way of calculating the AAPCC, they have got to be unlinked.

We would suggest, therefore, that the capitation methodology be altered so that we remove the Medicare payment to providers for medical education from the HMO payment, and a different way of paying for medical education be determined. We would suggest that the method chosen should encourage HMOs to participate in the education of young physicians because we believe that that would improve the educational opportunities for young physicians. We also are very concerned, as this commission always has been concerned, about the way in which the DME payments and IME payments have fostered an oversupply of physicians in this country. We believe that the oversupply of physicians is an inflationary factor, and needs to be addressed. We are not convinced as a commission that the mechanisms that have been proposed to date will deal with this oversupply of physicians in the long term, and we have suggested to the Congress in the past and would be pleased to work with the Congress in the future to develop ways of dealing with this problem.

Now let me in brief mention a couple of other issues. The first is coverage. We believe that Medicare's methodology for paying for new procedures needs to be altered. First, we believe that there needs to be a better information system so that Medicare can understand better the inconsistencies among its intermediaries and its carriers in their decisions about what gets covered by Medicare in different areas of the country.

Second, we believe that Medicare ought to pay up to the standard cost of care when a new service is introduced and it is substituting for an old service while it is being evaluated rather than simply not paying for a new service. We believe that that is injuri-

ous to the dissemination of potentially advantageous new advances in medical care.

Third, if the safety and efficacy of a new technology is questionable, we believe that Medicare ought to pay only those programs, those providers, physicians, hospitals and others, who are participating in a serious evaluation of that new technology.

Finally, if two covered services provide the same level of efficacy and the same level of safety, the PPRC believes that Medicare should pay the less expensive price of the two services.

We also have some recommendations with regard to Medicaid. We would like to encourage the Congress to continue its encouragement of the demonstration projects for Medicaid by modifying the so-called 1115 waivers to mandate more explicit research in those programs but on the other hand consider offering a new waiver authority to allow State Medicaid programs to use managed care programs and to expand coverage to the poor.

Now I want to emphasize one last issue which is the use of medical practice guidelines. We do not know, nobody knows, why the volume and intensity of medical services has fallen, but many physicians believe that at least a part of it, a part of this decrease, is because of an increased sensitivity of the medical community to practice a more cost effective medicine. We believe that the contributions of both the physician community, the research community, and the Agency for Health Care Policy and Research are very important in moving us toward a better understanding of what works and what does not work in medical care. We believe that the AHCPR, the Agency for Health Care Policy and Research, should be encouraged to continue its work on guidelines, to consider ways in which it might disseminate guidelines that it develops and others develop to help to build the infrastructure for the continued evaluation of safety and efficacy and efficiency of medical care. And that the AHCPR continue to work closely with the Congress and the administration to improve the quality, the effectiveness and the efficiency of medical care.

Let me just say, Mr. Chairman, that it has been a pleasure for me to serve on the PPRC. I am one of the inaugural members of the commission, and it was an honor to be able to fulfill the last 2 years of Phil Lee's term, and as Mr. Stark said, I have been flattered by the Congress, by the Democratic majority in the past, by the Republican majority now, at the attention and the care with which the Congress has communicated with the commission. I think that this commission stands for the best in health policy, health policy that is based on data, that is based on listening to the community, the physician community and the beneficiary community, and on relying on an outstanding staff of commission analysts, an outstanding group of commissioners, in bringing to the Congress what has been, I think, bipartisan, data-based, fact-based recommendations, and I am sure that the Commission will continue to do that in the future. Thank you.

[The prepared statement follows:]

TESTIMONY OF JOHN M. EISENBERG, M.D.
PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to be here today to discuss aspects of the Physician Payment Review Commission's 1995 *Annual Report to Congress* that are of interest to this committee. Two major developments set the context for the analyses and recommendations in the report: implementation of Medicare physician payment reforms passed in the Omnibus Budget Reconciliation Act of 1989 (OBRA89), and the rapid evolution of the health care market from indemnity insurance to managed-care products and from solo practitioners to integrated systems of care. These developments will challenge the Congress as it seeks to improve performance of the Medicare program and to further policy goals, such as containing costs, expanding access, and ensuring quality of care, that affect all Americans.

The report speaks to these two different but linked agendas. Analyses of Medicare are intended to help the Congress understand how federal policy changes are affecting physicians and beneficiaries, to investigate how to make changes in Medicare and Medicaid consistent with innovations in the private sector, and to pinpoint areas where action is needed. Chapters on payment rates of Medicare and private payers, the Medicare risk-contracting program, coverage decisions, and telemedicine specifically consider how the program can respond to the changing health care marketplace.

Several chapters reflect the Commission's ongoing responsibilities to monitor the implementation of physician payment reform. These assess the effect of the Medicare Fee Schedule on access to care for beneficiaries, consider the impact of the fee schedule on physician practice and payments, and analyze the changes needed to make the Volume Performance Standards (VPS) system more effective in slowing growth in Medicare expenditures to a sustainable level. Policies to enhance states' flexibility in meeting the health care needs of the poor through their Medicaid programs are also considered.

In response to growing congressional interest in the potential of competitive markets, the report also considers the changing nature of health services delivery and its implications for purchasers, providers, health plans, and consumers, as well as for the Medicare and Medicaid programs. Chapters on relationships between plans and providers, provider-driven integration, network development in rural areas, monitoring quality and plan performance, and the changing physician labor market provide systematic information about the dynamic forces at work in the marketplace. The relationship between delivery system changes and public policy is addressed through chapters on antitrust policies, insurance market reform, medical liability reform, and development and use of practice guidelines.

Because of this subcommittee's interest in reforming the Medicare program and its concerns about the size of the federal deficit, my comments today will focus on the Medicare issues considered in the first part of the Commission's report. In particular, my testimony will touch on three critical issues: addressing limitations of the Volume Performance Standard system, improving Medicare's payment policies for managed-care plans, and monitoring access for program beneficiaries, including the implications of the differential between the rates paid to physicians by private payers and those paid by Medicare. I will also briefly touch on two other important issues: making Medicare coverage decisions for new services, and development and use of practice guidelines. To set the context for these issues, I will begin by outlining the elements of the 1989 reforms, the progress that has been made in meeting the policy goals set out by that legislation, and the new challenges facing this Congress.

Given this subcommittee's recent hearing on the financing of graduate medical education (GME) and its interest in exploring changes in Medicare support for physician training, I would like to take this opportunity to remind you of the Commission's work in this area. In our past three annual reports, the Commission has provided analysis and recommendations on how Medicare could leverage its GME dollars to help achieve broader policy goals. We are now developing a series of options for changes in direct medical education payment policy and will assess their effects on numbers of residents, distribution by specialty, as well as their impact on different types of hospitals. We have also recommended that the capitation payment methodology for Medicare HMOs be revised to remove Medicare payments to providers for medical education costs from HMO payments. Instead, separate mechanisms should be explored for paying HMOs directly for medical education expenses they may incur in training residents or using teaching facilities. We have begun to consult with committee staff to identify options for GME reform and will keep them and you apprised as this work progresses.

Overview of Issues Related to Medicare Physician Payment

With the passage of OBRA89, the Congress created a new system of Medicare physician payment consisting of a fee schedule based on resource costs, limits on the amount physicians may charge beneficiaries above the fee schedule amount, and Volume Performance Standards (coupled with expanded federal support for effectiveness research and development of practice guidelines) to control expenditure growth. This package of reforms built on a series of policy changes enacted since the early 1980s. Subsequent legislation in 1990, 1993, and 1994 reaffirmed the direction of these reforms.

The effects of these changes have been substantial, and many of the policy goals set out in OBRA89 have been achieved. The pattern of relative payments has been significantly realigned. Moreover, other payers, including private insurers and state Medicaid programs, are adopting Medicare's relative value scale in realigning their own payments. A mechanism was put in place to link fee updates to performance in slowing volume growth, giving Medicare a tool to rein in expenditures. Balance billing, the practice of charging patients more than Medicare's allowed charge, decreased dramatically, reversing the trend of beneficiaries paying an ever larger proportion of income on out-of-pocket costs. In addition, there has been considerable progress in producing and synthesizing information on clinical effectiveness and creating tools to improve decisions about appropriate medical care, both by the federal Agency for Health Care Policy and Research and by the private sector.

In hindsight, however, payment reform has not been an unqualified success for several reasons. In part this reflects inconsistencies within the policy that resulted from compromises made in crafting the reform. For example, distortions in relative values have been reintroduced due to the existence of separate Volume Performance Standards for different categories of services: surgical, primary care, and other nonsurgical. As a result, the shifts in relative payments accomplished over the past several years will likely be reversed unless further legislative changes are made.

Second, despite progress in slowing the rate of growth in expenditures for Medicare physicians' services, there are questions about whether this signals a change in trend or if expenditures will start rising again at a rate that is unaffordable. At issue is whether price constraints can hold down expenditures sufficiently within the context of a fee-for-service payment structure or whether a more fundamental restructuring of the program, consistent with movement in the private sector toward capitated payment to organized systems of care, is necessary.

Third, although changes in physician payment have not diminished access to care, neither have they led to improvements for the most vulnerable beneficiaries, including the poor, the disabled, and minorities. These populations use fewer physicians' services, are more likely to receive care in the emergency room, and have poorer health outcomes. Finally, although there is great enthusiasm about progress in developing practice guidelines, new directions are needed to ensure that these can be effective tools for reducing inappropriate care and encouraging more cost efficient practice styles.

In addition to these concerns, Congress is also facing new challenges. Although fee for service is still the predominant form of payment under Medicare and the option chosen by over 90 percent of beneficiaries, dynamic changes in the private sector are creating pressures to shift Medicare's focus from its roots in traditional indemnity insurance to more innovative methods of service delivery and payment. At issue is how to maintain Medicare's commitment to its beneficiaries while taking advantage of the benefits that a competitive marketplace may offer.

In its 1995 report, the Commission presents its ideas about how Congress might address these important issues, offering both descriptive analyses and specific recommendations for legislative changes. We suggest different strategies for the fee-for-service and managed care sectors, recognizing that, at least in the short term, Medicare beneficiaries will continue to be served in both of these settings. In addition, where we have made recommendations for immediate changes, we have developed approaches that are consistent with the anticipated direction of more comprehensive reforms.

Addressing Limitations of the Volume Performance Standards System

Medicare's primary mechanism for addressing expenditure growth is the system of Volume Performance Standards. The VPS system serves two purposes. First, it curbs the rise in Medicare spending by linking payment levels to the growth in volume and intensity of physicians' services. Second, it is intended to serve as a collective incentive to the medical profession to find ways to reduce inappropriate care, such as developing and disseminating practice guidelines that promote cost-efficient practice styles. Methodological limitations within the VPS system may, however, prevent it from working as intended. The Commission has some specific suggestions on how to fix these problems.

Given pressure to find additional Medicare savings, the Congress may be inclined to achieve the savings by making adjustments to the VPS default formula. It is the Commission's view, however, that the technical problems should be corrected first in a budget-neutral manner. Then an across-the-board cut in the Medicare Fee Schedule conversion factor could be considered as a means of budget savings. Before explaining these issues, it may be helpful to describe the experience with the VPS.

Experience with Volume Performance Standards. The VPS system is used to determine updates in the conversion factors for the Medicare Fee Schedule. Under OBRA89, performance standards

(essentially target rates of expenditure growth) are to be set annually either by the Congress after consulting with the Commission and the Secretary of Health and Human Services or by a default formula specified in law. In fact, the default formula has been used in most years. Payment rates are then either reduced or increased two years later as actual expenditure growth exceeds or falls below these standards. Performance standards were first applied to physicians' services in 1990; conversion factor updates based on how well physicians met these standards were first applied in 1992.

Although the Commission had recommended a single performance standard, OBRA89 created a system with two: one for surgical services and one for nonsurgical services. A third standard (primary care) was added under OBRA93 in response to concerns that growth in volume for technical procedures in the nonsurgical service category was depressing fee levels for primary care. Even though this has resulted in larger conversion factor updates for primary care than under the two standard system, the existence of more than one standard has resulted in distortions in the patterns of relative payment, the very problem the Medicare Fee Schedule was intended to correct.

After extremely high growth during the early 1980s, annual growth in expenditures for physicians' services has slowed considerably relative to the historical trend. Between 1991 and 1993, estimated expenditure growth slowed to an average annual rate of 3.8 percent, primarily as a result of sharp decreases in growth in volume and intensity. As a result, Medicare conversion factor updates for 1994 and 1995 were much larger than had previously been anticipated.

The reasons for this slowdown in growth are unclear as are the prospects for its continuation. The slowdown may reflect secular changes in the practice of medicine. For example, growth in technologies introduced during the mid to late 1980s (such as cataract surgery and magnetic resonance imaging) has slowed. In addition, practice styles may be becoming more efficient as a result of the increased penetration of managed care. Others suggest that low volume growth in recent years merely reflects its inherent volatility. In fact, the trend probably reflects a combination of these factors.

Recommendations for Change. The current VPS system has several flaws. First under OBRA89, performance standards are determined in part by the historical trend in volume growth. At the time the law was written, historical trends were viewed as including some amount of inefficiencies and inappropriate care and therefore a decision was made to reduce the performance standard accordingly. Initially, deductions of one half of a percentage point were taken from the standard, phasing in over time to 2 percentage points. Under OBRA93, the deduction was increased to 4 percentage points.

The problem is that this deduction is now permanently embedded within the default formula and applies even as the 1991 to 1993 growth rate is the lowest two-year growth rate since 1985. In effect, the formula demands that however well physicians did in meeting the previous standard, they must reduce volume by an additional 4 percentage points each year or pay a penalty in reduced fees. Clearly, it is impractical to expect that physicians will continue to achieve such reductions year after year.

The combination of the 4 percentage point deduction enacted in OBRA93 and a lower than anticipated volume growth rate may make it extremely difficult to get additional savings by reducing physician payment. Since it is unlikely that volume growth will fall 4 points below current levels, reductions in fees are already anticipated to begin in 1997 and continue through 2005. In fact, projections suggest that within the next ten years, the conversion factor could fall below $31, its level when the Medicare Fee Schedule was implemented in 1992.

The bottom line is that changes in the VPS default formula are urgently needed. To address this problem, the Commission recommends replacing the current formula (historical trend in volume and intensity and a 4 percentage point deduction) with a formula linked to the projected growth of real gross domestic product (GDP) per capita plus 1 or 2 percentage points to allow for advancements in medical capabilities. This would permit a reasonable rate of growth that is affordable over the long term and reflects changes in medical practice or in the economy as a whole.

The Commission also recommends two additional changes to limit further distortions in relative payments and to improve accuracy and accountability within the system. First, because the existence of three performance standards is introducing serious distortions in payment rates, separate performance standards and updates for categories of services should be replaced with a single standard and conversion factor update. If separate standards are retained, they should be based on the trend in volume growth for each category as required by OBRA90, and differential updates should be in effect for one year only. As long as you have differential updates and allow the differences to be built into the baseline, you will distort relative payments.

Second, conversion factor updates should reflect comparisons of total actual expenditures with total targeted spending accumulated since a base year. This method can be likened to a banking mechanism that maintains a running balance across all of the years since the account began. Under current policy, a performance standard is set in one year, and then two years later, adjustments to the conversion factor are made to bring spending back to target levels. Any shortfalls and surpluses in spending that accrue over the intervening two years, however, are not captured. A revised policy, establishing a cumulative VPS, would address this shortcoming, recouping the excesses or shortfalls and making adjustments to the conversion factor that keep total Medicare spending for physicians' services within its budget targets. This policy should only be considered, however, if the Congress also adopts the single performance standard and update, and the performance standard is linked to growth in GDP.

If Congress adopts this recommendation for a cumulative VPS, it should also adopt two companion policies to ensure that there is full accountability for total Medicare expenditures for physicians' services and that annual conversion factor updates are relatively stable and reasonable. First, it should develop a new default formula for the conversion factor update that would reduce volatility, either by shortening the delay before the update is set, or by incorporating a "smoothing adjustment." Limits on the size of both reductions and increases should be established to lessen the volatility of fee increases and reductions. Currently, updates are limited to a 5 percentage point penalty if actual expenditure growth exceeds the performance standard by more than 5 percentage points. No comparable limit constrains the size of increases. Symmetric limits of 5 percentage points should be used to prevent extraordinarily high increases as well as reductions. Second, the performance standard for the first year under the new method should also allow for previous fee increases in excess of the Medicare Economic Index. Otherwise, the revised policy would count the fee increase as excess spending (rather than the result of previous expenditures falling below the standard) and recapture it through a reduction to the conversion factor. For example, if this revised policy were implemented in 1996 without this allowance, physicians would face four years of a 3 percent fee reduction just to repay the 1995 fee increase.

Managed Care

As the health care system has moved toward managed care and integrated delivery systems, both the willingness of health maintenance organizations (HMOs) to participate in the Medicare program and beneficiary enrollment in these plans have increased. Currently about 9 percent of Medicare beneficiaries are enrolled in HMOs, up from 7 percent in 1993. Enrollment rates vary considerably across the country, with higher rates tending to occur where commercial HMO penetration is high. About 75 percent of enrollees are in HMOs with risk contracts which are paid on a per capita basis; the rest are in plans with cost contracts that are paid based on reasonable costs.

Further expansion of managed care within the Medicare program will depend upon the capacity of HMOs to accommodate elderly and disabled patients, plans' willingness to do business with the program, and beneficiaries' willingness to receive care under these arrangements. Inadequacies in the current payment method have impeded plans' participation in Medicare. Changes in this methodology are needed and should be considered a first step in encouraging a more substantial role for managed care within Medicare. The Commission has made a number of recommendations in this area which would enhance program performance and help Medicare capitalize on innovative changes in the health care market.

Issues Identified. Inadequacies of the current Medicare payment policies have created problems of limited HMO participation, low beneficiary enrollment rates, and higher costs per enrollee than their fee-for-service costs would have been. These payment problems include:

- payment rates that are tied to Medicare fee-for-service expenditures, so that low HMO costs do not result in savings for Medicare;
- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- volatility of county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

In addition, the current enrollment policy with its lack of coordination in enrollment periods may have contributed to low enrollment and risk selection. The Commission is recommending that a more structured enrollment process be established that provides for coordinated open enrollment periods and furnishes beneficiaries with objective, comparative information to allow them to make informed choices for HMO enrollment. Permitting beneficiaries to disenroll at the end of any month allows individuals

to leave managed care plans when they require more services. This policy should be reevaluated, weighing benefits of reducing opportunities for risk selection by locking beneficiaries in over a longer period against the risk of beneficiaries being unable to "vote with their feet" in response to poor service and quality.

In the Commission's view, the first step in expanding managed care should be improving payment policy for risk contracts by correcting flaws in current capitation rates (referred to as adjusted average per capita costs or AAPCCs). If Congress fails to address these problems, a greater role for managed care will not necessarily lead to cost savings. Building upon this foundation, additional managed-care choices (such as Medicare SELECT and other preferred provider or point-of-service options) could be expanded. In addition, other approaches that would create competition among both fee-for-service and managed-care options within Medicare could also be explored.

Capitation payment rates should be improved so that they (1) cover costs of an efficient HMO, (2) are better adjusted for risk selection, and (3) are predictable from year to year. The Commission suggests two approaches for improving capitation payments: competitive pricing methods and refinements to the current AAPCC geographic adjustment method. Because competitive pricing would be effective only in markets with multiple HMOs, both approaches are needed in the short-term. Also important is the need for payment adjustments that mitigate the financial impact of adverse risk selection (having a patient population with higher than average health care use) and reduce the incentives for HMOs to select good risks. Given the inadequacies of current risk adjustment methods, partial capitation methods that base HMO payment partly on a capitation rate and partly on actual experience could also be tested. Each of these is discussed below.

Competitive Pricing. Competitive pricing would uncouple HMO payment rates from Medicare fee-for-service expenditures, using market mechanisms to establish payments that reflect the costs for an efficient HMO. The process could work as follows. First, HMOs meeting the qualifying conditions for risk contracts would submit offers of the minimum payment rate they would be willing to take. Then the Health Care Financing Administration (HCFA) would establish a payment rate based on the bids submitted. To create incentives for plans to bid low, plans that bid higher than the final rate should be penalized, perhaps by requiring these plans to charge the balance of their bid to beneficiaries in the form of premiums.

Whether Medicare would save money from using competitive bidding would depend upon how the final payment rates established from the bidding process compare with the level of the AAPCCs in those markets. Because it is not clear how competitive bidding might affect Medicare costs, some have proposed using payment limits. One approach would be to use the national average per capita cost as an upper limit. (This rate should be adjusted for local input prices and possibly for some variation in service use.) Such an approach is not an ideal one, however, because it would reintroduce the very problems that competitive pricing was intended to correct and distort competition by preventing the established price from reflecting local market conditions.

To enhance prospects for successful implementation, the Commission recommends that HCFA be given sufficient authority and flexibility to introduce competitive bidding in markets with the best chances for success (e.g., those with high HMO penetration) and gradually increase the number of markets as competitive conditions change.

Refinements to the AAPCC Geographic Adjustment Method. Because competitive pricing would be effective only in competitive markets, there will continue to be a need for the AAPCCs or some other form of administered payment rates in the foreseeable future. AAPCCs also might be used during an interim period in locations designated for competitive pricing, until the new method was ready to implement.

Adjustments are currently made for differences in costs across geographic areas by taking the ratio of county-level per capita costs to the national average. This method is flawed because it establishes payment rates that are unstable over time and are susceptible to extreme geographic variation in service use patterns. It also creates an incentive for HMOs to choose to serve those counties within their service area with the highest payment rates.

Theoretically, geographic variation could be addressed by making payment adjustments that recognize input price factors that HMOs cannot control, such as local wage rates, and the portion of service use variation that is attributable to differences in health status. The current AAPCC reflects all service use variation, a portion of which reflects service underuse or overuse, and we are not able to measure the individual components accurately. Until more direct measures are developed, the Commission

recommends that a blended AAPCC be used, which is a weighted average of the AAPCC and the national average per capita cost (USPCC) adjusted for local differences in input prices.

To reduce payment volatility, two possible approaches are suggested. The first is to define geographic areas with larger Medicare populations, to obtain a more stable base of health care expenditures for calculating AAPCCs. The second is to use a statistical technique (called a shrinkage estimator) to establish county-level payment rates that are based partly on the county's AAPCC and partly on the payment rate for a larger area that contains the county.

Partial Capitation. When an HMO assumes full risk for its enrollees' health care costs under capitation, its financial results could range widely from large gains to large losses. Partial capitation would minimize these potential swings by having Medicare share risk with HMOs that had losses or gains outside specified thresholds. Two different partial capitation methods could be used (1) blended rates based on a weighted average of a capitation payment and fee-for-service payment for actual health care services provided, using existing Medicare payment rates, and (2) risk corridor payments that would adjust capitation rates in proportion to an HMO's net financial gains or losses exceeding established thresholds.

Despite its promise, partial capitation could be difficult to administer. Before using this method widely, therefore, demonstrations are needed to test different models and their data requirements for HMOs, and to develop needed information for setting risk thresholds and risk sharing percentages.

The Role of Cost Contracts. Cost contracts have long been made available to HMOs that do not want risk contracts. While this flexibility has ensured that a range of options is available to Medicare beneficiaries, it has also contributed to favorable selection for risk-contracting HMOs with increased costs to Medicare. In markets where competitive pricing or partial capitation are implemented, limits should be placed on the use of cost contracts.

Coverage Decisions

The report also considers the processes Medicare uses to determine coverage for new technologies and treatments, decisions which ultimately affect the cost and quality of care available to its beneficiaries. Medicare, like all health plans, has been grappling with coverage issues, such as the exclusion of experimental treatment and the role of information about cost and comparative efficacy of alternative treatments. Because most Medicare coverage decisions are made by carriers, they are often inconsistent. In addition, critical information to assess new technologies is often lacking.

The Commission recommends that Medicare take the initiative in addressing these difficult issues, setting an example for other payers. It has some advice for steps HCFA should take to reduce variation in coverage decisions. It also proposes a series of options for provisional coverage to balance the desire to provide access to new promising technologies with the need to evaluate their benefits and safety in high-quality clinical studies.

Access for Medicare Beneficiaries

As the Medicare Fee Schedule nears full implementation, access to care remains good for most Medicare beneficiaries. Few beneficiaries have had trouble getting care and most are satisfied with the care they receive. In addition, physician participation in Medicare continues to grow. Finally, there has been no systematic drop in service volumes where Medicare payment levels have been reduced since 1991.

Vulnerable populations who experienced restricted access prior to payment reform, however, continue to face barriers to care. Beneficiaries who are African American or who live in both urban poverty areas and urban Health Professional Shortage Areas have access problems including low use of primary care services, high use of emergency rooms and hospital outpatient departments, and high mortality rates.

The range of access problems experienced by these individuals suggest that a multipronged approach must be pursued to maintain and expand service delivery for underserved Medicare beneficiaries. These approaches cover a broad range of policies including ensuring the appropriate number and distribution of health professionals; paying providers, including qualified nonphysician health professionals who serve these beneficiaries; and making certain that these beneficiaries have access to new health care delivery systems.

Also of concern to the Commission is the gap between Medicare and private payer rates. If Medicare rates fall too far below private sector levels, physicians may be less likely to serve Medicare

beneficiaries, limiting their access to care. Even if Medicare payments cover the cost of care, physicians may prefer to accept patients with private insurance over those with Medicare.

Medicare's 1995 payment rates are projected to be 68 percent of private rates, averaged across indemnity and managed-care payers. In its 1994 annual report, the Commission estimated that Medicare's 1994 rates were 59 percent of the average private insurers' rates. Five percentage points of the difference between the 1994 and 1995 estimates are due to using more recent data for 1994 showing a reduction in inflation of private payment rates after 1991, and including a correction for HMO payments. Thus, a more accurate 1994 estimate would be 64 percent. The previous estimate of 59 percent is outdated and should no longer be used. The remaining 4 percentage points of the difference between the 1994 and 1995 estimates is the result of the high 1995 Medicare fee update.

The Commission has found no evidence that the current gap is causing an access barrier. It is possible, however, that a substantially larger gap could affect physicians' willingness to treat Medicare patients, but the point at which that might occur is unclear.

Development and Use of Practice Guidelines

Because the quality of care provided to Medicare beneficiaries, as well as to the general population, depends upon the availability of information to physicians on best practices, the report includes analyses and recommendations to facilitate use of practice guidelines to reduce uncertainty and promote cost-efficient practice. Mere dissemination of guidelines is insufficient; appropriate incentives and implementation in an environment that supports their use is also critical.

Given significant activity in both the public and private-sectors in this area, the Commission has some specific recommendations to build on and strengthen the role of the Agency for Health Care Policy and Research so that its activities complement and support those in the private sector. It should facilitate guideline development and use by (1) publishing and updating summaries of scientific evidence on salient medical conditions and services, (2) coordinating a public-private partnership for developing a clearinghouse to evaluate and disseminate guidelines, and (3) strengthening the research infrastructure needed to improve guideline development and use.

Looking Ahead: Medicare and the Market

The Commission's report also provides some advice to the Congress about the role of Medicare in the changing health care market. It is important to recognize that as a public entity, Medicare faces significant handicaps in keeping up with the pace of change in the health care market. What employers can accomplish through contracting and negotiation, the Medicare program must do with the much slower processes of legislation and rulemaking. Where employers can restrict choice of insurer or institute significant financial incentives for cost-conscious choices, the Medicare program has historically maintained beneficiaries' freedom of choice of provider and has had more limited influence in encouraging beneficiaries to use managed-care systems.

While these aspects of the Medicare program make it slower to respond to the changing market, they serve as a significant protection for Medicare beneficiaries. These protections are especially important for the elderly and disabled, many of whom have both substantial health care needs and longstanding relationships with particular physicians. The challenge that lies ahead will be to accelerate use of managed-care providers while preserving beneficiaries' access to high-quality care.

Medicare cannot remain unchanged if the markets and organizations with which it deals are evolving rapidly. Given the growth in managed-care organizations, Medicare currently risks becoming the last large fee-for-service program with unrestricted choice of physician. As a first step, the Medicare program might assess ways to monitor developments in the market over time. Markets may continue to change at a rapid pace, and Medicare needs to be able to adapt to both the current state of affairs as well as to any trends that are expected to continue.

Chairman THOMAS. Thank you, doctor. You can be assured that we will make sure that it continues in the nonpartisan fashion that it has in the past. In addition to that, the second half of your testimony was almost a review of the recent hearings that we have had over the question of medical education payments, methods of payments, new procedures, and especially in the medical practice guidelines. We look forward to exploring in more depth those particular areas which clearly will lead us to not only reviewing but changing the way in which practitioners are compensated. The gentleman from Nevada will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman. Dr. Eisenberg, I want to explore a little bit on what you talked about with the HMOs and putting this out to competitive bid. You talked a little bit about having a blend between capitation and fee-for-service. I just want to have you explain that a little further because the argument obviously against HMOs in this area would be that especially on a competitive bid, there would be incentive for them to deny services. So explain exactly how you think that that would work where you would not have that incentive to just deny maybe unnecessary service, as least as far as the physician and the patient feels is necessary where the HMO does not feel that it is necessary.

Dr. EISENBERG. Right. Right. Well, let me explain the theory, and then we can talk about how it might be implemented. The theory is that there is some equilibrium between paying the capitation rate that would give the HMO a certain amount for taking care of a patient for a year, and a fee-for-service rate which would pay for the services provided. And that some balance of the two would, as you point out, offset those two competing incentives. We do not know what the right percentage is. We do not pretend to know what the right percentage is, and we joke with one of our commissioners who is an economist who has done work in this area that it is typical of economists who say that they can come up with an idea in theory. Now let us just go see if it works in practice.

But we believe that this is a promising idea that we ought to try, and I would not pretend to be able to tell you what percentage it ought to be, but let us say it is 75 percent capitation and 25 percent fee-for-service. The advantage is that the HMO would then be able to be paid extra, if it happens to have a substantial number of very sick patients, we believe that that would reduce the aversion to taking high-risk patients. On the other hand, it does not encourage the HMO to churn patients and to see more of them.

It does present a serious problem in terms of data because it does require that the managed care organization collect data on utilization of individual services that some of them do not currently collect because they do not have to since they do not deal with fee-for-service medicine, but we would be happy to work with the Congress to think about some of the details. Our sense is that perhaps some demonstration projects first might be tried but then that we might move forward if they were to work. David, do you want to add to that?

Mr. COLBY. No.

Mr. ENSIGN. What we are looking at here with the whole health care reform debate is the graduate medical program, the physician payments, and hospital payments. It seems to me that we are com-

ing up with government solutions to government problems, and that because the government was so heavily involved in all of this in the first place instead of the market forces we are having to have very burdensome and complex government type problems where the marketplace without so much government involvement seems to be much more efficient in other areas of our economy at solving some of these problems. Your comments?

Dr. EISENBERG. You are right that a part of the problem that we have with the large number of residents is because the mechanisms whereby Medicare has paid for graduate education have encouraged hospitals to increase the number of residents, and a substantial number of them are residents who did not go to U.S. medical schools but will stay in the United States afterward. So you are right. In some ways this was a government problem or government induced problem. Your question effectively is "Will the marketplace or could the marketplace solve this problem?" I think you have to divide the marketplace into two different markets. One is the market for physicians. The market for physicians does seem to be changing. Primary care physicians seem to be more in demand. Subspecialists and other specialties seem to be in less demand, and yet we still have threefold differences and there are three- to fourfold differences in their average income. We are looking at changes, but the amount of change that we would have to have in order to equilibrate the different incomes would have to be much more substantial than what we have seen.

There are many people who are skeptical that the market alone will solve that although it is addressing that problem. I think more problematic is the market not for physicians but the market for residents. The market for residents is such that the residents in the specialties that are relatively undersupplied will by and large will be the least attractive residents for the training programs, especially if hospitals continue to be the major site for education. This is because those residents are mostly working in ambulatory or should be working in ambulatory settings, not providing service in the hospital, and we are convinced as a commission, and I am even more convinced as an individual, that the market will definitely not solve the problem of the market for residents. There will also continue to be inflationary incentives for hospitals to continue to recruit individuals to work in this country and then to potentially stay in this country.

We are one of the few countries in the world that allows as many individuals to train as we do, and it causes problems for other countries, brain drain problems for other countries as well. So my response to your question is, yes, the market might help us with demand for physicians, and that might influence American medical school students in which specialty they enter. It will not address the problem of the excessive number of residency positions, in my opinion. I do not think that weighting will make a big difference. I do not think that freezing the number of years of training at 3 years will make a big difference. I think that this is not just a government problem created by government decisions. It is a national problem, and I am personally not convinced that the marketplace will solve it by itself.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from California will inquire.

Mr. STARK. Thank you, Mr. Chairman. John, you went over this in your statement, the issue of Medicare reimbursement as compared to private reimbursement. And I come back to that with you. Were you suggesting that currently Medicare is no longer in the fee-for-service structure the lowest payer in time? Is that what you were getting at, suggesting that you saw the changes in the way the reimbursement structure is as between the private and Medicare?

Dr. EISENBERG. Well, the direct implication of our comment is that the gap between Medicare payments on average and private payment on average is narrowed. We have not looked at whether or not Medicare is the lowest payer in town, but we do know from reports that we have had that in many parts of the country Medicare is not the lowest payer in town. That, in effect, the conversion factor is lower in some parts of the country than the private sector. What we know as a commission is that in almost every State, Medicaid is lower than Medicare.

Mr. STARK. Yes.

Dr. EISENBERG. So Medicare has not been the lowest payer in town for a long time. Medicaid has.

Mr. STARK. Excuse me. I guess I should leave Medicaid out. The question is that whether or not with the growth in many areas of managed care plans, whatever, however you care to define those, that the savings has largely been borne by the providers who have been bargained down, if you will, by the large purchasers.

Dr. EISENBERG. Right.

Mr. STARK. And that as a result, the physician's fees paid by the major insurance companies are often lower than those fees now paid by Medicare.

Dr. EISENBERG. Right.

Mr. STARK. Is that a fair assessment of what you are suggesting to us?

Dr. EISENBERG. Yes. I think it is important to distinguish the impact of managed care in two different ways. One is that many managed care programs offer integrated systems of care, coordinated care. Some simply negotiate prices with physicians. And those price discounted HMOs are, I think, the ones that are bringing in some areas the price below that for Medicare, and that is what the market will bear.

Mr. STARK. We are going to hear today from a variety of groups, pros and cons on the three existing volume performance categories, if you will, and also some questions about how we calculate the component for overhead. My own sense is that those pros and cons will largely be driven by the presumed increase or reduction in payments for overhead or payments for fees. Is there anything else in that argument that I am missing? In other words, I am sure that those who think their fees will go up if we go to a blended payment volume performance group will be for it. Those who think they will lose money will be against it. And the same thing. Those who suspect that their overhead payments would go down will oppose it, and those who think they can squeeze a little more overhead payment out of us will support the change. Am I missing any-

thing else in there other than a pretty straight economic relationship to the support or opposition of these changes?

Dr. EISENBERG. Well, I think you are right. To some extent, this is a pie that is going to be divided up among the various types of physicians, and I think we will see the forces that you are describing as we talk about whether or not there ought to be separate standards, separate performance standards. But the other part of this problem that we have addressed, which is embedding the 4-percentage point reduction into the VPS, affects all physicians. So it really does not matter which group you are in for that factor.

Mr. STARK. Just one final question. One of the things we considered long and hard was how you divide up whether it should be by specialty, and the only reason really we did it was the AMA fought us and some of the good specialists helped us on the condition that we would give them separate payments, which is all right with me. But one of the things that has not come back for discussion is the issue of doing this State by State, and, in effect, regionalizing it. Practice habits are different, we find, State by State anyway. Is there any reason that we could not turn this over in a sense to the State medical associations or some other group, and do it regionally? Is this something that you have no longer considered in your performance standard groupings?

Dr. EISENBERG. Well, it is interesting that you bring that up because there is a table at the beginning of the PPRC report in which we describe some of the reasons why we needed reform in the first place, and one of the reasons we needed reform was because of extremely disparate payment rates across different parts of the country that you could not explain except that they were embedded in history. And our sense was that one of the important contributions that the Congress made in 1989 was in developing a national fee schedule so that those unexplained differences across States or across regions could be eliminated.

Since then we have worked with you to try to figure out if there are justifiable differences based upon the cost of living or based upon the cost of practice in different areas, and we think that that is appropriate. In general, as the commission looked at this issue when we first dealt with it, our sense was that there are certainly regional differences in practice patterns, but that by and large the practice of medicine is a national phenomenon.

And the literature that guides practice is a national phenomenon, and we did not think that it would be wise to have different payment schemes State by State. And a second issue is that there is a need for a database in order to guide the Congress in determining how these updates ought to be calculated, and the best database that we have now, in our opinion, is the Medicare database and it has improved substantially over the past several years. Now that could be divided up State by State, and you could give each State their data, but we think that it has been a major advantage to be able to have a national database that we can use.

Mr. STARK. Thank you. Thank you, Mr. Chairman.

Mr. ENSIGN [presiding]. The gentleman from Texas, Mr. Johnson.

Mr. JOHNSON. Thank you. Well, I do not like your idea that it is a national problem, and it tells me that you think you can say more about how medical care is delivered in this country than the

doctors on the local scene can, and I am appalled that you are saying that quite frankly, but I am glad that you are considering some sort of regional program, and I thank the gentleman from California for bringing that up. I would like to ask you did the PPRC recommend increasing the deduction to 4-percentage points originally, and where did that proposal come from, and what was the rationale behind it?

Dr. EISENBERG. Well, first let me respond to the first part of your comment. I want to discriminate between two different issues, and my response about a national problem was addressing the work force issue, that I believe that the work force problem, the surplus of physicians and the surplus of many specialists, is a national problem.

Mr. JOHNSON. Well, does that mean, if I can interrupt you, that you are going to tell the States and the State schools how many doctors they can put in training each year because it is a State-defined problem, is it not?

Dr. EISENBERG. Right. Well, that is exactly the problem. The problem that we have is not the number of medical students in training in the United States. The problem that we have is the number of residency positions that we and our hospitals pay for, which is 140 percent of the number of U.S. graduates. My concern—now I will speak as an individual—my concern is that we deny some American students the opportunity to go to medical school. There are not slots in medical school for them, but there are plenty of residency positions for people other than U.S. graduates to do residencies and then practice medicine in this country. And I think your point is well taken.

Mr. JOHNSON. Well, are you suggesting then that we try to stop aliens from coming in or immigrants of any sort——

Dr. EISENBERG. It is not an issue——

Mr. JOHNSON [continuing]. Until we can resolve it locally?

Dr. EISENBERG. I think that we ought to have a limit on the number of residency positions in the United States.

Mr. JOHNSON. Well, why do you not make that recommendation?

Dr. EISENBERG. We have. We made it last year. We made it the year before, and we stand behind that recommendation that there ought to be a limit to the number of residency positions that are funded.

Mr. JOHNSON. An immigration policy, so to speak?

Dr. EISENBERG. Well, your point was earlier that we have a Federal problem because of some Federal mistakes that were made in the past.

Mr. JOHNSON. Right.

Dr. EISENBERG. I'm agreeing with you that this is a phenomenon that was created by Federal policy, and I think we can address it by Federal policy. The other issue has to do with practice patterns. I could not agree with you more that the right way to influence physicians' practices is at the local level, but I think you will hear from all the national organizations who will follow me today that local physicians will be able to influence each other best if they have good solid research data from the Federal Government and from their national professional societies that help them to teach each other at the local level. That is why I think it is a national

issue. Each individual doctor and his colleagues are not going to be able to do the research on what works and what does not. They need the government and they need their professional associations to help them with that.

To the point of the 4-percentage point reduction, that was a decision which was reached for budgetary reasons. That is my understanding, and it was not based on a recommendation from the Physician Payment Review Commission. In fact, our hope was that the Congress would make decisions on a year-by-year basis which were based upon the rate of growth and what the Congress felt was affordable rather than getting locked into a formula that would tie the hands of the Congress in terms of the amount of growth that it thought would be justified.

Mr. JOHNSON. Well, are you saying that that was not based on empirical data then?

Dr. EISENBERG. The 4 percent. No, I suspect——

Mr. JOHNSON. It was just an out of the air number?

Dr. EISENBERG. I think at the beginning it was better than out of the air because of the rate of growth in physician services was perceived to be intolerable. And something had to be done to get it down, and I think you did what needed to be done to get it down. Now we are locked into a default formula which ties us to a solution for a problem in 1989 that does not seem to be a problem in 1995.

Mr. JOHNSON. I got you. Thank you for your comments.

Dr. EISENBERG. OK.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. ENSIGN. The gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. Dr. Eisenberg, let me join my colleagues on the committee in congratulating you for your service on the commission and the help that you have been not only to the committee and Congress but to this Congressman's office in supplying information that has helped us in dealing with our responsibilities here. You will be missed.

You have also, I think, pointed out over the time that you have been with the commission the fact that the philosophy of just discounting rates and that Medicare trying to get the lower rate in and of itself is not going to save costs for the Federal Treasury, that we need to take a look at more sophisticated ways. I come from Maryland, as you know, and we do not believe in discounting rates for hospitals. We believe that we can save money by reviewing and managing utilization and other ways rather than trying to get discounts or allowing different entities, including the Federal Government, to get discounts.

So we need to take a look at other methods and you have been helpful to me and to the committee in looking at how to achieve that. I wanted, though, to change gears a little bit. In your testimony, you deal with a problem that evidently has now surfaced in Maryland with clinical trials and the need for Medicare to allow beneficiaries to benefit from clinical trials and new technology. I have heard from Johns Hopkins that they no longer are going to include Medicare beneficiaries in clinical trials for cardiac devices because of a recent change in the interpretation of Medicare's coverage rules.

I am wondering whether your commission has made any decisions as to how we could modify the Medicare rules to make sure that Medicare beneficiaries will not be discriminated against by being excluded from these very important types of new technologies?

Dr. EISENBERG. Right. We have recommended to you in what is chapter 6 of this year's report some specific ways in which we believe that you can assure that both Medicare beneficiaries will have access to trials and that the Medicare program can help to foster appropriate evaluation of medical services. So what we have suggested is that when a new service is being evaluated that Medicare should pay up to the standard amount of care that would be provided for that patient in the normal setting, and the fact that the patient gets an experimental treatment should not nullify the entire cost of care that Medicare would reimburse.

And second, we would like to encourage the Medicare program to work with what might be considered centers of excellence or centers where evaluation can be carried out so that new technology gets evaluated quickly with large numbers of patients so that we understand quickly what the safety and efficacy of those services are. By doing that, we believe that we can avoid the current situation which is sort of akin to a dam breaking, that for awhile nobody pays for a service and then all of a sudden Medicare pays, but in a somewhat indiscriminate fashion, for the service anywhere by any physician in any hospital.

We believe that what ought to happen is, and this is my analogy, not the commission's, but that the dam ought to let the water out in a more controlled fashion so that we can be sure that as the new technology is disseminated, it is disseminated in an appropriate way and that we gather data on side effects and on the effectiveness of those services. Now I will not speak specifically to Johns Hopkins, but I would guess that Johns Hopkins would be considered by at least some a center of excellence, and that we would see some of these trials being carried out in Baltimore.

Mr. CARDIN. I am wondering whether you have had discussions with the academic centers or the centers of excellence as to whether that type of recommendation would take care of most of the concerns that they are currently having with HCFA regarding Medicare reimbursement.

Dr. EISENBERG. During our hearings, many of the organizations who represent academic health centers weighed in with their opinion on this and on other issues. By and large, though, our discussions on this issue have not been so much with the academic medical centers as with the people who are expert on technology assessment, who feel that we need an improved method of assessing new technologies and allowing Medicare to participate in that process. In general, I think the academic medical centers were supportive but our input was really much more from those who were concerned about getting the technology evaluated appropriately.

Mr. CARDIN. Well, I thank you for bringing forward the recommendation. I think it is an important recommendation, and I hope we will move on it. Thank you.

Mr. ENSIGN. Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman. Doctor, good to see you. Thank you for being here. I know that your primary emphasis is in terms of physician payments, but there are a couple of other issues in your report. Maybe I could ask you about them on pages 11 and 17. One, it really concerns the rural areas. This is something which I am particularly concerned with, and then also it involves specifically the network development in telemedicine. A lot of people come to me because I do represent a rural area and say, you know, with all this great planning that goes on that we are afraid that the concentration is going to be in the metropolitan areas.

And with so many economic problems visited upon the teaching hospitals we fear that we are going to be forgotten. I would appreciate any comments you have on two areas, network development, and telemedicine, which I happen to be interested in.

Dr. EISENBERG. OK. Well, as you may know, chapter 7 of this year's report deals with telemedicine. The way the commission has usually dealt with new issues is that for 1 year we will try to understand the issue as best we can but not issue a recommendation, and that is really where we are with telemedicine. We are concerned, however, because of the fact that telemedicine is here. In one form or another telemedicine is here, but Medicare's rules for payment require that the physician and the patient have personal interaction which, of course, makes telemedicine extremely difficult for reimbursement. So we have met with the Health Care Financing Administration to hear what they are thinking, and our staff has thought a lot about this issue, and I cannot tell you today that we have a solution, but I will say that we are concerned about the potential that Medicare's reimbursement scheme would get in the way of appropriate dissemination of telemedicine.

Mr. HOUGHTON. If I could just interrupt a moment. I would urge you to take another close look at this thing. The technology is there. The need is there. And there will be a communications bill coming out which will pour enormous amounts of investment into this country because of the interlocking of cable and telephone and what other services you have. This is something which is not only important for the patient, but also it is important economically for the areas because it enables you to keep hospitals open and physicians in small communities which you could not do if you did not have access to this type of thing.

Dr. EISENBERG. Right. I agree with you, and, in fact, we are very interested in the fact that several components of the Federal Government are dealing with this issue. You know the Office of Rural Health Policy has some grants out for evaluating and disseminating telemedicine, and we are looking forward to working with those groups, and I assure you the commission will continue to deal with that. We also have struggled with the other issue that you addressed, which is the ability to get physicians to work in rural areas, and we recognize how difficult this is to achieve.

And the solutions that we have recommended have included increases in payment of relatively modest amounts for physicians who practice in rural underserved areas. We would like to find some better solutions and would like to work with you to that end. We do not know whether or not the small increase in Medicare

payment to physicians to go into rural areas has had a big difference in their going there, but at least we will assume it has not hurt.

Mr. HOUGHTON. Thank you.

Mr. ENSIGN. The gentleman from Wisconsin, Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman. Dr. Eisenberg, let me shift gears again on you and address some of my concerns and questions about managed care. In your statement, you do address the issue. In fact, you indicate that one of these days we should look at improving the payment policy for risk contracts, but with that being said and aside, the reason I bring up the managed care issue is because I recall reading yesterday some news accounts where Speaker Gingrich addressed the AMA and called for either an investigation or a complete review of managed care programs and systems in this country. It is my recollection that the chairman of this committee is going the other way, saying that maybe we should be looking at, and I do not want to put words in his mouth especially since he is not here, but words to the effect that maybe we should be looking at moving more of these Medicare recipients into managed care programs. Give me your broad view of the effectiveness, of the criticism, and your views on continuation or expansion of managed care.

Dr. EISENBERG. One of the problems with managed care is that it is such a heterogeneous group of payment mechanisms, and in our report, this year and last year, we have tried to address this problem by pointing out that what we call managed care ranges all the way from group model HMOs that are fully capitated with salaried physicians to very loose organizations who by and large negotiate fee discounts. And therefore when you look at the research data in this area, it is very important, I think, to be sure that you are interpreting the research data in light of the kind of HMO or the kind of managed care program that you are considering.

Our commission has been concerned about the degree, for example, the degree to which beneficiaries understand the contract that the HMO has both with the physician and the contract the HMO has with the Medicare beneficiaries themselves because they are very confusing. We are also concerned about some of the issues of enrollment. For example, Medicare will allow an HMO to choose between a cost contract and a risk contract. Well, the odds are that a managed care organization that believes that it is going to make money in the risk contract will move to the risk contract, but still has the option of having a cost contract, cost-based contract if it would like to offer its services to Medicare beneficiaries. Well, that is really not limiting Medicare's financial exposure by going through the managed care organization, and we believe that those cost contracts ought to be eliminated except perhaps in some areas where there otherwise would be limited access to managed care organizations.

As we have looked at this literature, there probably are gains for many of the better managed care organizations in this country, cost saving potential, as well as the opportunity for Medicare beneficiaries to have access to the various new kinds of health care delivery systems in their region, and for that reason we believe that Medicare beneficiaries ought to have access to managed care pro-

grams. But we are concerned about the diversity of managed care organizations, and we also are concerned about the literature that we have seen which suggests that the savings in managed care might not be as great as some have felt because it may be the case that Medicare beneficiaries who have signed up with managed care organizations are less ill. The literature suggests that they are younger and that their previous expenditures are less than the rest of the Medicare rolls.

Mr. KLECZKA. Well, I might point out, doctor, that the committee recently went through the issue of Medicare Select and the extension of that program, and we did find during our discussion that there was a savings to the patient, to the beneficiary. However, that same savings was not realized by the government itself.

Dr. EISENBERG. Right.

Mr. KLECZKA. So by saying managed care we should not think of saving oodles of dollars and everything is going to be okey-doke.

Dr. EISENBERG. We do not think it is a panacea, but it does have promise to help with access and cost.

Mr. KLECZKA. Depending how it is formulated and how it is——

Dr. EISENBERG. Exactly.

Mr. KLECZKA. OK. Thank you very much. Thank you, Mr. Chairman.

Mr. ENSIGN. The gentleman from Illinois, Mr. Crane.

Mr. CRANE. No questions.

Mr. ENSIGN. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Dr. Eisenberg, thinking about the three separate performance standards, and you talk about that in your testimony. And you say that the existence of more than one standard has resulted in distortions in the pattern of relative payment, and that is the problem we were trying to get at with the Medicare fee schedule. Can you elaborate on how these distortions are impacting the program and maybe how long you think it will take to get us back to where we were before we made the adjustments?

Dr. EISENBERG. Sure. You will receive soon, tomorrow, I believe, a copy of the report. And table 3 and 4 gives the answer to your question. In 1992, the conversion factor was $31 across the board. In 1995, our estimate is that the conversion factor will be $34.62 for nonsurgical; primary care will be $36.38; and surgical will be $39.45. So that surgical payments will be about 10 percent higher than the payment to primary care. If we had one single conversion factor, then we would have a conversion factor that would be $36.63. So that it would be $36.63 compared with surgical $39, primary care $36, and other nonsurgical $34.

Mr. STARK. Would the gentleman yield?

Mr. MCCRERY. Sure.

Mr. STARK. Would the Chairman consider unanimous consent to extend him some extra time?

Mr. MCCRERY. Sure.

Mr. STARK. And I might ask a question about this point?

Mr. MCCRERY. Sure. Be glad to yield.

Mr. STARK. Is not the $39, which is higher than the $34 and the others, for the surgeons partially a bonus or a reward for holding down volume?

Dr. EISENBERG. Partially, yes. And may I expand upon that?

Mr. STARK. Sure.

Dr. EISENBERG. There has been a reduction in the volume of surgical services. There are two services that account for a large portion of that, a decrease in cataract extractions and a decrease in transurethral resections of the prostate, in both of which there have been some major technical changes over the past few years, and a big increase several years ago in cataract extractions because of some very impressive advances. So that we may have seen a blip in the cataract extractions and we may be coming back to normal.

The second factor here is a very important one, which is that the baseline rate of growth, against which these rates of growth for the three different categories is measured, is the same. If you were to use three different baselines and three different rates of growth, then what you would see is less of a difference than we currently have, and I believe we have that in the report, and maybe, David, if you can find it for me, that would be helpful.

Mr. STARK. I just wanted to ask the gentleman to yield. I guess what I hear you saying then perhaps is that we are not getting that much benefit or differentiation out of this benefit or incentive pay. That really these differences are a result of changes in practice, and I hope, Mr. Chairman, you will yield him some more time, but I am not sure of that myself. And I am just curious——

Mr. MCCRERY. Yes. No, I am glad you asked that.

Mr. STARK [continuing]. If you intended that if you reduced your volume, it would give you a higher index. And I am just trying to find out whether we think that is working or whether it is too early to tell.

Dr. EISENBERG. Well, about half of the difference is due to a difference in baseline given our data, and about half of the difference is due to the decreased rate of growth among surgical services, and it is a judgment call as to whether or not that decrease in the rate of growth of surgical services is because of those couple of services that I mentioned or because of overall changes. I think the surgical community has done an excellent job of communicating with surgeons about the need to be more cost effective. And when we have looked at data on interviews with physicians about whether or not their professional societies have communicated with them, surgeons know that this is an issue. So at least a part of this is because the surgical community has been responsible and tried to get the rate of growth down. Does that address your question?

Mr. MCCRERY. Yes, it does. What about the impact of increased emphasis on primary care? Does that not also have some effect on the volume of specialty care?

Dr. EISENBERG. On the volume of specialty care?

Mr. MCCRERY. It could indirectly have an effect on the volume of specialty care, at least in the long term. It is hard to know in the short term what the effect of changing primary care payment is going to be on specialty care. You could, I think, argue it both ways, and I do not know of data that would answer your question specifically. Do you, David?

Mr. COLBY. No.

Mr. MCCRERY. OK. Thank you, Mr. Chairman. Oh, new Mr. Chairman.

Chairman THOMAS. The gentleman from Washington will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Dr. Eisenberg, first of all, I want to be on the record as saying your service to the country in terms of sitting on the commission and educating this committee, is unmatched, and you should be recognized for that.

Dr. EISENBERG. Thank you.

Mr. MCDERMOTT. And I came down here because I wanted to hear you talk some more about this capitation idea. Take my 5 minutes and explain how you think it might work.

Dr. EISENBERG. The partial capitation idea?

Mr. MCDERMOTT. Partial capitation, yes.

Dr. EISENBERG. OK.

Mr. MCDERMOTT. Because I think it is an idea that people on the committee, do not totally understand how you envision it working.

Dr. EISENBERG. The way it would work is in one of two fashions, as we have thought this issue out. One of them would be a mechanism whereby some percentage of the total dollars that are paid to a managed care organization would be prospective and capitated, and some portion would be based upon the amount of services that that organization and its physicians and associated hospitals provide to the Medicare beneficiaries. Now what that specifically would boil down to in terms of a percentage, I wish I could say, but I cannot, and I also wish that we had more than 1 page of our report that deals with this issue because you obviously, the committee obviously finds this interesting, and we will be dealing with it more in the future.

But this idea of a blended rate implies that there is an appropriate mix, which we would not pretend to be able to tell you in terms of the percentage, but an appropriate mix of fee-for-service payment and capitation payment to an organization that allows it both to protect itself against the cost of having adverse risk selection—that is the term that is used—which means that they would have more ill patients signing up with them, and having the risk that, even if unintended, they might limit services to their enrollees because of the incentives that are implicit in full capitation.

Mr. MCDERMOTT. The idea being that if they did not actually deliver the service, they would not get the money?

Dr. EISENBERG. Exactly.

Mr. MCDERMOTT. So they would get 50 percent of what they would expect on a capitated rate up front, and then the other would be if they delivered the service or some percentage thereof?

Dr. EISENBERG. Exactly. Right. Whatever percentage you decide or HCFA decided to use.

Mr. MCDERMOTT. Now right now not all of medicine is organized in HMOs. So how would that work with the people who are not presently primarily involved in HMO arrangements where they are still operating as standard fee-for-service stand-alone clinics or individuals?

Dr. EISENBERG. It would not affect them. They would still be in the standard traditional Medicare system. This is simply an alternative way of paying managed care organizations that we believe has some potential.

Mr. MCDERMOTT. Explain to me the benefits of it. Why would you want to use this blended rate? I think I might be able to read your mind, but I would rather have you say it.

Dr. EISENBERG. Let me read it to you. I will read you from the report because this way I will get it exactly right.

To varying degrees, all of these methods would mitigate risk selection at the expense of capitation's efficiency incentives. That is, if you just simply paid managed care organizations something that reflected their utilization. Capitation reduces costs by creating incentives for HMOs to control the price they pay providers and to achieve a less costly service mix. Some partial capitation model would weaken only the incentive to achieve service mix efficiencies while others would weaken the incentives associated with both price and service mix components.

I am not sure that really helped, but let me try it out myself. I think what we are trying to do——

Mr. MCDERMOTT. That is why I asked you.

Dr. EISENBERG. Yes, right. I should have just said it rather than read it. What we are trying to do is to reach some compromise between what we believe to be competing perverse incentives of fee-for-service medicine and capitated medicine. We all agree fee-for-service medicine has a perverse incentive to overutilization. We all agree that managed care with full capitation has a potential perverse incentive to underutilization. Now if that is the case, theory would lead you to think that some combination of those two would allow you to offset those two potentially perverse incentives.

Joe Newhouse, who is a member of the commission, has written about this in scholarly journals, but this really is a theory right now. And I have to say that.

Mr. MCDERMOTT. Can I ask you one followup question. Would it make the point-of-service option by an HMO more likely or less likely?

Dr. EISENBERG. Well, I think it would make the point-of-service more feasible.

Mr. MCDERMOTT. Feasible.

Dr. EISENBERG. Yes.

Mr. MCDERMOTT. Maybe that is a better word.

Dr. EISENBERG. One reason for that among others is that the HMO, the managed care organization, is going to have to have data on utilization, and point-of-service plans provide a mechanism whereby managed care can get that data about the utilization of services by its enrollees.

Mr. MCDERMOTT. Mr. Chairman, with your indulgence may I ask one more question?

Chairman THOMAS. Sure. Because I am going to continue this line of questioning so if you ask then I may not have to.

Mr. MCDERMOTT. Well, I was going to shift a little bit, but there are certainly more questions on this issue. But one of the questions you raised was this whole business of the experimental threshold, something rises up to a level where it is no longer experimental. Cardiac surgery is probably the place where you see it most, but there are other places.

Dr. EISENBERG. Yes.

Mr. MCDERMOTT. What kind of standard or by what kind of process do you decide about clinical efficacy without respect to whether the FDA has made a decision or not, but in terms of frequency, and what the journals say? I mean how do you make a decision as to

what should be paid that might be still in some people's minds experimental?

Dr. EISENBERG. It is extremely difficult if it is not something which the FDA deals with because the FDA has a gate that it opens and says you are no longer experimental, and before that gate is opened, you are experimental. What happens today unfortunately is that payer has to decide if the service is sufficiently experimental.

Mr. MCDERMOTT. So you are talking about the intermediaries in the various States. In our State it is Aetna. Aetna decides whether this is experimental without respect to the FDA. If enough of them are done in Washington State, they——

Dr. EISENBERG. That is one way in which it can be done. It is the way in which it is done today, but there are such huge differences across the country in which the intermediary decides when a service is experimental that we have recommended at least as a first step that there be a national clearinghouse, a national database where you and the Health Care Financing Administration understand these differences in the decisions about what is going to be considered experimental. But the gap between allowing every intermediary to make this decision on its own and having an agency like the FDA that makes these decisions is a huge gap.

Mr. MCDERMOTT. Yes.

Dr. EISENBERG. And there is nothing in between so far as we can tell except practice guidelines and perhaps the Agency for Health Care Policy and Research working with the Health Care Financing Administration to evaluate these technologies as they come out. And that is our concern is that we have done very little as a nation to deal with figuring out how new services, new technologies, should be disseminated. We have just left it up to the carrier medical directors or to the payers. We, and I think the medical community in general, and certainly the beneficiary community, are not satisfied with that.

Mr. MCDERMOTT. Thank you, Mr. Chairman, for your indulgence.

Chairman THOMAS. Oh, certainly, because what you are doing is wrestling with all the decisions that we are going to wrestle with. At the beginning of your statement, I was transported to, oh, pick any number of hearings in which Alan Greenspan has appeared in front of whichever committee talking about this business of shortening lag time, of not overreacting in one direction or another in terms of trying to either overheat or cool off the economy.

I mean we are always faced with this in macroeconomics when we have a relatively arbitrary figure that we are trying to move toward without over- or undercompensating. It is that swing concern that you focused on, and we do have to worry about that, but I also want to make sure that we worry about getting right while we are worried about controlling the swing. The AAPCC is rather an imperfect tool, and obviously we are looking for ways to deal with that. That is why I think you will find that this subcommittee is very interested in the concept of partial capitation, which would give us not only the ability to perhaps control some swing, but maybe a better chance of getting it right. At the same time I think we have all begun to feel that creating an adverse risk selection adjustment mechanism is harder than we thought it was. Its a little

bit like Lucy and Peanuts when she looked down the sidewalk and saw that it came to a point, and Lucy was going to walk down to look at the point. The next box of the cartoon was "Whoa, it's farther than I [Lucy] thought it was."

It is something that has eluded us for more than a decade, and the idea of perhaps some kind of a blended rate will mitigate or minimize the adverse risk selection while at the same time the fears of those who in a managed care structure, in a capitated structure, would not put emphasis on particular things that we thought were important, can be emphasized by those particulars while at the same time providing a point-of-service option more likely in those specific preferred service areas that we might want to support. So it has a lot of attraction to us obviously in trying to come up with it.

And then a comment that you made to the gentleman from Washington about needing a national database pops up virtually every time we try to look at these numbers. We have got to get not just that database but a structure in which we can retrieve information from that database in a shorter period of time. It is very frustrating with the kinds of changes that are going on to look at data that is 2 years old. Even data that is 1 year old, in today's dynamics, makes it very, very difficult for us to nail this down. So your testimony has been very helpful to us primarily by piquing our continued interest in "solutions" that may be out there that we can agree on in a bipartisan way to create a better Medicare, and I appreciate your comments very much, doctor.

Dr. EISENBERG. Thank you very much.

Chairman THOMAS. Any additional questions from the panel? Thank you very much.

If I could ask the second panel to come up, please. Dr. Johnson, Dr. Ebert, Dr. Graham, Dr. Weaver, and Dr. Nelson. I thank the panel for coming, and I would say that any written testimony that you have will be made a part of the record without objection. And that we will simply begin with Dr. Johnson and move along the dias in terms of your presentation. But before I ask you to begin, Dr. Johnson, I believe there is a home State pride exhibiting itself to my immediate right, and I would recognize the gentleman from Louisiana.

Mr. MCCRERY. I thank the Chairman for allowing me to welcome to the committee Dr. Johnson, who is from the New Orleans area in Louisiana. I have gotten to know Dr. Johnson because of our instate unity and even though I am from the north in the State, which sometimes is described as a different State, still we are in the geographic boundaries of the State of Louisiana, and I have gotten to know Dr. Johnson because of that. I have a lot of respect for him and the integrity with which he approaches the issues that we deal with in this Congress. So I want to welcome Dr. Johnson, who is the speaker of the House of Delegates for the American Medical Association, and look forward to your testimony as well as the testimony of each of you who are before us today.

Chairman THOMAS. With that, Dr. Johnson, if you would like to proceed in any way you see fit to inform this subcommittee in the 5 minutes that you have.

STATEMENT OF DANIEL H. JOHNSON, JR., M.D., SPEAKER, AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Dr. JOHNSON. Thank you, Mr. Chairman, and before I begin, I thank you for your courtesies and particularly for the courtesies of Mr. McCrery. The Congressman is very well appreciated in our State, and I thank him for his kind remarks. Mr. Chairman and members of the subcommittee, my name is Daniel H. Johnson, Jr. I am a practicing diagnostic radiologist and serve as speaker of the House of the Delegates of the American Medical Association. On behalf of the AMA, I appreciate the opportunity to testify before you this morning. My remarks will address the PPRC's recommended revisions to the medicare volume performance standards (MVPS), related conversion factor projections, and the implications of Medicare part B cuts.

We have several concerns about the MVPS. First, the annual HCFA and PPRC MVPS recommendations have not reflected the original intent of the MVPS to be a true estimate of needed Medicare spending. Unfortunately, both HCFA and PPRC have used the MVPS primarily as a deficit reduction tool.

Second, the baseline projections of expenditure of growth in the MVPS do not allow for forecasting uncertainty. Historical differences between actual and predicted physician payments under Medicare have sometimes been quite large. We support the use of an MVPS range rather than a single number.

Third, we have consistently opposed splitting the MVPS into surgical and nonsurgical categories and conversion factors. We also oppose divisions of the nonsurgical category into primary care and nonsurgical/nonprimary care categories. Such differentials have undermined the premise of the RBRVS that relative payments should reflect relative resource costs. Therefore, we agree with the PPRC's recommendations that separate MVPSs and updates be eliminated.

Last, revisions in OBRA 1993 further eroded the volume and intensity component of the MVPS. These changes further reduced its volume factor with arbitrary budget-based assumptions, not rational judgments about the health care needs of our Medicare patients.

Under the current system, unless volume growth each year goes down 4 points from the previous year, physicians will face a conversion factor cut of at least 2 percentage points each year. Does it really make sense, that, no matter how much volume is reduced, the MVPS asks physicians to reduce volume by 4-percentage points?

Underlying these concerns are disturbing conversion factor projections. Under current law, the Medicare conversion factor is projected to fall steadily after a small projected increase in 1996 from nearly $36 in 1995 to about $30 by the year 2005. The real inflation adjusted conversion factor for that year in 1995 dollars will be even lower at $24.67. This represents a 31-percent reduction in value. The PPRC has recommended a series of changes to the MVPS. Like the commission, we believe that these changes should not be used to further reduce the Medicare conversion factor in order to generate budget savings.

Indeed, the AMA supports most of the PPRC's proposals including the general recommendation to replace the current MVPS default volume factors that includes the 4-percentage point deduction,

with a formula linked to GDP plus 1 or 2 points. We think this additional factor should be at least 2 points.

However, the AMA has consistently and strongly opposed the cumulative MVPS. It is simply a tool to lower the conversion factor. Congress could have enacted a cumulative MVPS in 1989. It did not. Changing the rules in midstream, we believe, is unnecessary and unfair.

We want to emphasize that not all of the problems of the cumulative MVPS and associated corrections have been fully identified.

Mr. Chairman, we recognize that this subcommittee will be searching for additional Medicare budget savings this year as you continue your efforts to reform the Medicare program. The answer is not another round of huge Medicare physician payment budget cuts. Physicians, who account for 23 percent of Medicare outlays, have absorbed 32 percent of Medicare payment cuts over the last decade. OBRA 1990 imposed 32.9 billion in cuts over 5 years, and OBRA 1993 imposed an additional 47.4 billion in provider cuts over 5 years. Physicians have succeeded in actually holding down the volume increases below that predicted for 1992 and 1993, thus saving the program billions of dollars. The MVPS formula as modified by OBRA 1993 will impose annual cuts of 2- to 3-percent each year in physician payments even without any further congressional action.

Moreover, because of continuing transition and OBRA 1993 cuts, even if the Congress were to freeze the conversion factors for 1996, physicians would feel an additional 2 to 3 percent reduction in payments.

We urge you to acknowledge physicians' recent success in moderating growth in Medicare expenditures for physician services. According to the PPRC, average spending growth fell to 3.8 percent between 1991 and 1993. These increased costs are still being driven primarily by new technology, increased rate of use of services by enrollees, insulation of the enrollees from the cost, and flawed financing structuring.

In conclusion, physicians should be recognized for the savings we have accomplished and should not be forced to shoulder unjust burdens in another round of budget cuts. Mr. Chairman, Medicare payments that lose their value year after year pose a real threat to patient access to care. In the weeks and months ahead, we look forward to continued work with the subcommittee and with the Congress on long-term Medicare reform strategies. Thank you.

[The prepared statement and attachment follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives

RE: Physician Payment Review Commission's 1995 Recommendations

Presented by Daniel H. Johnson, Jr., MD

March 30, 1995

Mr. Chairman and Members of the Subcommittee:

My name is Daniel H. Johnson, Jr., MD. On behalf of the American Medical Association (AMA), I appreciate the opportunity to testify before you this morning. I am a practicing diagnostic radiologist and also serve as Speaker of the AMA's House of Delegates. The AMA commends your examination of the important issues relating to the Physician Payment Review Commission's (PPRC) 1995 recommendations to Congress. My remarks today will principally address the PPRC's recommended revisions to the Medicare Volume Performance Standards (MVPS), related conversion factor projections, and further implications for Medicare Part B cuts.

THE MEDICARE VOLUME PERFORMANCE STANDARDS

Background

The MVPS was a central element of the physician payment reform legislation enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) and was viewed as an improvement over more stringent expenditure targets that were proposed at that time. The MVPS is a projected goal for Medicare Part B spending growth. When actual spending exceeds (or is less than) the MVPS target, the Medicare physician payment schedule conversion factor is reduced (or increased.)

The MVPS can be viewed as a budgeting tool that helps improve predictability in Medicare expenditures by relating physician payment levels to the growth in volume and intensity of physicians' services. By April 15th of each year, the Secretary of the Department of Health and Human Services is required to recommend an MVPS for the following year. The recommended MVPS is supposed to incorporate the effect of changes in enrollment, aging, the impact of new technology, access to care, and the degree of unnecessary or inappropriate care. The PPRC is then required to comment on the Secretary's recommendation. Under current law, separate volume performance standards are established for primary care, surgical, and other non-surgical services.

If Congress does not explicitly establish an MVPS, then it is determined by a default formula. The default formula is calculated as the product of the percentage change in these four factors: (1) Medicare payments; (2) Medicare non-risk plan (i.e. HMO enrollment); (3) the five year trend in volume and intensity (V/I) for physician services; and (4) Medicare physician spending due to changes in law and regulation. This figure is then reduced by a "performance standard factor" that is currently 4.0 percentage points.

Conversion factor updates under the default formula are equal to the change in the Medicare Economic Index (MEI) plus the relevant MVPS minus the actual change in spending for that year. The downward adjustment to the conversion factor is limited to five percentage points in any one year; there is no upward limit on adjustments.

The current MVPS represents a series of compromises that were made in 1989 by the Congress, Administration officials, physicians, and Medicare patients. The AMA was pleased at that time that important elements of the MVPS differed substantially from the arbitrary expenditure targets that

were under consideration. We were especially appreciative of the fact that there was a 3% floor (since increased to 5%) on MVPS-associated reductions from the MEI that was the starting point for annual payment updates. We also welcomed the legislative intent for the Congress to act each year based on all available data rather than relying on an automatic formula.

AMA Concerns

The AMA believes that the annual Health Care Financing Administration (HCFA) and PPRC MVPS recommendations have not reflected the original intent of the MVPS to be a true estimate of the expected Medicare spending on physician services needed to meet current demands for care, based on full consideration of all of the statutory factors. Unfortunately, both HCFA and PPRC have used the MVPS as a deficit reduction tool without taking into account the gap between Medicare and private insurance rates.

A second major area of AMA concern with the approach used by HCFA and the PPRC is that the baseline projections of expenditure growth and the MVPS do not allow for forecasting uncertainty. Historical divergences between actual physician payments under Medicare and predicted levels have sometimes been quite large. This large margin of error in year-to-year projections should be incorporated into MVPS-related deliberations through use of an MVPS "range" rather than a single MVPS number.

Third, we have consistently opposed the initial split of the MVPS into surgical and non-surgical MVPSs and conversion factors, as well as the later division of the non-surgical category into primary care and non-surgical/non-primary care categories. Such differentials undermine the fundamental premise of the resource based relative value scale (RBRVS) that relative payments should reflect relative resource costs. They do not reflect the substitutions across types of service inherent in medical practice, nor can they be readily supported by underlying forecasts and data. **We agree with PPRC's recommendations contained in the Commission's draft report that separate VPSs and updates should be eliminated. If separate categories are retained, they should use category-specific volume data.** In addition, budget scoring rules have resulted in causing the "default" MVPS and payment increases to be the ceiling on annual updates.

Last, MVPS revisions in OBRA 1993 further eroded the volume and intensity component of the MVPS by reducing the MVPS historical volume factor four percentage points (and increasing the maximum conversion factor reduction) based on arbitrary budget-based assumptions, rather than rational judgments about the health care needs of Medicare beneficiaries.

The AMA is pleased that over the past two years, the MVPS process has helped meet the original commitment made in 1989 that the MVPS would correct for any errors in establishing the initial 1992 Medicare conversion factor. The 1994 and 1995 updates and the probable default update for 1996 reflect the fact that the initial 1992 conversion factor was artificially depressed by an excessive reduction for projected volume growth, as well as by technical errors in the initial HCFA baseline. These recent updates help correct for these initial mistaken estimates.

A misleading picture has been painted in the press of the 1995 payment updates. It is true that the conversion factor updates were 12.2% for surgical services, 7.9% for primary care services, and 5.2% for other nonsurgical services, with a weighted average increase of 7.7% for all services. The conversion factor is, however, only **one** component of a complex formula for determining payments. An AMA analysis of the 1995 Medicare Payment Schedule (MPS) indicates that total Medicare payments for physicians will increase by 5.3% (rather than 7.7%) in 1995. This lower actual update is due to the RBRVS transition as well as to the continuing effects of the practice expense cuts enacted as part of OBRA 1993. Also, these factors tend to have the greatest impact on surgical services. Thus, for many surgical services and specialties, the 12.2% "conversion factor" update will be largely offset by reductions due to the transition and other legislative changes. This more accurate estimate of the 1995 update makes even more worrisome the projected downturn in Medicare physician payments.

With respect to these seemingly "high" updates, we concur with the PPRC's draft statement that was set forth in its recommendations to Congress for the 1995 conversion factor. The PPRC stated that "[w]hile this update would be very large by historical standards, it should be viewed in the context of the sharp erosion of Medicare payment rates relative to private insurers. Between 1989 and 1994 Medicare payment rates relative to those of private insurers declined from 68 percent to 59 percent. Further declines might adversely affect Medicare beneficiaries' access to care." The PPRC has recently revised upward somewhat its estimate of the ratio of Medicare to private payments.

However, it is essential to recognize that the precise size of this gap is far less important than the fact that it is large and projected to grow after 1997 given the default conversion factor projections. The high 1994-1995 updates are essentially short term corrections.

Moreover, we believe that the PPRC analysis embodies some subjective adjustments to its private sector data base that tend to reduce the estimated payment gap between Medicare and the private sector. For example, the analysis assumes no private sector payment inflation during the 1993 to 1995 period.

CONVERSION FACTOR PROJECTIONS

The attached figure illustrates the projected downward spiral of the Medicare conversion factor under current law. It is based on AMA simulation. It is consistent with, although slighly different from, PPRC projections due to use of different assumptions. **Under the Medicare actuary's volume assumptions, the Medicare conversion factor is projected to fall steadily from nearly $36.00 in 1996 to $30.07 by 2005.** It should be noted that the Congressional Budget Office forecasts that this downturn begins in 1998, but the basic pattern is the same.

The real inflation adjusted conversion factor for that year in 1995 dollars will be even lower at $24.67, a 31% reduction in value. This analysis translates into a projection that Medicare payments would fall from the PPRC's estimated 67% of private levels in 1995 to 56% by 2005 if there is **no** growth in private payments during this period. If there is a modest 3% growth in private payments, the gap is even larger, with Medicare at 41% of private payments. **This will dramatically undermine physician and beneficiary confidence in the Medicare program.** The need for revisions to the MVPS formula must be viewed in this context.

PROPOSED MVPS REVISIONS

At its February meeting, the PPRC agreed to recommend a series of revisions to the MVPS that refine similar proposals in the Commission's 1994 Annual Report to Congress. The AMA supports most of these proposals, with one important exception -- the "cumulative MVPS." Our support is also conditioned on the PPRC's 1994 and 1995 perspective that these MVPS revisions should **not** be used to further reduce the Medicare conversion factor in order to generate budget savings. Indeed, in its 1994 Annual Report to Congress, the Commission stated that such revisions should not be used to secure further payment cuts. The current PPRC recommendations as we understand them, and the associated AMA positions, are as follows:

PPRC Recommendation

Eliminate separate MVPSs and conversion factors for the three service categories -- surgical, primary care, and non-surgical/non-primary care. If categories are kept, they should reflect volume trends for each category; separate updates should be in effect for one year only.

AMA Position

The AMA supports these recommendations. We have opposed multiple MVPSs since 1989 and continue to believe that, as demonstrated by empirical analyses, these separate MVPSs have distorted the RBRVS, introducing arbitrary differentials in place of resource cost data.

PPRC Recommendation

Replace the historical volume/intensity factor and the four percent performance standard factor with a formula linked to projected growth of real gross domestic product (GDP) per capita. An additional factor of one to two percentage points should be added to projected GDP growth to allow for "advances in medical capabilities."

This policy would produce a higher V/I allowance than current law and would credit physicians for lowering V/I growth. If implemented with the current MVPS formula, a V/I factor of GDP +2 would substantially, although not completely, offset the current forecast downward spiral of the Medicare conversion factor. Annual conversion factor reductions after 1996 would still occur under current volume projections.

AMA Position

The AMA has reluctantly agreed that the current MVPS V/I and performance standard factors should be replaced by a formula linked to growth in real GDP. Linkage to economic performance is not necessarily logical since the demand for health services is not dependent on the state of the economy. The AMA has, therefore, generally opposed linking expenditures to GDP. Although GDP growth is an exceedingly arbitrary measure of appropriate V/I growth, the current MVPS as modified by OBRA 1993 is also arbitrary and flawed. A formula that uses GDP as a base, with an appropriate additional factor to reflect real patient needs, can potentially be less arbitrary than the current MVPS historical volume factor.

PPRC Recommendation

If Congress enacts a single MVPS and links the MVPS to GDP, it should implement what has been called the "cumulative MVPS." Updates would be based on a comparison of total actual and total MVPS-allowed spending since a particular base year. A ceiling on MVPS-related conversion factor adjustments of MEI plus five percent would also be enacted. The PPRC also recommends several complex technical adjustments to the simple cumulative MVPS model to reduce the volatility of annual updates and to eliminate unjustified conversion factor reductions that would result only from the switch to the new system.

AMA Position

The AMA has consistently and strongly opposed the cumulative MVPS on technical, practical, and fairness grounds. The cumulative MVPS would only amplify projected payment reductions, further threatening the viability of Medicare Part B and access to care. The PPRC has recommended several complex technical "fixes" to make the cumulative MVPS "work," although at the expense of clarity. We are not convinced, however, that all of the technical properties of the cumulative MVPS and associated corrections have been fully identified.

From a practical standpoint, the cumulative MVPS reverses much of the benefit of a V/I factor of GDP+2. Under current volume projections, the PPRC's combined policies are apparently forecast to cut the conversion factor even more than current law through 2005.

From the standpoint of fairness, the technical virtue of the cumulative MVPS -- that it holds spending to a fixed baseline, allowing the recapture of all excess spending -- may be true but is irrelevant. Even without its various technical problems, the cumulative MVPS is simply a tool to lower the conversion factor below where it would have been under the broad MVPS approach enacted as part of OBRA 1989. Congress could have enacted a cumulative MVPS in 1989; it did not, recognizing that the MVPS was unprecedented in the U.S. and must be approached with care. Changing the rules in mid-stream simply to achieve lower spending is unjustified, especially given that this change would reduce even further the extent to which physicians could understand the linkage between the conversion factor update in a particular year and a previous year's MVPS.

ADDITIONAL MEDICARE PART B PHYSICIAN CUTS

We recognize, Mr. Chairman, that this subcommittee will be searching for additional Medicare budget savings this year as you continue your efforts to reform the Medicare program. Consistent with the view of the PPRC both last year and this year, we oppose the use of MVPS revisions in order to cut spending.

The Congressional Budget Office recently issued a report, Reducing the Deficit: Spending and Revenue Options, that discussed one option that would implement the PPRC's 1994 version of the MVPS revisions. This option would produce savings of $6.6 billion over five years, far less than most of the other eight major Part B budget savings options discussed in the report. We must emphasize, however, that the PPRC's 1995 version of the MVPS revisions would probably not produce even this level of savings given the strong caveats attached to its current version of the cumulative MVPS -- that this policy would require a complex series of technical revisions.

Greater cuts could seriously harm Medicare patients. The answer is **not** another round of huge part B Medicare payment cuts. By any measure, physicians have contributed at least their fair share to

recent deficit reduction efforts. Consider, for example, the following facts: physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade. Between 1981 and 1993, budget reconciliation has been the vehicle for reducing Medicare baseline expenditures by some $98 billion. In this process, Medicare projected physician payments have been cut by $39 billion. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) imposed $32.9 billion in Medicare Part A and Part B cuts over five years. OBRA 1993 alone imposed an additional $47.4 billion in provider cuts over five years for Medicare, including conversion factor cuts for 1994 and 1995. Physicians have succeeded in actually holding down the volume increases below that predicted for 1992 and 1993, thus saving the program billions of dollars. Moreover, the MVPS formula as modified by OBRA 1993 will impose annual cuts of 2% to 3% each year in physician payments even without any further congressional action.

We urge you to recognize physicians' recent success in moderating growth in Medicare expenditures for physician services. HCFA data indicates that Medicare expenditures for physician services increased by only 4.5% during FY 1993. In the two years preceding that, the average annual rate of growth for Medicare physician spending was only 5.8%. Lower rates of growth in physician spending between 1989 and 1993 have reduced the Medicare baseline by $50 billion, nearly as much as the total 1992 outlays for physician spending. Physicians should be recognized for these savings and not be forced to shoulder inequitable burdens in another round of budget cuts.

Medicare payments that lose their value year after year, with the likelihood of a widening gap between Medicare and private sector payments, pose a real threat to patient access to care. Current data strongly suggests that further reductions in Medicare and Medicaid provider payments will have an adverse impact on access to high quality care for some of the most vulnerable segments of the population. We are aware, for example, of numerous anecdotal reports that new Medicare patients are experiencing delays in scheduling physician office visits. Increased Medicare costs are being driven primarily by an increasing number of enrollees, an aging population, new technology, increased per capita rate of use of services by enrollees, and flawed financing structures.

We certainly agree with PPRC Chairman John Eisenberg, MD, who was quoted in the New York Times this past summer as saying that "[t]he problems in access to physicians' services for Medicare beneficiaries are just below the surface. People in areas underserved by doctors, members of minority groups and poor people already have the beginning of a problem. This should be a red flag."

In considering the potential impacts of these changes on access, we must be realistic. A future of year in and year out conversion factor reductions, in the face of steadily rising practice costs, can transform Medicare into a Medicaid-like program. Practice modes would have to shift radically to adjust to the growing disparity between payment levels and physician cost structures. Our patients can only suffer from such a transformation. It should be noted that an October 7, 1994, CBO analysis of steep Medicare cuts that were contained in health system reform legislation stated that the:

> ...growing disparities in rates between Medicare and the private sector [that would result from these cuts] could impair the access of Medicare beneficiaries to health care. . . . Although access for Medicare beneficiaries has not, apparently, been adversely affected by the drop in Medicare's payments (relative to those of private payers) that has occurred since the mid-1980s, there is probably a point at which access would be threatened.

When public health programs are under-reimbursed, costs are shifted to other payors. An increasing portion of private payor costs are due to under-reimbursement from Medicare and Medicaid to providers. To make up for the under-reimbursement, the shortfall is typically shifted to private payors. Government underfunding creates a hidden tax on businesses that provide health care benefits.

CONCLUSION

The AMA would like to pursue MVPS revisions that would more accurately reflect patient needs and, at the same time, place future Medicare payments on a more reasonable path. We also find noteworthy that CBO has acknowledged that further Medicare physician cuts will not be nearly sufficient to place the Medicare program on a sound financial footing.

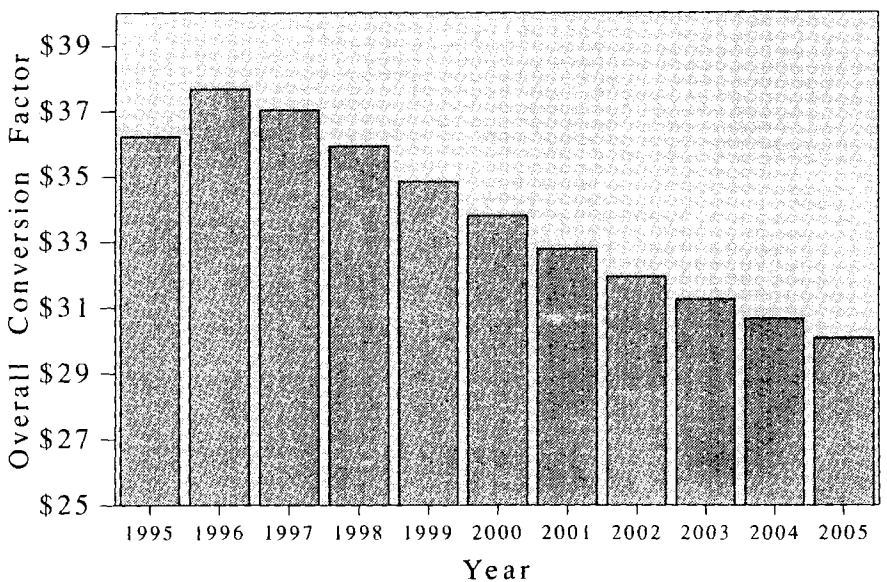
Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of Americans who expect to be able to rely

on this program in the future. Continuation of past stop-gap measures, such as chopping away at rates paid to providers in hopes of getting more services for less money, will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care.

Americans who depend on the Medicare program for their health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. In the weeks and months ahead, the AMA pledges to work with the Subcommittee, the Committee on Ways and Means, and the Congress to convince the American people that long-term reform is necessary and in the nation's best interest in order to keep the Medicare promise.

Conversion Factor Simulation

Baseline/Current Law



Source: American Medical Association

Mr. MCCRERY [presiding]. Thank you, Dr. Johnson.
Dr. Ebert, director of the American College of Surgeons.

STATEMENT OF PAUL A. EBERT, M.D., FACS, DIRECTOR, AMERICAN COLLEGE OF SURGEONS

Dr. EBERT. Thank you very much, Mr. Chairman. I think I sit here to be the minority voice on the MVPS. But I would like to make just a few comments. Historically in the eighties, increased spending for surgical services was really considered the cause of the rate of growth or at least part of the rate of growth problems of the Medicare program. It was very obvious then when the MVPS was created, it was really called an expenditure target. Its creation made sense at that point, for when the relative value scale came forth, there was concern that there might be overusage of medical services. At that time, the surgical community went at-risk and took our chances, saying that we did not think that the volume of surgical service would increase.

I would just like to comment that I do not know which trackline one uses, but each specialty within each MVPS, so to speak, was asked each year to give an assessment to HCFA and to PPRC regarding the anticipated rate of growth within their particular specialty, based on age and population, new technology, et cetera. So these trend lines certainly had opportunity to be modified. I do not know whether others did, but we did submit a report each year providing such assessments. We even pointed out that we thought cataract operations would decrease in volume. However, I would just like to say I do think these incentives being offered to the profession are like line item budgeting. If you had one budget line for the entire government, it probably would be difficult to control it.

I can see having 20 MVPS, or 20 budget lines. How you address them is your issue. I have difficulty saying if we have one MVPS, we felt we would be victims of a proliferation of services which could increase in volume where we did not think surgery could. We support the concept that this 4-percentage point reduction in the fee update formula has to be looked at very seriously. I would just like to read you the one small section of our testimony, because we think the problem with the default mechanism is that it really contains duplicative mechanisms for restraining increase in volume and intensity.

The explicit 4-percentage point reduction that was legislated in OBRA 1993 and the 5-year rolling average for volumes and intensity were included in the original physician payment reform law. While the second adjustment really was originally intended simply to reflect prior historical trends for volume and intensity, which many observers assumed would continue at these high rates, the changes that have occurred in physician spending since 1989 have reduced this 5-year average.

I think by taking both adjustments, the default mechanism way overshoots the mark and creates targets for volume and intensity that are really totally unrealistic. We do not even think that they are realistic for surgical services, even if we see them continue to decrease, because we have no way of keeping up with that 4-percent reduction.

Two weeks ago, we talked about the fact that the college has always been concerned about the overregulatory nature of the Medicare fee schedule (MFS). We noticed in the report this time, for instance, that PPRC recommends legislative changes that would provide a transition period for the introduction of so-called resource-based practice expense relative values into the MFS.

If we really look at that, all Congress has said so far is to do a study and see and then evaluate the results. Now PPRC is jumping the gun, we think, a little bit in saying let's put that out and have a transition into it. We think we have always favored using a single number for determining physician reimbursement. We did not like the fact relative values could be broken down into multiple components. We have great concern yet about the relativity of the relative value scale. The problem seems still to be that there is a tendency to augment for cost containment the relative values. This is probably more prevalent in surgical services than in others and, because of the MVPS, does not really affect the other specialties or the others sitting at the table today.

We are basically still without a reference list of surgical procedures that relate between surgical specialties. It is said now that we are going to repeat, so to speak, the mistakes of William C. Hsiao. That is, we are going to do all the vertical integration, so to speak, within each specialty and then figure out how to compare them. We recognize and even HCFA recognizes that their reference procedures, so to speak, probably are inaccurate. Trying to compare them first would make much sense to begin with, because then you could build vertically upon established comparative values.

We support the commission's conclusion that it really is incorrect to achieve budget neutrality, so to speak, through changes in the RBRVS. I think Dr. Eisenberg made a very important point when he said many private carriers are picking up the RBRVS, and thus every discrepancy that is in it makes it less accurate. We certainly appreciate the opportunity of making comments to the subcommittee. Thank you.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS

to the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

presented by

Paul A. Ebert, MD, FACS

RE: PPRC Recommendations

March 30, 1995

Mr. Chairman and members of the Subcommittee, I am Paul A. Ebert, MD, FACS, Director of the American College of Surgeons. I am pleased to appear before you once again to share the College's views on the Physician Payment Review Commission's (PPRC's) 1995 report and its recommendations regarding the Medicare program. Of course, we have not yet had an opportunity to review in detail the final version of that report; nonetheless, we are prepared to offer comments on a number of issues that were included in draft chapters of the report that were circulated by the Commission last month.

Medicare Volume Performance Standards (MVPS)

The College is especially concerned about the Commission's recommendations regarding the Medicare Volume Performance Standards (MVPSs) and methodologies for updating the Medicare fee schedule (MFS). As I indicated in previous testimony before the Subcommittee, the American College of Surgeons has been a strong advocate of policy devices, like the MVPS, that provide performance-based incentives to meet explicitly set spending targets for surgical and other physicians' services. These targets also involve physicians and physicians' organizations, like the College and the surgical specialty societies, in efforts to address growth in the costs and in the volume of services provided to Medicare patients.

From the beginning, however, the College's support for the MVPS approach has been premised on the need for a separate, identifiable standard for surgical services. We believed then, as we do now, that if the nation's surgeons are to be held accountable for meeting expenditure growth targets, then a separate performance standard for surgical services is also indicated.

We took no position about whether other service categories should have a separate MVPS, although we did urge Congress to favorably consider requests made by physicians' organizations to establish other appropriate MVPS service categories. In fact, we testified before this subcommittee in 1993 in favor of a separate MVPS and fee schedule update for primary care services. We believed that such a change would allow policymakers to consider volume issues relating to justifiable increases in the number of primary care visits under a separate standard, at least until definitive medical necessity criteria, practice guidelines, and/or a workable system of physician profiling could be developed to judge the appropriate utilization of those services.

However, the Commission has repeatedly opposed the use of more than one standard for setting targets for very broad categories of quite distinct kinds of physicians' services. Instead, PPRC recommends eliminating separate volume performance standards and fee schedule updates for the various categories of physicians' services. Further, the Commission urges that, if the current system of standards and updates is retained, it should be based on the recent trends in volume and intensity growth for each service category. In addition, the

Commission states that any differential fee schedule updates should be in effect for only one year, and that any such differential should be eliminated after that year is over. The College does not support these recommendations, since they will only dilute the incentives that are, in fact, working to influence the rate of growth in the volume and intensity of surgical and other services included in broadly-defined, yet distinctly different, MVPS service categories.

In a related recommendation, the Commission proposes replacing the current method for setting default volume performance standards, which involves consideration of historical trends in volume and intensity growth and an arbitrary statutory percentage reduction, with a formula linked to the projected growth of real gross domestic product (GDP). In addition, estimates of the growth in the real GDP should, according to the Commission, be increased by 1 or 2 percentage points.

The College agrees that the current default mechanism needs to be reexamined. At present, the performance standard default formula takes a fixed deduction of 4 percentage points from the historical trend for the prior five-year period. This automatic deduction is made regardless of the sort of changes in physician service volumes that may actually be occurring over time. Thus, even if all surgeons and physicians succeed in reducing the number and the intensity of their services, they will have to further reduce service volumes by an additional 4 percentage points or face arbitrary reductions in fees. PPRC notes that, depending on the assumptions made, this formula could lead to several years of "negative updates"--in other words, fee cuts unrelated to realistic performance expectations. We are certain that such an outcome was never intended by Congress.

As we see it, the problem with the default formula is that it contains two essentially duplicative mechanisms for restraining increases in volume and intensity: (1) the explicit 4 percentage point reduction that was legislated in OBRA '93; and (2) the five-year rolling average for volume and intensity that was included in the original physician payment reform law. While the second adjustment was originally intended simply to reflect prior historical trends for volume and intensity, which many observers assumed would continue at the relatively high levels reflected in the 1980s, the changes that have occurred in physician spending since 1989 have reduced this five-year average as they were factored into this rolling average. By including both adjustments, the default mechanism "overshoots the mark" and creates targets for volume and intensity that are unrealistic, even for surgical services, for which Medicare spending has actually decreased in the past few years.

The College is also concerned about the Commission's proposal to link performance standards and fee updates to the GDP index. This is essentially the same approach that the Clinton Administration included in the Medicare portion of its massive health system reform plan. The use of the GDP index as the formula proxy to adjust for volume and intensity to set a single MVPS target, as the PPRC proposes, means that Medicare would disregard actual trends in the demand for most physicians' services. Instead, real growth in the economy, plus a 1 or 2 percentage point add-on, would become the standard for determining how much should be spent on physicians' services in tomorrow's Medicare program. If adopted, this provision further underscores a shift in Medicare spending policy from finding cost-effective ways to pay for the care older Americans actually need, to financing their care solely on the basis of what the economy can afford.

Medicare Fee Schedule Issues

In testimony before you last month, I pointed out the enormously complex and regulatory burden that has been created in connection with the Medicare fee schedule. Over the years, an incredibly complex administered pricing system has been developed for determining payment amounts for services covered by the Medicare program. The Commission's report on the physician fee schedule further highlights just how regulatory and unnecessarily complex this process has become.

The report contains recommendations affecting complex calculations relating to work values in general and the five-year review of those values under the fee schedule; practice

expense relative values and the complex work needed to make these calculations for more than 7,000 services; changes in relative values for the professional liability component of the MFS; geographic adjustment factors; service-level site-of-service payment differentials, and so on. The current level of government micromanagement in connection with Medicare is amazing and certainly ought to be reconsidered at some point.

However, given the nature of this regulatory process, we feel obliged to offer views on a number of the Commission's proposals affecting the fee schedule. First, PPRC's draft report recommends legislative changes that would provide a transition period for introduction of so-called resource-based practice expense relative values in the MFS. Present law requires the Secretary to conduct a study and report back to Congress on the methodology that would be used to develop these relative values before any plan is expected to go into effect, while also giving the Health Care Financing Administration (HCFA) the authority to implement its proposal unless Congress intervenes.

Obviously, we are very concerned about the potential impact that such changes may have on payment for surgical services, especially in light of the very significant payment reductions previously made for these services as a result of using a resource-based approach to set physician work values. The Commission has already noted that, based on its analysis, resource-based practice expense relative values could redistribute as much as 26 percent of Medicare payments for such expenses, or about 11 percent of total Medicare spending for physicians' services. A disproportionate share of these reductions would fall on many surgical and other physicians' services. We hope that this subcommittee and the Congress will weigh very carefully the research work of Medicare program managers before allowing any such plan to be implemented. In any case, if such a proposal goes forward after Congress has reviewed it, we think that, as a matter of principle, the implementation of almost any change in the design of Medicare should be phased-in over a transition period that will minimize disruption to the program and to those who participate in it.

The Commission's report also describes expected activities associated with the five-year review of the relative value scale. The report confirms HCFA's plans to rely on a small-group refinement process in collaboration with the AMA/Specialty Society RVS Update Committee (RUC) to complete this review. In our February appearance before this Subcommittee, we expressed our concern that HCFA's approach to the five-year review does not include a thorough examination of the issue of cross-specialty linkages between services or the validity of the current reference service list that will be used in proposing refinements to the fee schedule. The draft PPRC report warns that, "An important flaw in the process is that the reference set of services contains cross-specialty comparisons that have not been validated . . . (and) Further, the reference services themselves were not necessarily chosen because their values were thought to be correct."

According to the Commission, comparisons of services across specialties will be deferred until the last stages of the refinement process. Absent a thorough review of such services and linkages, the results of the five-year review may be just as flawed as was the initial process for determining work values in the original Harvard project. We again urge that at least some effort be made to examine the validity of the reference service list at the beginning, and not at the end, of the refinement process.

Finally, Mr. Chairman, we would like to support the Commission's proposal that HCFA be authorized to achieve budget neutrality or implement legislative directives for savings through the conversion factors used under the fee schedule, rather than through changes in relative values. We believe that such adjustments will help reduce unnecessary disruption to the relative value scale and could be applied, in the case of work value changes, for example, to the conversion factor applicable to the appropriate MVPS category of physicians' services.

Thank you, once again, for the opportunity to present the College's views. I would be pleased to answer any questions you may have.

Mr. MCCRERY. Thank you, Dr. Ebert.
Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. GRAHAM. Thank you, Mr. Chairman, members of the panel. I am Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians. We represent some 80,000 family physicians, residents, and medical students across the country. Since much of what is in our testimony has already been discussed with the committee, let me try to just briefly place some of that within the context of our general concerns about the evolution of the Medicare program, and how we are able to provide services to Medicare beneficiaries.

There is no question that family physicians and general internists provide the bulk of services to Medicare beneficiaries. Yet, as we have seen the changes in the program over the last 10 to 20 years, it has become increasingly difficult for many of these physicians to maintain that level of service or to make decisions which will allow them to accept new Medicare patients. The heart of that problem has been the Medicare payment system. When the original attempts were made to institute the relative value schedule, we had some hopes that it would take the first steps toward rebalancing what had become considerable inequities in payments within the physician community for Medicare beneficiaries.

We think now that with 5 or 6 years of history, we have to say that we have only partially addressed those primary issues of concern for us, and indeed we continue to hear from our practicing members that it is difficult for them to provide services to Medicare beneficiaries, particularly if they have a large number of beneficiaries in their practice because for the office visit to a family physician, quite frankly, the reimbursement of that is less than the actual cost for running the office for the family physician. I suspect that it is similar for many of the general internists also.

The particular issue for us is the service to beneficiaries in rural areas. Preponderantly, the physicians in rural areas are family physicians. There are a higher percentage of Medicare beneficiaries in rural areas. We see that as becoming a real issue in the coming years. Therefore, the recommendations before you from the PPRC that would address some of the evolving difficulties in the reimbursement schedule we think are worthy of your careful consideration. I will not go through the full list. You have already had a long discussion with Dr. Eisenberg about that. They are detailed in our testimony. I would simply single out two of them to make sure you know where we stand. We think that there is greater wisdom in having one conversion factor than multiple conversion factors.

That is where we were in the original debates in the late eighties. The decision of the Congress at that point was to split them into two conversion factors. That was so inequitable that we did support the later change to three conversion factors, but we saw that as a temporary step. The practice of medicine and the practices of individual physicians between generalists and subspecialists are seamless. A lot of the changes that have taken place in surgical volume, we think, has to do with the changes in overall

medical practice, not just the decision of the surgeons. We treat ulcer disease. We treat prostate disease very differently now than we did 5 or 6 or 7 years ago. So the fact that the recommendation before you is now to look at having a single volume performance standard we think is one of merit.

You have also heard comments already about using the GDP factor in terms of the update rather than the 4-percent default. We also think that this is a proper evolutionary decision to be made. We have enough experience in history. We recognize that that original factor was based upon what may have been a very atypical period of time in American medicine in terms of the way volume and expenses were rising. We now have that sort of tied around our neck. We think the PPRC's recommendation in this area is very well taken.

Other specific recommendations to you and comments on the PPRC testimony are in our comments in the written form. Those are before you, and I will yield the rest of our time so that we may have questions and answers.

[The prepared statement follows:]

TESTIMONY OF ROBERT GRAHAM, M.D.
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Introduction

My name is Robert Graham, M.D., and I am Executive Vice President of the American Academy of Family Physicians. On behalf of the Academy's 80,000 members, I appreciate the opportunity to comment today on Medicare physician payment, including several proposals in the Physician Payment Review Commission's 1995 Report to Congress.

I note at the onset that the Ways and Means Committee must consider a wide range of proposals to lower Medicare expenditures. This Committee faces the challenge of developing Medicare policy recommendations necessary to reach the House leadership's balanced budget goal. In facing this task, we urge you to recognize that many Medicare reform proposals hold some theoretical possibility of reducing program expenditures, but there is only one factor that has been consistently proven to hold down per capita Medicare outlays: **the availability of primary care services.** Your long-range success in controlling Medicare outlays will be directly related to your success in improving beneficiary access to primary care services. Accordingly, we ask you to weigh the Commission's proposals according to how they support access to primary care services.

Primary Care and Medicare

As you may already know, the Council on Graduate Medical Education applies the term "primary care physician" to family physicians and general practitioners, general pediatricians, and general internists only. These primary care physicians deliver health care services more efficiently and in a less costly manner than subspecialists. Family doctors, for example, treat directly 85 - 90 percent of the presenting conditions of an undifferentiated patient population and assume responsibility for managing the care of those patients who are referred for subspecialty services.

Extensive medical literature supports the conclusion that primary care is cost-effective. Several of these studies are specific to the Medicare population. For example:

- There is an inverse relationship between the extent to which a nation's primary care system is developed and the per capita cost of health care. (Starfield, JAMA, October 23/30, 1991).

- Per capita health expenditures decrease as the proportion of family and general physicians increases. A systematic evaluation of variations in Medicare expenditures for physician services across the U.S. concluded that a higher proportion of primary care physicians in a metropolitan statistical area is associated with a significantly less expensive practice of medicine overall, for both in-hospital and out-of-hospital care. (Welch, et al; NEJM, March 4, 1993).

- A study of per beneficiary Medicare expenditures for physician services found that the most important factor explaining lower expenditures in rural areas is the mix of physician specialties. Expenditures are significantly lower when the proportion of general and family physicians is higher and

expenditures are significantly higher when the proportion of subspecialists is higher. (Dor and Holahan, Inquiry, Winter, 1990).

- Increased availability of primary care services for low-income populations reduces the inappropriate and expensive use of emergency departments. In one study, nearly half (45 percent) of patients waiting for emergency department care cited unavailability of primary care services as their reason for using the emergency department. Only 13 percent of those waiting had conditions clinically appropriate for the emergency department; 38 percent were willing to trade the emergency department visit for assurances of an appointment with a primary care clinic within 3 days. (Grumbach, et al; AJPH, March 25, 1992).

These studies illustrate a glaring reality of American medicine: it is overly specialized and overly costly, and the two factors are directly linked. No matter which Commission proposals the Congress may choose to adopt, **the cost explosion in the Medicare program will not be brought under control until Congress improves the availability of primary care services.**

Beneficiary Access to Medicare Services

As the studies mentioned above demonstrate, the Medicare program generates savings when primary care physicians in general, and family physicians in particular, are available to and used by beneficiaries. Such favorable prospects for savings stand in stark contrast to Medicare's inadequate reimbursement for primary care services. It troubles the Academy greatly to know that more than one-quarter of family physicians nationwide no longer accept new Medicare patients. In some areas more than 35 percent of family physicians do not take new Medicare patients.

Inadequate reimbursement is the most commonly cited reason for this problem. Simply put, family physicians are finding it more and more difficult to accept new Medicare patients, because to do so jeopardizes the financial stability of their practices. On average, it costs approximately $134 per hour to operate a family practice, while Medicare payment for visit services is less than $100 per hour.

Of additional concern is that PPRC predicts that Medicare fees will continue to plummet downward as a percentage of private sector rates. Because of cuts already mandated in OBRA93, the PPRC estimates that Medicare fees will drop to 54 percent of private sector rates. It is even possible that Medicare fee levels could sink to 43 percent of the private sector--below current Medicaid rates--if tens of billions of cutbacks proposed last year are adopted by this Congress in an effort to achieve a balanced budget. The disparity between program versus private fee rates may force even more family physicians to consider closing off their practices to new Medicare patients. Hence, we are genuinely concerned that further reductions in Medicare physician fees may create real access problems for elderly patients especially those in rural and inner-city areas.

This Congress must take the necessary steps now to prevent an access crisis that could occur as early as the turn of the century. In this vein, the Academy would like to thank this committee for its support of an earlier PPRC recommendation favoring a resource-based practice expense (RBPE) component in the Medicare fee schedule. Enacted as part of OBRA93, this shift in Medicare's method of paying for overhead expenses should bring practice expense payments up to their actual costs for office-based services--the sort performed most often by family physicians. It is actions such as adoption of the resource-based practice expense

policy that will enable generalists to continue delivering services to elderly patients.

Changes in the Medicare Fee Schedule

A Single Conversion Factor and a Single Volume Performance Standard (VPS)

The AAFP supports the PPRC recommendation that the three separate conversion factors and VPSs be discarded in favor of a single conversion factor and VPS applicable to all medical services. Such a policy would correct a flaw that undermines the integrity of Medicare physician payment.

Under the current VPS system, a performance standard or expenditure target is determined for a given year. Two years later, actual expenditure growth for the year is compared to the performance standard. Updates to the fee schedule are reduced or increased by the amount the actual expenditure growth exceeds or falls below the performance standard. Under the default formula that determines the annual updates, the Medicare Economic Index, which is a measure of inflation in the cost of medical practice, is used to set the conversion factor update. The MEI is increased or decreased depending on how actual expenditures compare to the VPSs. If expenditures exceed the VPS, the MEI can be reduced by a maximum of five percentage points.

The VPS takes into consideration a number of factors that contribute to the increase in Medicare expenditures for physician services. These factors include increases in fees, increases in the average number of Part B enrollees, the impact of changes in laws and regulations, and the average annual percentage growth in the volume and intensity of physician services for the previous five years. This last factor is automatically reduced by a performance standard factor of four percentage points.

The MFS was established with the passage of OBRA89. As originally conceived, the resource-based fee schedule put all physician services on a common scale. Relative reimbursement for all services would have been based on a single conversion factor, and physicians would have been collectively responsible for controlling expenditures for all physician services. During the negotiations leading up to passage, a separate conversion factor for surgical services was established. This created a problem for primary care physicians, because primary care services were combined with other non-surgical services, expenditures which were increasing rapidly. Because at that time Congress was unlikely to reverse itself and establish a single conversion factor, the Academy supported the creation of a third conversion factor for primary care services. The third primary care category was created in OBRA93.

Separate VPSs and fee updates for three categories of services has led to distortions in the worth of relative values so that they no longer reflect resource-based relative values. The RVUs in each category are no longer worth the same amount. Currently, the conversion factor for surgical services is 8.4 percent and 14.0 percent higher than the conversion factors for primary care and other non-surgical services, respectively. Because the conversion factor updates are permanent, consecutive higher updates for surgical services are compounded.

The distortion in relative value is exacerbated by HCFA's use of a single pooled trend line for the growth in volume and intensity in all three categories of service. In other words, instead of the a separate volume and intensity factor being calculated for each of the three categories of service based on the average

increase in expenditures for services within each category, HCFA applies uniformly an all-service average to all three categories. OBRA90 requires that a separate volume and intensity trend be used for each category. But, for several reasons mostly having to do with the availability of data, HCFA has continued to use a pooled volume and intensity factor. With the continued use of a pooled volume and intensity factor, the discrepancy in conversion factors becomes virtually perpetual. Surgical services, which have experienced the lowest expenditure growth, will always compare favorably to the pooled expenditure growth and, therefore, always receive a higher update.

The Physician Payment Review Commission projects that discrepancies between the conversion factors may soon become large enough to erase the redistribution in payments from surgical and other non-surgical services to primary care services that was supposed to occur under the MFS.

For these reasons, **the Academy endorses the adoption of a single, all-service conversion factor and a single VPS for all services.** As it was originally intended, the VPS system provided an incentive for physicians in all specialties to exercise collective responsibility for reducing inappropriate care. Theoretically, establishing a single conversion factor would recognize the substitution of services that occurs between categories of service. For example, in peptic ulcer disease, advances in medical care have led to the substitution of endoscopy (a service that is in the other non-surgical service category) and office visits (services that are in the primary care category) for surgery. Another example would be the substitution of watchful waiting, which results in more office visits, for surgery in the care of prostate disease. In both examples, medical advances have led to a decrease in surgical volume and an increase in volume in the other two categories of service. These examples illustrate that responsibility for increases or decreases in expenditures within a category of services cannot be claimed by the physicians in any particular specialty. However, because Medicare services are artificially divided into three different categories, primary care physicians are penalized for these appropriate increases in expenditures for visit services through reductions in the update for the primary care conversion factor, and surgeons receive a bonus for a decrease in surgical volume for which they had little responsibility. Primary care physicians should not have to "pay" for advances in medical care that reduce the need for surgery any more than surgeons should have to "pay" for the increased volume due to innovative new surgical procedures.

Using Five Year Trends to Estimate Volume and Intensity

By taking a fixed four percentage point reduction from the five-year trend in volume and intensity, the performance standard factor unlinks the volume and intensity factor from actual trends in health care delivery. Regardless of how much physicians reduce the volume and intensity of services, volume and intensity must be reduced by an additional four percentage points or the updates will be reduced. In addition, using historic growth rates will eventually undermine the incentive to control volume and intensity. Lower growth rates initially yield higher updates, but as they are incorporated into the rolling five-year averages, the VPS will be lowered.

PPRC has estimated the impact of the current default formula utilizing various estimates of future expenditure growth. In all cases, updates beginning in 1997 are negative. Within the next five to seven years, Medicare fees will drop below their current level, even without considering inflation. The large penalties in the updates would occur, in part, because of the low rates of growth from 1992 to 1996 will be reflected in the five-year average growth of volume and intensity.

Considering that Medicare payment rates are already below cost for most of the services provided by family physicians, these current-law reductions cannot be sustained.

PPRC recommends that projected increases in per capita gross domestic product (GDP) plus one or two percentage points substitute for the five-year rolling average growth in volume and intensity. The extra one or two percentage points are meant to reflect advances in technology. This recommendation is intended, in part, to link Medicare expenditure growth to the rest of the economy. **The Academy believes that the Commission's recommendation for calculating volume and intensity is preferable to the present formula as modified by OBRA93.**

On a theoretical level, support for this option hinges largely on its linking increases in Medicare expenditures to growth in the rest of the economy, with provision for advances in medical care. Since this recommendation affects the VPS calculation only, there would still be allowance for increases in enrollment and prices and for changes in law and regulation. Furthermore, medical inflation, as measured by the MEI, would still be incorporated in the update.

Budget-neutrality Adjustments

In a matter related to revision of the formula for calculating Medicare fees, the Academy is concerned about HCFA's current practice of making adjustments to relative values in order to maintain budget neutrality in the Medicare physician fee schedule. **The Academy supports PPRC's recommendation that such adjustments be made in the conversion factor rather than the relative values.**

HCFA institutes across-the-board reductions in all relative value units to compensate for increases in aggregate relative work values added to the resource-based relative value scale (RBRVS) by the Relative Value Update Committee process and the HCFA "refinement" process. These reductions maintain the statutorily-mandated budget neutrality of the fee schedule.

While it may be necessary at times to manipulate Medicare payment to achieve defined policy objectives, such as budget neutrality, the AAFP believes these objectives should be met without distorting the relative value scale. Although not perfect, the RBRVS goes a long way toward describing the appropriate relationship between several thousand physician services. Accordingly, adjustments to relative values should only be related to changes in resource consumption. Other adjustments, unrelated to changes in resource consumption, will only distort the RBRVS. Thus, the AAFP believes that budget-neutrality should be accomplished through manipulations in the conversion factor or by establishing a new budget neutrality adjustment factor.

Furthermore, **the AAFP believes that in the budget-neutrality process, evaluation and management (E/M) services should be protected from changes in the relative values of other services,** since such services are more likely to be reduced as a result of the "RBRVS creep" associated with procedural services. Ideally, protection of E/M services would be accomplished by a separate budget-pool for E/M services. E/M services would be subject to budget-neutrality resulting from relative value refinements within their own pool. However, this would require a change in the law.

HPSA Bonus Payments

By whatever measure you might employ, this nation suffers from a severe shortage of primary care physicians, and some geographic areas are particularly underserved. Since 1986, the number of federally designated primary care health professions shortage areas has increased from 1949 to 2492, and the number of primary care physicians needed to eliminate these shortages has grown from 4314 to 4677.

Since 1989, physicians who treat Medicare patients in HPSAs have been entitled to bonus payments equal to 10 percent of the amount Medicare pays for services. In theory, the bonus payments act as incentives to attract new physicians to underserved areas and to discourage physicians in those areas from leaving. However, as noted by PPRC, the Council on Graduate Medical Education, and the HHS Inspector General's Office confirm, Medicare bonus payment program is not well structured for this purpose. Almost half of the bonus payments accrues to physicians who provide little or no primary care. In addition, almost 15 percent of bonus payments go to urban, hospital-based subspecialists.

As the Inspector General noted in a June, 1994 report, providing "incentive" payments to non-primary care physicians who fail to deliver primary care services or who practice in attractive environments is both unnecessary and inconsistent with Federal priorities. Congress should modify the Medicare incentive payment program to target it more effectively to primary care. **The Academy supports the Inspector General's recommendation that the program be changed to provide 20 percent bonuses to physicians providing services in HPSAs and eliminate bonuses for non-primary care services in urban areas.** The increase in the size of the payments would make them more effective incentives. The elimination of incentives for specialty services in urban areas would more effectively target the program to primary care. The Health Care Financing Administration has also expressed support for these changes.

Geographic Adjustment Factor (GAF)

The AAFP has long advocated the elimination of the geographic adjustment factor, which is a differential in physician fees based on practice location. Instead, there should be a single fee for the same service regardless of the geographic location of the physician providing the service. This position is based on the premise that equivalent service should result in equivalent compensation. Further, this position is consistent with federal policies that incorporate uniform national rates. For example, uniform national rates apply to federal income tax, social security payments, and the Medicare Part B premium. A policy of uniform payment should only be modified to achieve explicit policy goals (e.g., targeted adjustments for demonstrated shortfalls in access to care).

The impact of the GAF can be seen in by comparing the Medicare allowable amount for a mid-level established patient office visit across geographic payment areas. For example, the Medicare allowable amount for this service in Oakland, California is $38.87 while Medicare allows only $31.75 for the same service in Nebraska. The allowance for the physician in Oakland is 22 percent more than the allowance for the physician in Nebraska.

And, the GAF's impact is not limited to practice costs. In the example above, Medicare allows $20.71 for the physician work component in Oakland, but only $19.13 in Nebraska. By definition, the work is the same, but Medicare pays physicians differently simply based on where they practice.

The GAF is based on a set of geographic practice cost indices (GPCIs) developed by the Urban Institute and the Center for Health Economics Research (UI/CHER). With the exceptions of malpractice insurance costs, for which HCFA maintains a national data set, and equipment, supplies and other costs, for which HCFA assumes there are uniform national prices, the UI/CHER indices utilize proxy data assessing geographic variation in costs.

The current GPCIs allege that there is substantial geographic variation in physician practice costs. This variation in practice costs corresponds with community size. Specifically, the indices show urban communities as having higher costs and rural areas as having lower costs.

The large variation in practice costs suggested by the GPCIs means that their use in adjusting the Medicare physician fee schedule has a substantial impact on physician payments. That impact is to perpetuate a substantial portion of the geographic differential in Medicare prevailing fees which existed before HCFA implemented the Medicare physician fee schedule. Given the impact of a geographic differential on the maldistribution of physician services, it is of essential policy importance to verify the accuracy of the current GPCIs.

There are several grounds on which to challenge the ability of the GPCIs to accurately and appropriately reflect true and legitimate differences in physician practice costs (i.e., those differences that are not attributable to practice style for which adjustment would be inappropriate).

Physician surveys conducted by Medical Economics and the American Medical Association (AMA) provide a sharply contrasting picture of the geographic variation in physician practice costs. These surveys tend to show the cost of rural physician practice to be as high or slightly higher than in urban locations. Medical Economics has reported higher practice costs for rural physicians in recent years.

While neither the AMA nor Medical Economics surveys provide a definitive picture of geographic differences in physician practice costs, they are consistent and reliable. These data suggest that the finding of higher urban than rural practice costs may be erroneous and provide further evidence of the need to validate the current indices.

We note that eliminating inappropriate geographic differentials was a major focus of Medicare physician payment reform because geographic differentials proved to be a strong disincentive in regard to physicians choosing a rural practice location. HCFA has not systematically and verifiably demonstrated significant differences in the cost of practice, which might be used to justify continuing geographic differentials in the Medicare fee schedule. We believe that eliminating geographic differentials from a Medicare physician fee schedule is likely to have a significant and positive impact on the availability of medical care to rural beneficiaries. If a GPCI is to be utilized, we feel it incumbent on HCFA to validate any geographic index that it proposes to use in modifying physician fees.

Conclusion

The stakes are extremely high as this Committee begins the important task of determining how Medicare outlays will be reduced to help eradicate the federal budget deficit. At the end of this legislative session, we must be able to assure older Americans that their access to comprehensive, cost-effective health care services has not been compromised by Medicare reform efforts. Although reconciling deficit reduction with a high level of beneficiary services may seem

contradictory on its face, this is not necessarily so. Revising the Medicare fee schedule to boost primary care services--as intended by the authors of the resource-based relative value system--serves the purpose of controlling Medicare expenditures.

The studies cited above demonstrate conclusively that the availability of primary care services improves access for Medicare beneficiaries while lowering program expenditures. Indeed, support for primary care positions the Medicare program to interface effectively with the marketplace as it shifts to integrated systems of care. Moreover, improvements in the fee schedule that narrow the gap between reimbursement levels for primary care and other families of services would ensure access to the very type of service on which managed care is built.

These beneficial goals can be achieved in part by enactment of several important recommendations in the 1995 PPRC Report, including a single conversion factor and VPS applicable to all services. The Academy strongly supports this policy recommendation as an overdue, reasonable step towards eradicating confusion and inaccuracy in the fee schedule while restoring its original intent. Likewise, the Academy also urges you to replace the current performance standard factor formula with one based on projected GDP per capita plus one or two percentage points. This approach is preferable to the present formula as modified by OBRA93.

Let me close by noting that the PPRC recommendations noted in my comments provide excellent guidance for your efforts. As you work to craft a Medicare reform policy that achieves the goals of the Contract with America, please do not hesitate to call upon the American Academy of Family Physicians for counsel and input. Family physicians are eager to work with you on this challenging undertaking.

Thank you for this opportunity to speak with you about the PPRC's 1995 Report. At this time, I would be happy to answer your questions.

Mr. MCCRERY. Thank you, Dr. Graham.
Dr. Weaver.

STATEMENT OF KATHLEEN M. WEAVER, M.D., PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, AND ALAN R. NELSON, M.D., EXECUTIVE VICE PRESIDENT

Dr. WEAVER. Thank you, Mr. Chairman. My name is Kathleen Weaver. I am a practicing internist from Portland, Oreg., and president of the American Society of Internal Medicine. With me is Dr. Alan Nelson, ASIM's executive vice president. Internists are concerned that cuts in Medicare fees will do great harm to the elderly's access to medical care. The PPRC projects that because of the changes enacted in OBRA 1993, Medicare fees will start declining in 1997 and will continue to experience annual reductions for the foreseeable future. As a result, Medicare payments in the year 2005 will be lower than they were in 1992, and after adjusting for inflation, payments would be reduced by 36 percent from 1992 to 2005.

Because the overhead costs of running a physician's office cannot be reduced to offset this cut, ASIM estimates that this will translate into a 61-percent cut in net payments for a typical midlevel office visit. I do not know many primary care physicians who can afford a cut of 60 percent or more in net revenue from Medicare over the next 10 years. Many of my colleagues are already closing their practices to new Medicare patients. Those of us who are in our fifties and have a practice dependent on Medicare, and as you get older, your patients get older, and I am in that age group, we are thinking more and more about retiring early. When we retire and close our practices, who will take care of our Medicare patients who are left behind?

I think it is unlikely that our younger colleagues will choose to take on large numbers of Medicare patients knowing that Medicare fees are steadily dropping and will barely cover their costs. Those who conclude that because there is no widespread access problem today there is no reason to fear one in the future remind me of my 45-year-old patient who smokes three packs a day, drinks a six-pack, and says, "I feel fine." The patient may believe and convince himself that he is fine, but as his physician I know that the odds are overwhelming that the damage being inflicted today will cause a medical crisis not too long in the future.

Likewise, I firmly believe that the damage being inflicted now by cutting the Medicare program will lead to an access crisis in the near future. Our concerns are exacerbated by flaws in the current method for determining these fee updates. ASIM strongly supports the commission's recommendation of a single volume performance standard and update for all categories of services. Let me give you four good reasons why the current policy of separate categories for surgical procedures, primary care services and all other nonsurgical services should be changed.

First, the current policy will magnify and accelerate the access problems resulting from budget cuts. Because the conversion factors for primary care and other nonsurgical services start out so much lower than for the surgical procedures, further cuts will disproportionately hurt access to primary care physicians. Second, it

is contradictory to the intent of the resource-based relative value scale. The RBRVS was intended to pay physicians the same amount for services that involve equal physician work, but the current policy of different conversion factors has resulted in physicians being paid 25 to 30 percent more for their surgical procedures than for a nonsurgical service requiring the same amount of work. Third, it encourages inefficiency by penalizing some physicians for changes in practice patterns that may reduce Medicare expenditures while rewarding others for reductions in volume over which they have no direct control.

Medicare saves money and patients benefit when physicians can substitute less costly nonsurgical treatments for more expensive surgical ones. Unfortunately, when nonsurgeons find ways to treat patients and avoid the need for surgery under the current policy, they are penalized for providing more nonsurgical services. A single VPS would reward physicians and encourage us to collaborate to control volume rather than the current policy of basing rewards and penalties on shifts in the number of services provided in each category that have no rational relationship to physician performance.

And fourth, the current policy is overcomplicated. A single VPS and conversion factor would be a more important step toward simplifying the Medicare fee schedule. However, we agree with the commission that if separate categories are maintained, they should be based on recent trends for each category. In conclusion, ASIM appreciates the difficulty of reducing the Federal deficit and at the same time honoring Congress' 30-year-old contract with America's elderly which guaranteed access to quality medical care through the Medicare program. We recognize the debate on reforming Medicare is imperative, but the purpose should be to develop proposals that would guarantee that Medicare remains solvent rather than on focusing on short-term cuts.

For example, ASIM supports creation of a voucher program that would expand the health plan choices available to beneficiaries and we would be pleased to work with the committee on the development of such a program. Mr. Chairman and members of the subcommittee, I would be pleased to answer any questions. Thank you.

[The prepared statement follows:]

Testimony to the Ways and Means Committee

on the

1995 Report of the Physician Payment Review Commission

by the American Society of Internal Medicine

March 30, 1995

Introduction

My name is Kathy M. Weaver, MD. I am a practicing internist in Portland, Oregon and President of the American Society of Internal Medicine. With me is Dr. Alan Nelson, ASIM's Executive Vice President.

My comments today will focus on two related issues that are addressed in the Commission's report to Congress. Those issues are access to care for Medicare beneficiaries and the methods used to determine payments under the Medicare fee schedule.

Internal medicine is the nation's largest medical specialty. As specialists in adult medical care, internists also take care of more Medicare patients than any other specialty. Our members are acutely aware of how changes made in Washington affect access to care for their elderly patients. They are extremely concerned that the changes made by Congress in 1993 in the way that Medicare fee updates are calculated, and any additional changes that may be made by the 104th Congress to reduce payments for physician services, will do great harm to the elderly's access to medical care, and especially, access to primary care services. I will explain in today's testimony why we have reached this conclusion, and present our recommendations for changes that would reduce, but not entirely eliminate, the adverse impact on access to internists' services.

Background on Medicare Fee Schedule Updates

Under current law, there are three separate volume performance standards (VPSs), or target rates of growth, for surgical procedures, primary care services, and all other nonsurgical services. There are also three separate conversion factors--the dollar multiplier which translates resource based relative values into fees--for surgical procedures, primary care services, and other nonsurgery. Prior to 1993, there were only two separate VPSs and conversion factors, one for surgical procedures and one for all other nonsurgery.

In OBRA 93, Congress amended this to add a category for primary care services--office, nursing home, home, and emergency room visits--in addition to the other two categories. Although the creation of a separate primary care category was intended to moderate any adverse impact on primary care services of other changes made by OBRA 93 that would lower payments for physician services, all services paid under the Medicare fee schedule--including primary care services--will begin experiencing payment reductions in the next two years and beyond, as explained in detail later in this testimony. The reductions will occur because OBRA 93 also tightened the way the VPSs for all three categories are calculated, by doubling from two to four percent the required "performance standard reduction" that is subtracted from the five year historical rate of increase for physician services. The changes made by OBRA 93 were intended to slow the rate of growth in physician services. Finally, OBRA 93 increased the maximum amount that fees could be reduced in any calendar year.

Access to Care

The Commission's report to Congress provides ample reasons to be concerned that access to care for the elderly is at risk. The report projects that because of the changes enacted in OBRA 93, Medicare fees will start declining in 1997. According to the report, if the volume of physician services increases to six percent, **under current policy the conversion factors will decline by 2.2 percent in 1997, 3.0 percent in 1998, 3.0 percent in 1999, 3.0 percent in 2000, 2.7 percent in 2001, 2.5 percent in 2002, and 2.0 percent per year from 2003 to 2005.** Even under assumptions that volume growth slows down to 3 or 4 percent per year, the Commission projects that the conversion factors will begin to decline in 1997, will experience reductions of approximately three percent per year from 1998-2000, and will experience further reductions of two percent annually thereafter. The Congressional Budget Office (CBO) has similarly projected that the reductions mandated by OBRA 93 will cause an annual reduction in the conversion factors beginning in 1997.

These reductions do not take into account the effects of inflation. **If the inflation rate is 3 percent per year from 1996-2005, the reductions (in constant 1996 dollars) in the conversion**

factors will be approximately 5.2 percent in 1997, 6 percent per year from 1998-2000, and between 5 and 5.7 percent per year in 2001-2002 (depending on volume assumptions), and another 5 percent per year from 2003 to 2005.

As a result of the cuts in the conversion factors, **Medicare payments in the year 2005 will be lower than they were in 1992, even before the effects of inflation are taken into account.** The Commission estimates that if volume and intensity growth rates rise to six percent, the conversion factor would be only $29.84 in 2005, or $23.17 in 1995 dollars (after adjusting for inflation). **For a mid-level established patient office visit that in 1995 is paid $36.38, this would represent a 36 percent cut in constant 1995 dollars.**

As bad as this sounds, the impact on physician net revenue from Medicare will be even worse. The Medicare fee schedule allocates approximately 40 percent of the payments for each service on the fee schedule to the overhead costs of providing the service. For a mid-level established patient office visit that is paid $36.38 in 1995, this results in overhead costs of $14.55 per office visit. (The Commission has previously reported that the method used to allocate overhead costs underestimates the overhead costs of office visits and other evaluation and management services, so the estimate of $14.55 overhead per office visit represents a very conservative, low estimate of actual overhead). In the year 2005, the same office visit will be paid $23.17 in constant 1995 dollars. **Because the overhead costs are fixed--meaning that the dollar costs of rent, utilities and supplies needed to run a physician office will be at least as high in 2005 as in 1995 and therefore cannot be reduced to offset the cut in Medicare fees--the net reimbursement to physicians for a mid-level office visit in the year 2005 would be less than nine dollars ($23.17-$14.55=$8.62), which represents a 61 percent cut in net payments from 1995 to 2005.**

I don't know many primary care physicians who can afford a cut of 60 percent or more in net revenue from Medicare over the next ten years. Many of my colleagues are already closing their practices to new Medicare patients. Those of us who are in our fifties and have a practice dependent on Medicare are thinking more and more about retiring early. When we retire and close our practices, who will take care of our Medicare patients who are left behind? I think that it is unlikely that our younger colleagues will choose to take on large numbers of Medicare patients, knowing that Medicare fees are steadily dropping and will barely cover their costs.

Congress should take no comfort in the Commission's chapter that suggests access "appears to be good" mid-way through implementation of the Medicare fee schedule. For one thing, there is growing evidence that new Medicare patients are having trouble finding primary care physicians. Moreover, the Commission's analysis on access is nothing more or less than a snapshot of the way things are now. It tells us nothing about how access will fare two, three, five or ten years from now as the cuts mandated by OBRA 93, plus any new cuts that may be imposed this year, take their full effect.

I worry that some may conclude that because there is no evidence of a widespread access problem today, there is no reason to fear one in the future. This kind of thinking reminds me of the 45 year old patient who smokes three packs of cigarettes and drinks a six pack of beer daily and says he feels fine. Although my patient may believe (and convince himself) that he's fine, as his physician I know that the odds are overwhelming that the damage being inflicted today will cause a heart attack or other medical crisis not too long in the future. Likewise, I firmly believe that even though the elderly's access for now may seem fine, the damage being inflicted by cutting the Medicare program now will lead to an access crisis in the near future.

Spending on Physician Services Compared to Other Medicare Expenditures

Additional cuts in payments to physicians might be understandable if physician fees were out-of-control or if we hadn't already been cut more than our fair share. **But the fact is that Medicare expenditures for physician services have already dropped from double-digit rates in the mid-1980s to only 3 percent in FY 1994, and are now increasing at a rate that is slower than for any other category of Medicare spending.** Average annual expenditures on physician services increased by only 6.34 percent from 1989-1993, compared to over 60 percent for skilled nursing facilities, 58 percent for hospital outpatient departments, almost 40 percent for home health, and over 12 percent for inpatient hospital services. Physician services are also a declining portion of total Part B expenses: in 1985, physician services constituted 75 percent of total Part B expenditures; in 1993, they constituted only 63 percent of Part B spending. Physician services have also been cut disproportionately more than other categories of spending: from 1981-1993, physician services absorbed 32 percent of the Medicare cuts, even though they constitute only 23 percent of total Medicare expenditures.

My plea to you is to consider the impact of proposed cuts in Medicare on the ability of the elderly to continue to have adequate access to physician services. The cuts that were enacted in 1993 will soon drive down fees to the point where many physicians, but especially primary care physicians, will have no choice but to limit the number of Medicare patients they can afford to treat. Additional cuts will threaten the economic survival of physicians who have large Medicare practices. Especially since expenditures for physician services have already been cut more--and are growing at a much slower rate--than any other category of Medicare spending, there is no justification for further cuts that will endanger access to care.

Medicare Fee Schedule Recommendations

ASIM's concern about the impact of Medicare cuts is exacerbated by the fact that the current formula for determining Medicare fee schedule updates, as modified by OBRA 93, will have a greater adverse impact on primary care and other nonsurgical services than on surgical procedures.

More specifically, the current formula, as modified by OBRA 93 has had two consequences that are disadvantageous to primary care and other nonsurgical services. As noted earlier, the reduction in the allowed rate of growth under the volume performance standards, and the increase in the maximum cuts that are possible in any calendar year, will result in payment reductions for all services, including primary care and other nonsurgical services. The impact on primary care and other nonsurgical procedures, however, will be worse than for surgical procedures, because the policy of separate VPSs and targets (and flaws in the way that HCFA has calculated the VPSs), have resulted in the conversion factors for primary care and other nonsurgical services being much lower than for surgical procedures.

To correct the flaws that will otherwise worsen the impact on primary care and other nonsurgical services, ASIM strongly supports the following recommendations in the Physician Payment Review Commission's 1995 Report to Congress:

> **A single volume performance standard and update for all categories of services should be adopted. If separate standards and updates by categories of services are retained, they should be based on the recent trend in volume and intensity growth for each category as called for by the Omnibus Reconciliation Act of 1990, and differential updates should be in effect for one year only.**

The 104th Congress has pledged to change federal policies that are irrational, inefficient, overly complex and contradictory. The existing method for determining the Medicare fee updates and VPSs is precisely the kind of irrational, inefficient, complex and contradictory government policy that should be changed. Let me give you four good reasons why it should be changed to require a single VPS and conversion factor:

First, the current method for determining the fee updates and VPSs will magnify and accelerate the access problems resulting from budget cuts. The elderly depend on primary care physicians for their access into the Medicare system. Primary care is therefore the first place where access problems will begin to become evident. The Physician Payment Review Commission estimates that under the current formula, the 1997 conversion factor for surgical procedures will be 26.7 percent higher than for primary care services and 29 percent higher than for other nonsurgical services. Because the conversion factors for primary care and other nonsurgical services start out so much lower than for surgical procedures, any additional cuts in the conversion factors will disproportionately hurt primary care physicians and other medical specialists. It is patently irrational to have in place a policy that is inherently disadvantageous to primary care when access to primary care is at the greatest risk of being reduced.

Second, the method for determining the VPSs and fee updates is inherently contradictory to the intent of the resource based relative value scale (RBRVS). The RBRVS was intended to pay physicians the same amount for services that involve equal physician work. But the current policy of different conversion factors has resulted in surgeons being paid 25-30 percent more for their surgical procedures than primary care physicians are paid for a non-surgical service requiring the same amount of time, mental effort and judgment, technical skill and stress. The Commission states that "determining separate performance standards and fee updates for different categories of service leads to distortions in the relative payments which no longer reflect the resource based relative value scales." The Congressional Budget Office agrees. In its 1995 report Reducing the Deficit: Spending and Revenue Options, the CBO states that

> "[the PPRC's proposal to re-establish resource based relative values for payment rates and maintain them by using a single target and update for all services, eliminating separate

> targets and updates now existing for primary care, surgical, and other nonsurgical services] would restore the integrity of the resource based relative value scale that was the foundation for the Medicare fee schedule, which was put in place to rationalize the basis for Medicare's payment rates. One of the objectives of the MFS was to improve payment rates for primary care in relation to specialists' services, in part because health care was expected to be less costly in a system less dominated by specialists. That objective has been undermined in recent years by the default update process, which has produced higher payment rate increases for specialists' services than for primary care services."

It is precisely the kind of contradictory federal policy exemplified by the VPS method that has led to widespread distrust and dissatisfaction with way that Washington does things. Consistency and fairness should dictate that Congress end this contradiction by adopting the PPRC recommendation for a single conversion factor.

Third, the current method encourages inefficiency, since it penalizes many physicians for changes in practice patterns that may reduce Medicare expenditures while rewarding others for reductions in volume over which they have no direct control. Some have argued that the policy of maintaining separate VPSs and conversion factors should be supported because it "rewards" surgeons for reducing volume by more than other physicians. The evidence suggests, however, that the reduction in surgical volume is due principally to changes in practice patterns, such as the substitution of less expensive forms of treatment by internists for conditions that used to require surgical intervention and a predictable reduction in the need for certain surgical procedures.

One of the objectives of physician payment reform was to encourage physicians to reduce the need for high cost surgical treatments by increasing payments for evaluation and management services, such as visits and consultations, and by encouraging the substitution of less costly treatments for more expensive ones. The shift in practice patterns to less invasive outpatient treatments that has occurred over the past several years is dramatically lowering the demand for surgical procedures. Unfortunately, when non-surgeons find ways to treat patients that avoid the need for surgery, they are penalized under the current VPS and update methods for providing more services, even though those services allow patients to be treated more efficiently by reducing the need for surgery.

To illustrate, many heart patients that in the past may have eventually required coronary bypass surgery can now be treated through medication and careful management by an internist of their diets and lifestyles, and when necessary, by a procedure called angioplasty that can clear blocked arteries without resorting to more invasive (and costly) bypass surgery. Under the current VPS methods, internists and cardiologists are penalized because substituting visits and less invasive nonsurgical treatments for surgery increases the "volume" of primary care and nonsurgical services. Cardiac surgeons receive a reward for the reduction in the number of coronary bypass procedures, even though the reduction in volume was due to changes in practice patterns over which they had no control.

Similarly, the Physician Payment Review Commission, citing the Agency for Health Care Policy and Research, reported in 1994 that "Reductions in the volume of prostate-related procedures mostly reflect changes in treatment through increased use of drugs, less invasive surgical procedures, and watchful waiting" (PPRC, Fee Update and Medicare Volume Performance Standards for 1995, May 15, 1994). If Congress' goal is to increase efficiency, it makes absolutely no sense to penalize physicians for substituting less costly evaluation and management services and other nonsurgical treatments for more costly surgical interventions.

The evidence also suggests that much of the reduction in surgical volume is due to an inevitable "bottoming out" of the number of patients who have a need for cataract surgery and several other surgical procedures that experienced explosive growth in the mid-1980s. In the same 1994 report from the PPRC that is cited above, the Commission noted that "The period of greatest growth in volume for a new medical procedure or technology is often the first few years following introduction, largely because it is during this period of diffusion that patients with existing indications are treated along with those newly identified."

In the mid-1980s, the volume of new technologies such as cataract surgery was growing at double-digit rates, because there were tens of millions of patients who needed--and could benefit--from those treatments. As time has passed, however, the demand for such procedures has naturally declined. As the Commission noted in last year's report on the 1995 Volume Performance Standards:

> "Cataract lens replacement surgery provides an illustration [of how the demand for technology can decrease over time because fewer patients require the procedure]. Lens implant improvements and new surgical techniques transformed cataract surgery in the 1980s into a safe, rapid, and convenient cure for cataracts. In 1988, however, the volume of cataract surgery began to decline on a per person basis . . . this decline may have indicated that the backlog of potential lens implant recipients created by the improved surgical technology had largely been depleted. In its 1990 report, the Commission noted that if this hypothesis were correct, the volume of cataract surgery should be expected to be level or possibly declined over the next few years. Noting the large percentage of total surgical volume associated with cataract surgery, the Commission observed that such a reduction in growth of this surgery, if not offset by increases in other types of surgery, would substantially reduce the growth of total surgical volume.
>
> Analysis of Medicare claims data supports the validity of the Commission's prediction. Volume of cataract lens replacement services declined by 7.0 percent from 1992 to 1993. These procedures, along with other eye-related surgical procedures, continue to account for a substantial portion of Medicare expenditures for surgery--currently about 30 percent. This decline in cataract surgery has had a substantial impact on growth in total surgical volume."

It makes no sense to maintain a policy of separate VPSs that rewards some physicians for changes in practice patterns over which they have no control, such as the reduction in the number of patients needing cataract surgery and the substitution of nonsurgical treatments for surgical procedures.

Nor does it make sense to penalize other physicians for changes in practice patterns that have led to increases in the number of nonsurgical treatments for conditions that in the past would have required surgery. The VPS should reward physicians as a whole for taking steps to control volume, rather than the current policy of basing rewards and penalties on shifts in the number of services provided in each category that have no rational relationship to physician performance.

Fourth, the current method is overly complicated. A single VPS and conversion factor would greatly simplify the method of determining Medicare payments. Currently, HHS must calculate three separate VPSs, monitor expenditure trends in each category, and determine three separate dollar multipliers, which are then transmitted to each Medicare carrier for use in calculating what is in essence three different fee schedules, depending on the type of service being billed. By contrast, under a single conversion factor, all resource based relative values would be multiplied by the same dollar multiplier. Physicians would know and be able to collectively respond to the same VPS (target rate of growth), and there would be no possibility of physicians being unfairly rewarded or penalized because of the substitution of one kind of medical treatment for another. The 104th Congress has rightly called for simplification of government rules. Moving to a single VPS and conversion factor would be one important step toward reducing the complexity of the Medicare fee schedule.

There is one other argument that has been offered in support of maintaining the current policy of separate VPSs that must be addressed. The argument made by some is that Congress should not eliminate the separate VPSs because this would be inconsistent with the intent of the 1989 law. But Congress never intended for the provisions of the 1989 law to be inviolate, and has in fact modified them on numerous occasions since then. The 1989 law specifically provided for a five year transition to the full Medicare fee schedule payment rates because Congress wanted the opportunity to enact "mid-course" corrections. Since then, Congress has changed the law by reducing the updates (OBRA 90 and 93), increasing the performance standard reductions and lowering the floor on minimum updates (OBRA 93), mandating reductions in practice expenses for procedures determined to be overvalued (OBRA 93), and mandating development and implementation of a resource based method for determining practice expenses (1994). The 104th Congress will likely be considering other major changes in the Medicare fee schedule. There is no reason that Congress should feel any greater obligation to preserve the policy of separate VPSs and updates than it has for other parts of the 1989 law. Further, Congress also made a promise in 1989 to pay physicians the same amount for services requiring equal work and to create incentives for primary care. That commitment is being violated each year that the separate VPSs and conversion factors are allowed to continue.

ASIM strongly urges Congress to adopt the Commission's recommendation for a single VPS and conversion factor for all services. A single VPS for all services should be required for fiscal year 1996. Budget neutral adjustments should be made in the current separate conversion factors until a single conversion factor is attained for all services. The Commission suggests that this might be accomplished by establishing differential updates that would bring each category to a common

conversion factor. We believe that a shift to a single conversion factor should be accomplished as expeditiously as possible, since we see no reason or justification for a lengthy transition period to a single conversion factor.

Other Changes in the VPSs

Although ASIM's strong preference is for a single VPS and conversion factor, we agree with the Commission's recommendation that if separate categories are maintained, they should be based on the recent trends in volume for each category, as required by OBRA 90, and the differential updates should be in effect for one year only. The PPRC argues that:

> "The distortion of relative payments is further exacerbated by the method the Health Care Financing Administration uses to determine the performance standards under the default formula. Although OBRA 90 requires the use of separate five-year historical trends to estimate the growth in volume and intensity for each category of service, HCFA uses a single historical trend in volume and intensity growth for all services combined. As a result, the performance standard for each category of service reflects a single pooled historical trend in volume and intensity growth rather than the growth for that particular category of service. Using a single pooled trend instead of separate trends leads to more favorable updates for the category with the lowest volume and intensity growth. For this category, the pooled historical trend results in a higher target than it would have had otherwise. When the conversion factor update is determined two years later, the separate expenditure growth rate for this category of service is compared to the target based on the pooled historical trend . . . Use of a pooled historical trend therefore leads to an ever-increasing distortion in relative payments across service categories. In 1995, for example, payments for surgical procedures are $39.42 per RVU, while those for primary care are $36.38 and other nonsurgical services, $34.62. This discrepancy . . . becomes systematic because most surgical services, which have the lowest five-year historical trend in volume and intensity growth, in most years will compare favorably to the pooled historical trend and thus get higher updates than are warranted. **Eventually, the discrepancy between surgical services and primary care services may become large enough to erase the relative gains for primary care and other evaluation and management services that were integral to physician payment reform."** [Emphasis added by ASIM].

ASIM and 22 other primary care and medical specialty groups recently wrote to HCFA and urged that it follow the requirements of OBRA 90 by withdrawing the 1995 VPS, published in December 1994, and recalculating and republishing it based on separate volume trends for each category; propose default fiscal year 1996 VPSs that are based on separate volume trends for each category; and make a recommendation to Congress on calendar year 1996 conversion factor updates that would bring the conversion factors to the levels that would have occurred had HCFA followed the OBRA 90 requirements for the 1993 and 1994 VPSs. If separate VPSs are maintained, we strongly urge Congress to direct HCFA to use separate volume trends, as required by OBRA 90, and to enact updates for calendar year 1996 that would bring payments to the levels intended under the OBRA 90 policy.

The Commission has also proposed that the current formula--five year historical trends minus a four percent performance standard reduction--be replaced by per capita GDP, plus an additional factor of one or two percent. Although ASIM has strong reservations about the concept of linking growth in expenditures on physician services to the performance of the economy as a whole, we believe that the Commission's recommendation may be preferable to the current formula as modified by OBRA 93. The Commission makes a persuasive case that the current formula will result in annual reductions in payments for the foreseeable future, because

> "under any scenario that projects a steady rate of volume and intensity growth, such as the slowdown to 3 percent and 4 percent, the five year historical trend used to determine the VPS equals the actual trend. The default formula for the VPS, however, continues to deduct four percent. The update to the conversion factor, therefore, would remain -2 percent indefinitely . . . Regardless of the eventual level of growth in volume and intensity, these reductions would persist as long as there was no change in the rate of growth."

The Commission believes that its recommendation to convert to a GDP plus one or two percentage point default formula would result in increased expenditures, and therefore would not be budget neutral. It suggests that budget neutrality could be maintained by making a one-time reduction in the 1996 conversion factors. ASIM believes that if budget neutrality rules require that the current conversion factors be reduced, this change should be accomplished in a manner that does not further distort the RBRVS and that is consistent with the objective of moving to a single

conversion factor for all services, such as by reducing the surgical conversion factor by more than the primary care and other nonsurgery conversion factors.

ASIM opposes the Commission's recommendation that the VPSs be made cumulative. This would mean that changes in payment levels would reflect whether total actual spending had exceeded targeted spending since a base year. Since this change has the potential of greatly magnifying any of the reductions that otherwise may occur, it should not be accepted by Congress.

Future of the Physician Payment Review Commission

It is our understanding that Congress may be considering eliminating authorization or funding for the Commission or consolidating its functions with those of other advisory bodies. Although ASIM has not always agreed with the Commission's recommendations, we do believe that it has provided valuable, objective, and independent advice to Congress. The 1994 PPRC report to Congress shows how important the Commission's analysis is in framing the decisions that need to be made on the Medicare fee schedule. The Commission has also provided a means for physicians to express their views on Medicare fee schedule issues without having to take our case directly to Congress. Eliminating the functions of the Commission in its entirety would force Congress to rely more on analysis by HCFA and the administration, which inevitably is affected by the administration's political agenda, and may reduce the input physicians have into decisions that affect payments for their services.

ASIM understands the need for Congress to reduce spending, but would prefer that the PPRC continue to receive full funding and be preserved as a separate, independent advisory group to Congress. But if changes are made, we urge the Ways and Means Committee to assure that the essential functions of the Physician Payment Review Commission--providing an independent source of advice and analysis on technical Medicare fee schedule issues, with strong physician representation and input--are not lost in the desire to consolidate functions or reduce expenditures.

Conclusion

ASIM appreciates the opportunity to present testimony to the Ways and Means Committee. We fully understand the magnitude--and difficulty--of the responsibilities you've accepted. Reducing the federal deficit and simplifying government rules and programs are admirable objectives, and ones in which you will have the support of the medical profession. As you act on the Contract with America, we believe it is essential that Congress also honor the Contract with America's elderly--which promised continued access to affordable care--that was made by your predecessors when Medicare was enacted thirty years ago.

We urge that you not enact further cuts payments for physician services because of our concern that access will suffer as a result. We believe that since expenditure growth on physician services is already much lower than any other category of Medicare spending, there is no justification for seeking additional cuts in this area. If additional cuts are enacted, they should be focused on areas that are having more explosive growth, provided that savings can be achieved without sacrificing access, and extreme care must be taken to assure that any cuts that may be made in payments for physician services do not further distort the resource based relative value scale (i.e. they should close--not widen--the gap between surgical procedures and primary care and other nonsurgical services).

ASIM recognizes that a debate on reforming Medicare is imperative. Virtually all experts agree the program cannot remain solvent for much longer. The focus of such a discussion should be on developing a package of proposals that would guarantee the continued solvency of the program, rather than on short-term cuts that would ask beneficiaries and physicians to contribute more than their fair share to deficit reduction or financing tax cuts. For this reason, we do not advocate increases in beneficiary cost-sharing if the savings are to be used for purposes other than maintaining the long-term solvency of Medicare. ASIM would support changes in beneficiary contributions and adjustments in the age of eligibility as part of a balanced plan to preserve Medicare solvency.

ASIM also supports creation of a voucher program that would expand the health plan choices available to beneficiaries, and would be pleased to work with the Committee on the development of such a program. Over the next several months, we intend to develop detailed recommendations for your consideration on how to expand choices for Medicare patients while continuing to assure access to high quality care.

Finally, if other changes are insufficient to assure the continued viability of Medicare, it may be necessary to initiate a process for putting priorities on the benefits available under the program. As an internist from Oregon, the only state that has attempted to do this for its Medicaid program, I can tell you that such a process can work and enjoy broad support from the public and the medical profession.

I'd be pleased to answer any questions from the committee.

Mr. MCCRERY. Thank you, Dr. Weaver.

I would like to thank all the members of the panel who were kind enough to appear before the subcommittee today. Unfortunately, we have a vote on the floor in which we have about 3 or 4 minutes left to get over there to vote, and then we have a series of 5-minute votes following this one. So all of your written testimony will be made a part of the record.

Dr. WEAVER. Thank you.

Mr. MCCRERY. Once again thank you very much for appearing before us today. We will look forward to working with you further as we go through some difficult times ahead in terms of our Medicare system and our health care system generally. We look forward to sharing our views with you——

Dr. WEAVER. Thank you.

Mr. MCCRERY [continuing]. And hearing more of yours in the future. Thank you.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY IN RESPONSE TO RECOMMENDATIONS OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

Interest of ASCO

The American Society of Clinical Oncology (ASCO) represents more than 9,300 physician researchers involved in cancer treatment and research. Many ASCO members participate in the extensive clinical trials network established under the auspices of the National Cancer Institute (NCI). Treatment given in the context of high quality, peer-reviewed clinical trials like those sponsored by NCI often represents the best available care for patients diagnosed with life-threatening cancer.

Position of Third-Party Payers on Investigational Therapy

Many third-party payers, both public and private, exclude from coverage patient care costs incurred in connection with clinical trials. As a result, clinical investigation is deterred, appropriate reimbursement is frequently denied, and patients with serious or life-threatening disease are deprived of the best available care. Automatic exclusion from coverage of investigational therapy for critically ill patients represents a form of insurance abuse that denies policyholders (and in the case of Medicare, beneficiaries) the value of their insurance.

Problems with PPRC Recommendation

Rather than recognize that investigational therapy is an integral part of care for many cancer patients, the Physician Payment Review Commission (PPRC) suggests that some -- but not all -- research should be financed through a separate budget specifically designed for that purpose. This approach denies the value of investigational therapy for cancer patients and creates opportunity for disparate treatment of similarly situated beneficiaries. At least in cancer care, clinical investigation is not an unnecessary adjunct to standard therapy, but instead is a reasonable alternative, and one that is as likely to be successful for a patient with life-threatening disease as standard care.

ASCO Recommendation

ASCO has long recommended that third-party payers, including Medicare, provide reimbursement for all patient care costs incurred in those clinical trials when all of the following is demonstrated:

- Treatment is provided with a therapeutic intent[1/];
- Treatment is being provided pursuant to a clinical trial which has been approved by the National Cancer Institute (NCI), any of its cancer centers, cooperative groups or community clinical oncology programs; the Food and Drug Administration in the form of an investigational new drug (IND) or investigational new device (IDE) exemption; the Department of Veterans Affairs; the Department of Defense; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants (such as the American Cancer Society or the Leukemia Society of America);

1/ Treatment with a therapeutic intent may be aimed at improving patient outcome relative to either survival or quality of life.

- The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;
- There is no noninvestigational therapy that is clearly superior to the protocol treatment; and
- The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as noninvestigational therapy.

This recommendation was reflected in a number of health care reform proposals introduced in the 103rd Congress. We believe that imposing the ASCO standard as a requirement will advance medical research and improve patient care at little or no incremental cost in most cases.

AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Statement
of the
American Speech-Language-Hearing Association
to the
Committee on Ways and Means
Subcommittee on Health

For the Record of the Public Hearing - March 30, 1995

Submitted April 13, 1995

Re: 1995 Annual Report to Congress
Physician Payment Review Commission

The American Speech-Language-Hearing Association (ASHA) represents more than 75,000 audiologists and speech-language pathologists, most of whom are qualified to render Medicare-covered services. ASHA appreciates this opportunity to comment on the 1995 Annual Report to Congress of the Physician Payment Review Commission (PPRC).

Medicare Payments to Non-Physicians. ASHA was concerned that the 1995 report contained little or no discussion regarding payment to non-physicians such as audiologists, nurse practitioners and psychologists. While these services do not represent a large percentage of total Medicare expenditures, thousands of practitioners are affected. ASHA has voiced strong concerns to the Health Care Financing Administration (HCFA) that gross inequities are created in the payment system because some professions are not paid from the professional component or (work relative value units or RVWs). This practice totally excludes a portion of the fee schedule from independent practitioners even though the non-physician provides the total service. HCFA is currently examining the legality of recognizing additional professions in the work component. The PPRC should be calling for legislation, if necessary, to allow non-physicians (such as audiologists and psychologists) to be paid on an equal categorical status with other non-physicians (such as physical therapists and occupational therapists) that are paid from RVWs. ASHA believes that the statute regarding the resource-based relative value scale should be amended so that non-physicians providing covered services are appropriately reimbursed.

Medicare HMOs - Inadequate Rehabilitation Services (Chapter 5). The PPRC is clear in its understanding that "HCFA executes annual contracts with HMOs and CMPs to provide all Medicare-covered services for enrolled beneficiaries (both Part A and Part B) . . . "(p.90) [emphasis added]. This full range of services is required by 42 CFR 417.414(b)(1):

> . . . an organization [HMO/CMP] must furnish to its Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled that are available to Medicare beneficiaries who reside in the organization's geographic area but are not enrolled in the organization.

It is of concern to ASHA that no reference is made to data that shows that the full scope of Medicare coverage is often not provided. ASHA has received reports of services in Medicare HMOs curtailed dramatically below the Medicare medical review guideline standards for reasonable and necessary speech-language pathology services. Such abuse should be investigated as it probably occurs in other covered areas as well.

Improving Medicare Coverage Decisions (Chapter 6). The Subcommittee on Health should know that PPRC's call for standardization of coverage policies applies to fiscal intermediaries as well as carriers. The statement, "Coverage policies can differ because criteria and processes for making them vary among carriers (p.119)," equally applies to intermediaries. ASHA joins in PPRC's support for more coverage decisions at the national level based on formal technology assessments. The Office of Health Technology Assessment has an annual budget that permits only five full-time staff, a severe limitation. This limitation has resulted in the absence of a formal evaluation of a cost-effective alternative to a radiologic procedure used to evaluate swallowing disorders. ASHA is concerned because some carriers consider the alternative fibreoptic procedure to be "experimental" or "investigational," absent a national coverage decision. This will often result in a higher expenditure for the radiologic procedure.

Medicaid Demonstration Programs (Chapter 8). Regarding waivers granted under Section 1115 of the Social Security Act, the report criticizes some demonstrations for lacking merits such as adequate planning and appropriate systems to monitor access, quality and marketing. ASHA members have substantiated much more severe shortcomings. In particular, HCFA should be questioned on how its own policies and procedures could allow the TennCare program to be implemented with such gross inadequacies regarding information and services not available to beneficiaries. This includes TennCare's reluctance to deliver comprehensive services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (ages 0-20) even though EPSDT requirements were not waived by HCFA. It is hoped that revised procedures are in place at HCFA to prevent such failures from occurring again.

Statement of

the Association of American Physicians and Surgeons

to the Subcommittee on Health

of the House Ways and Means Committee

With Reference to: Recommendations of the Physician's Payment Review Commission presented on March 30, 1995

The Association of American Physicians and Surgeons was founded in 1943 to preserve and promote private medicine and the sanctity of the patient-physician relationship.

The AAPS recognizes the need to cut back on government subsidies. As predicted, they are bankrupting the nation. We are not requesting preferences for our members.

With respect to physician payment, AAPS takes the position that it is pointless to revise the Resource-Based Relative Value Scale because it is fundamentally flawed in concept, practice, and result. Instead, we propose alternate solutions to our dual problems of spiraling expenditures combined with restrictions on medical care.

Problems with the Resource-Based Relative Value Scale (RBRVS)

The concept of the RBRVS is that of the Marxist Labor Theory of Value, i.e. that the value of the service depends only upon the cost of production. This idea has been thoroughly discredited (for example, in its related form of "comparable worth").

Even if this theory were correct (it is wrong to the point of absurdity), the RBRVS is flawed in practice because it cannot accurately calculate the cost of production. The tables of costs are derived from subjective evaluations by a small panel, data (such as apartment rents) that may be completely inapplicable, and arbitrary extrapolations. The tables disregard variations in cost due to location, type of practice, individual abilities and training of the practitioner, individual complexity of the patient's case, and uncontrollable fluctuations in the marketplace for goods and services. Even if the data could be vastly improved, the tables of values would still give an erroneous price in every single individual instance because they are based on broad averages.

The result of the RBRVS is to restrict the provision of medical services. This is because the RBRVS is not simply a flawed means of calculating government reimbursement for Medicare beneficiaries. Rather, it is combined with restrictions on balance billing and thus imposes price controls on medical services rendered to all Medicare beneficiaries (as well as to retirees under the FEHBP). Like every example of price controls imposed over forty centuries of recorded history, it inevitably leads to market distortions, with shortages, dilution of quality, corruption, and destruction of incentives for excellence and progress.

Restrictions on Medical Care

Surveys undertaken by the PPRC have been cited to show that care is "still" available to Medicare beneficiaries. However, it is misleading to say that "only" 4% of patients had difficulty obtaining medical care and 0.3% of patients surveyed had difficulties finding a new physician. At any given time, most Medicare beneficiaries are either healthy or already under the care of an established physician. In addition, patients may not be aware of services that a

physician might have offered in a free market but simply fails to mention when he knows he cannot provide them without incurring a loss.

Furthermore, many physicians are in a marginal situation. A slight increase in the pressures that they have so far managed to endure could lead to a sudden increase in retirements or dramatic changes in practice patterns.

Testimony before this Subcommittee by the American Academy of Family Physicians stated that in some locations more than 35% of family physicians are not accepting Medicare beneficiaries. We believe the problem is actually far worse than that. In a 1993 survey by AAPS (see below), 60% of respondents reported restricting services to Medicare patients in some way, even if they did accept some new Medicare patients.

A Washington State survey conducted by AAPS of statewide physicians showed that about one quarter contemplated leaving the state or the practice of medicine if they were forced into government-run managed-care programs.

Proposed Solutions

Solutions must look beyond fine-tuning of the RBRVS. AAPS proposes the following for consideration:

- **Allow and encourage private insurance alternatives.**

AAPS believes that the long-term solution to the problem is to enable most younger persons to fund their own retirement medical insurance without being forced into government dependency. This means that market-based alternatives to Medicare must be allowed to develop, the burden of taxation must be eased, and savings mechanisms (such as Medical Savings Accounts) must be encouraged. Savers must be confident that the fruits of their prudence will be protected from governmental "recapture."

- **Establish fiscal solvency for Medicare.**

In order to preserve fiscal solvency of Medicare for those who are already dependent upon it, the demands on the program must be diminished. The only way to accomplish this without severe rationing (which will lead to the functional equivalent of involuntary euthanasia) is to allow private contracting and balance billing. The private marketplace could then partly compensate for the distortions that occur in any governmentally fixed reimbursement system.

- **Minimize fraud and abuse.**

Fraud and abuse are believed to be rampant. Draconian enforcement cannot eliminate this problem, not even by terrorizing all practitioners and depriving them of their constitutional rights. The current system rewards and facilitates fraud and abuse. Until the easy profits are removed, the skillful gamers of the system will thrive. Medicare should stop paying providers directly and should reimburse patients only.

- **Reduce regulatory and administrative cost.**

To enable physicians to serve patients at a more reasonable cost, the government should immediately repeal all regulations that serve no demonstrable purpose of protecting public health. This includes regulations under the Clinical Laboratory Improvement Act and the Occupational Safety and Health Administration, other than those that have been scientifically shown to produce benefits justifying their cost.

Medicare must also reduce the tremendous clerical costs incurred in the claims-filing and documentation requirements. Many of these costs would be eliminated if payments were to be made only to beneficiaries. In addition, the system could be greatly simplified by increasing

patient deductibles while eliminating the copayment requirement. No claims need be filed until (and unless) the deductible is exceeded. After that point, Medicare should pay an indemnity for services. (The PPRC could continue to advise on the amount of the indemnity, preferably by some means other than the flawed RBRVS.) The patient would be responsible for the balance, which could be less than 20% (even 0%) or more than 20%, depending on the individual circumstances of both patient and provider, and determined without the need for costly and intrusive bureaucratic intervention.

Conclusions

AAPS states no opinion regarding the specific amount that any physician should be paid; in a free market, payments may be determined only by the provider and the recipient of a service. We do note that members report receiving on the average about 50% of the usual price when caring for a Medicare beneficiary, and that this must inevitably have an impact on the quality and availability of service.

We expect that the implementation of the suggestions above would lead to a substantial drop in Medicare expenditures, with preservation or improvement in the quality of care.

Attachment: Survey of physicians' response to Medicare

Responses to AAPS survey on attitudes toward Medicare and its impact on patient care. About 3000 questionnaires were distributed, with self-addressed, nonstamped envelope, and 480 were returned by the time responses were tallied. If the same question was asked in 1990, the response at that time is tallied for comparison. (Compiled May, 1993)

Question	% positive responses (% who circled option or answered "yes")			
	1993 all (N = 480)	1993 FP,IM (N = 209)	1993 surg (N = 116)	1990 (N = 922)
1. ***Accept new Medicare pts?***				
A prefer	1	0	3	8
B same basis as others	56	43	75	67
C special circumstances only	30	37	19	17
D not at all	12	19	3	8
2. ***Restrict services to Medicare pts?***	51	60	41	16
If services restricted, why?				
A Limits on balance billing	58	58	63	
B Cut in reimbursement	71	74	83	
C Physician must submit claim	45	46	46	
D New coding requirements	40	45	40	
E Hassles and threats from Medicare	71	71	69	
3. ***Have you received:***				
A Refund demand (service "unnecessary")	38	48	31	36
B Refund demand for coding errors, etc.	39	40	39	NA
C Notice of "substandard quality"	5	8	6	8
D Sanction threat	15	20	17	21
4. ***Any difficulty making referrals?***	37	36	35	
5. ***Consider retiring earlier than you would have thought possible 5 yrs ago?***	73	70	74	74
6. ***Your position on caring for Medicare-eligible patients outside the system:***				
A Do offer, or plan to offer such care	22	25	19	
B Would like to work outside system but fear government reprisals	56	54	59	
C I'd do it but patients uninterested	15	15	18	
D Oppose this option	2	4	0	
7. ***Mean number of years in practice***	21	22	19	21
8. ***Mean percentage of practice that involves Medicare***	33	34	38	
9. ***Percentage of regular fee received in caring for a Medicare patient***	49	53	54	61

MEDICARE END-STAGE RENAL DISEASE (KIDNEY FAILURE) PROGRAM

HEARING

BEFORE THE

Subcommittee on Health

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

APRIL 3, 1995

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MEDICARE END-STAGE RENAL DISEASE (KIDNEY FAILURE) PROGRAM

MONDAY, APRIL 3, 1995

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

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

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 27, 1995
No. HL-8

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARING ON THE MEDICARE END-STAGE RENAL DISEASE (KIDNEY FAILURE) PROGRAM

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will hold a hearing on the Medicare end stage renal (kidney failure) disease program. **The hearing will take place on Monday, April 3, 1995, in the main committee hearing room, 1100 of the Longworth House Office Building, beginning at 10:00 a.m.**

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

BACKGROUND:

Medicare covers individuals who suffer from end stage renal disease (ESRD) if they are insured under the Social Security program or are the spouse or dependent of a person insured under Social Security.

ESRD is fatal without treatment, which is either transplantation or dialysis. Successful transplants more than doubled between 1980 and 1992 in the general population due to the introduction of cyclosporine, an effective immunosuppressive drug. In 1991, there were over 4,600 transplants performed on Medicare ESRD patients. Nonetheless, dialysis remains the primary treatment due to a shortage of kidneys available for transplantation and medical factors which make transplantation unsuitable for certain patients.

In 1995, there are approximately 200,000 Medicare beneficiaries with ESRD, up from 97,200 in 1985. Medicare spending for ESRD patients will total $8 billion, or $38,900 per beneficiary. In 1985, Medicare spent $2.8 billion on ESRD beneficiaries, or $29,000 per beneficiary.

In announcing the hearing, Chairman Thomas stated: "The Medicare program has saved thousands of lives for persons suffering from end stage renal disease and will continue to do so in the future. I believe the subcommittee has a responsibility to make sure the program continues to meet its objectives in a cost-effective manner. I am anxious to hear from the Administration and the experts about the quality of care provided to patients, and the applicability of capitation and managed care to this portion of the Medicare program."

FOCUS OF THE HEARING:

The hearing will focus on oversight of the Medicare ESRD program, examining trends in costs, beneficiaries, and the number and organization of providers, as well as changes in medical practice patterns and the quality of care provided to beneficiaries. In addition, the hearing will examine current and alternative payment policies and how the ESRD program may fit into a broader reform of the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Monday, April 17, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

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

Chairman THOMAS. The Subcommittee will come to order.

Welcome to the Health Subcommittee hearing on the Medicare ESRD, End-Stage Renal Disease, Program. ESRD is unique within Medicare. It is the only disease which triggers Medicare coverage at any age. There is no disputing this program's dramatic and positive results in the lives of ESRD patients.

Medicare coverage of dialysis and other treatments has spared hundreds of thousands of Americans from premature death. We must not lose sight of that profound accomplishment.

Because the ESRD Program is unique within Medicare, I think we have a tendency to overlook it, but we shouldn't because it is a very significant and important program. In 1995 Medicare is expected to spend nearly $8 billion, or over 4 percent of all total spending on over 200,000 ESRD patients. That is about $40,000 per beneficiary.

Today's hearing is intended to meet several objectives. First, the Subcommittee needs an overview of the program and how well it is meeting its objectives. What are the treatments for ESRD patients and how has treatment changed over time, if in fact it has? What are the trends in terms of costs and numbers of beneficiaries? What is the quality of care provided to patients? What are the current payment policies for dialysis and other treatments, and are there alternatives that should be explored?

Second, this Subcommittee is going to examine opening up the Medicare Program to more coverage choices for the beneficiaries, much like employers in the private sector have done to enhance competition, improve quality, and reduce costs. We need to explore how the ESRD Program may or may not fit into such an approach.

I look forward to hearing from our witnesses, but prior to that, I would recognize my colleague from California, Mr. Stark.

[The prepared statement follows:]

STATEMENT OF CHAIRMAN THOMAS
HEARING ON THE MEDICARE END-STAGE RENAL DISEASE
(KIDNEY FAILURE) PROGRAM
APRIL 3, 1995

Welcome to the Health Subcommittee hearing on the Medicare End-Stage Renal Disease, or ESRD, program.

ESRD is unique within Medicare. It is the only disease which triggers Medicare coverage at any age.

There is no disputing this program's dramatic and positive results on the lives of ESRD patients. Medicare coverage of dialysis and other treatments has spared hundreds of thousands of Americans from premature death. We must not lose sight of that profound accomplishment.

Because the ESRD program is unique within Medicare, I think we have a tendency to overlook it. But we shouldn't, because it is a very significant and important program. In 1995, Medicare is expected to spend nearly $8 billion, or over 4% of all total spending, on over 200,000 ESRD patients. That's about $40,000 per beneficiary.

Today's hearing is intended to meet a couple of objectives.

First, the Subcommittee needs an overview of the program and how well it is meeting its objectives. What are the treatments for ESRD patients, and how has treatment changed over time? What are the trends in terms of costs and numbers of beneficiaries? What is the quality of care provided to patients? What are the current payment policies for dialysis and other treatments, and are there alternatives that should be explored?

Second, this Subcommittee is going to examine opening up the Medicare program to more coverage choices for the beneficiaries, much like employers in the private sector have done to enhance competition, improve quality, and reduce costs. We need to explore how the ESRD program may or may not fit into such an approach.

I look forward to hearing from our witnesses.

Mr. STARK. Thank you, Mr. Chairman.

I want to congratulate you for holding this hearing. The ESRD Program has been a success and literally saved, I suppose, millions of lives, but the program is fraying around the edges. I think that a comprehensive approach to the treatment of this disease could easily improve the quality of care and save money. We ought to reform the payment system, perhaps through a capitation method, and that ought to make the dialysis centers a little more anxious to ensure that hospitalization isn't necessary, and that where appropriate, we should see that patients receive transplants or are treated at home, with a caveat that treatment at home, I think, ought to be done in only the most extreme conditions.

While reform holds great promise, I think we have to be very careful. This is a vulnerable population, literally and figuratively, and underservice can quickly lead to death.

In March the Health and Human Services Inspector General issued a report that two-thirds of the ESRD and disabled persons in HMOs wanted to leave the HMO—but they felt they couldn't. They really felt trapped in them. They are twice as likely as senior enrollees in HMOs to say that the HMOs have hurt their health. They are twice as likely to complain, but those are the figures we are getting.

To date, capitated plans have not managed the ESRD patients well. HCFA, the Health Care Financing Administration, is about to begin a demonstration project to test whether some form of capitation might work, and more importantly, what quality measures we need to ensure we don't kill the patients. We can't cut corners in reforming this program, and I think we should wait to see what the demonstration shows us.

I have introduced two bills and I would like to ask the witnesses today to comment on them. One sets up a demonstration to see if we can save money and help patients by delaying the onset of kidney failure, and, at least in layman's terms, generally the onset of kidney failure is discovered early, and I think dietary changes can prevent a lot of failure if people will follow their instructions. I don't know whether a demonstration would show that we could encourage that, but I think it is worth a look.

Second, the second bill says we should not pay dialysis centers if they don't achieve a specific measurable level of cleaning the blood for most of their patients. I think that is—it is a measurable standard. It is an empirical standard, and if witnesses don't support the standards set in the bill I have introduced, what standards should we use?

I mean, it seems to me we can't move to a managed care system if we can't have a specific standard by which we manage the treatments that we are purchasing with Federal dollars. I hope that we can hear from the witnesses today about those issues, and I commend you for having the hearings.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF CONGRESSMAN PETE STARK
WAYS AND MEANS SUBCOMMITTEE ON HEALTH
APRIL 3, 1995

OVERSIGHT OF THE END-STAGE RENAL DISEASE PROGRAM

Mr. Chairman:

Congratulations for holding this hearing. I wish we had made the time to do this in the last Congress.

The ESRD program has been a success and literally a life-saver, but it is fraying around the edges:

> --some providers are gaming the payment system, charging extra for questionable tests and services;
>
> --hospitalization rates are much higher than they should be;
>
> --we are spending more and more on drugs with less and less to show for it;
>
> --some centers provide poor quality and are almost death traps for their patients; and
>
> --we talk about assuring quality in the program, but after more than twenty years, can't seem to agree on a specific standard for dialysis.

I think a comprehensive approach to the treatment of this terrible disease could easily improve quality of care and save money. Reforming the payment system--perhaps through a capitation system--could make dialysis centers zealous to ensure that hospitalization is not necessary, and that where appropriate, patients receive transplants or are treated at home.

But while reform holds great promise, we must be very, very careful. This is a very vulnerable population, and underservice can quickly lead to death. In March, the HHS Inspector General issued a report that 66% of ESRD and disabled persons in HMOs wanted to leave their HMOs but felt they couldn't. They are twice as likely as senior HMO enrollees to say that HMOs have hurt their health. To date, capitated plans have not managed ESRD patients well.

HCFA is about to begin a demonstration project to test whether some form of capitation might work--and what quality measures we need to ensure we don't kill patients.

We shouldn't cut corners in reforming this program--we should wait to see what the demonstration shows us.

In the interim, I've introduced two bills that I'd like today's witnesses to comment on:

> One would set up a demonstration to see if we can save money and help patients by delaying the on-set of total kidney failure and thus postpone the day that dialysis is needed.
>
> The second says we shouldn't pay dialysis centers if they don't achieve a certain specific, measurable level of cleaning the blood of most of their patients--as expressed in the formula Kt/V equal to or greater than 1.2. If witnesses don't support the standard set in this bill, what standard would they propose--and how can they support moving to a managed care system if they can't accept a measurable, specific life-saving standard?

Chairman THOMAS. I thank you very much.

Any other colleagues can put a written statement in the record.

Dr. Smits, the Deputy Administrator of the Health Care Financing Administration, your written testimony will be made a part of the record and you can begin to inform, enlighten, and educate us in any way you see fit in the time that you have.

STATEMENT OF HELEN L. SMITS, M.D., DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Dr. SMITS. Thank you, Mr. Chairman. I won't read my prepared testimony, but I will go through all of the topics since one of the aims of the hearing is to review in general the status of the program.

This is a serious matter and this is serious testimony, but I can't resist beginning by saying I am very sorry that Nancy Johnson isn't here. I used to run a hospital in her district and I am sure she will share with me the feeling that this is a very good day for Connecticut women.

Moving on to ESRD, when I was a resident, an intern starting in 1967, renal failure was a relatively common cause of death in hospitals. It was tragic, painful to watch, and I think all of us in the field greeted with great enthusiasm the passage in 1973 of Medicare coverage for this illness.

The cost of the ESRD Program is often held up as an example of how you can't control costs in government programs, but I think in fact as you dissect the program, you see that this is in many ways a very successful program in which per capita costs have dropped markedly and which we have also offered the treatment to very large numbers of people, much greater than were originally predicted.

As you know, all of those who are eligible for Medicare or spouses or children of those eligible for Medicare become eligible under the ESRD provisions 3 months after the onset of renal failure.

The original estimate was that 10,000 beneficiaries would be covered annually. We are now covering about 200,000 and the numbers continue to rise. I will talk a little more as we go along about why that is happening.

Treatment for complete kidney failure is dialysis, which can be mechanical with an extracorporeal machine or can use the body's own ability to dialyze through peritoneal dialysis where fluids are put into the stomach. Mechanical dialysis is done either in centers or at home. Peritoneal dialysis is always done at home. Facilities do receive facility rates for patients that they oversee who are either receiving mechanical or peritoneal dialysis at home.

Kidney transplantation is also a very satisfactory solution to this illness and is the cause for a number of beneficiaries leaving the ESRD status on Medicare, but there aren't enough kidneys to go around, and in addition, many of the successful kidney transplants remain on disability status even following transplantation.

The first chart which you see here shows you why the numbers have grown so dramatically since the early seventies. At the time that the program first started—this chart starts in 1978, 5 years after the program began—what we really expected is that the great

majority of patients would be those with glomerulonephritis or other attacks on the kidney itself, such as massive blood loss where the patient totally recovers but the kidneys were killed in the process.

We did not expect that very many hypertensive or diabetic patients would come into the program because these patients didn't do well on dialysis at the time. As you can see, the greatest rise has been in the diabetic patient who has many other ailments at the time they come to dialysis, while the hypertensive patient, after some early increased glomerulonephritis, has stayed fairly stable. We have seen some increase in hypertensive patients as well.

Beneficiaries are also older than we had originally anticipated. We are bringing into dialysis many people who are already Medicare qualified because of age.

In terms of cost, there are a number of ways to look at it, but this chart shows you one of the clearest ways and that is, if you look at the total cost of the ESRD Program per person compared to the cost of the rest of Medicare per person, you will see that we started out with the ESRD patients being about 30 times more expensive than everyone else in Medicare, and they are now in the vicinity of 10 times more expensive than everyone else in Medicare.

Also, you can see that the dramatic drop in cost took place at the beginning of the inclusion of ESRD patients, and up until about the middle eighties. Now the ESRD Program is inflating roughly as fast as the rest of Medicare.

The next chart gives you an idea of how the costs for the ESRD Program break out. Remember, this is two dramatically different groups of patients: transplant patients and dialysis patients.

Inpatient costs are still about 44 percent of the total cost. That does include the very high cost of transplantation in the year of the transplantation; outpatient costs, about 33 percent; and physician and suppliers costs, about 21 percent. As I am sure you know, the outpatient facilities are paid on essentially a capitated blended rate, and doctors are also paid on a capitated blended rate.

The capitated rate for facilities was set in 1983 when other prospective payment was established and hasn't been changed since then. Physician payment is now rolled into the general physician payment and I believe 1995 is the first time there has been an increase. In the future, it will be treated equally with other physician payments in its category.

One area that has been of great concern because of its impact on the total cost to Medicare is the Medicare secondary payer provision. Under OBRA 1993, anyone who has group health insurance is expected to treat Medicare as the secondary payer for 18 months. That provision is to expire. The President has asked you to extend this provision, and it has been marked up and reported out of this Committee as an extension.

I am very clear that the quality of the services received by Medicare beneficiaries is of great concern to all of you. The method by which HCFA influences quality in the ESRD is twofold. One is the regulatory process, the conditions of coverage by which we survey and inspect facilities; and the other is through the networks, private organizations with membership that includes all of the provid-

ers in a given region that collect and analyze data and are very active in the benchmarking process.

The conditions of coverage that we now use are like many of our conditions, rather old and very process oriented. We are in the first stages of moving them toward more outcome-oriented conditions.

I am also pleased to say that we are looking at a process by which we would inform patients about the quality of care. We would encourage patients to learn about the quality of their own dialysis to track their own rate of adequacy of dialysis. We believe this is a situation where the individual consumer can have a great deal of effect on quality.

Through the networks and working jointly with providers, we are also in a benchmarking quality improvement mode looking at four key factors which include: the adequacy of dialysis; the level of hematocrit because anemia is a consistent problem for these patients; adequacy of control of blood pressure; and the adequacy of nutrition as measured by a fairly simple blood test of protein in the blood.

That process is a collaborative one, and is intended to improve continually over time. As you probably know, the new definition of adequate dialysis was quite recently set by the profession at Kt/V of 1.2. Only about 40 percent of the patients were receiving that level at a point in time when the new rate hadn't been set. We do expect to see those numbers increasing over time.

I know that one of the primary goals of this hearing is to talk about whether ESRD patients should be more generously included in managed care. At present, you can be in managed care with ESRD only by acquiring the disease while you are already in a managed care plan.

The problem that we face—could I have the last chart again? The problem that we face in changing that law is severalfold. First of all, we need to have a reasonable rate to pay managed care. As you can see, since we are paying facilities and doctors on capitation, the part of the expenditures that are most amenable to control would be hospitalizations.

Right now we have a single rate for ESRD patients in managed care which mixes the costs of the posttransplant patient with the costs of the dialysis patient. Since posttransplantation is less expensive, that means the rate underpays for dialysis at least on average, overpays posttransplantation and leaves the facility—the HMO itself at something of a risk in terms of underpayment for the expensive short period in time during the transplantation.

We would like to have a better payment rate that distinguishes among those three groups of patients and doesn't put the HMO in the position of having to overcontrol costs in the area of dialysis for those patients who appropriately remain on dialysis for a long period.

We have had the RAND Corp. devise a payment method for us. We are in the process of soliciting sites for a managed care demonstration, and we estimate that service delivery will begin in about 1 year.

Our position at this time is that rapid movement into managed care before the demonstration is completed or at least before early data are available from the demonstration would be unwise.

Thank you very much. That concludes the formal part of my testimony. I would be glad to answer questions.

[The prepared statement and attachments follow:]

STATEMENT OF HELEN L. SMITS, M.D.
HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman, and members of the subcommittee, I am pleased to be here this morning to discuss Medicare's program for people with end stage renal disease (ESRD). I'd like to begin with a basic explanation what ESRD is and how it is treated. Following this, I'll discuss how it became a condition for Medicare eligibility, present a profile of ESRD beneficiaries and the current program, review new developments in quality improvement, and address issues relating to ESRD and managed care.

ESRD AND ITS TREATMENT

ESRD is a kidney impairment that is irreversible, cannot be controlled by conservative management alone, and requires dialysis or transplantation to maintain life.

Kidneys filter the blood and regulate concentrations of essential fluids and body minerals, such as magnesium, sodium, and potassium. When kidneys fail to perform adequately, toxins accumulate in the blood, which results in a complex condition called uremia. Left untreated, uremia is uniformly fatal. Even with aggressive use of the therapies currently available, mortality in the ESRD population is significant. About one-half of persons under age 35 will survive ten years on dialysis; one-half of those between the ages of 35 and 64 can be expected to survive for four years; and less than one-half of those over age 65 will survive two years after dialysis is initiated.

Treatment for poorly functioning kidneys is limited to dialysis or transplantation, with dialysis being the most frequent. Dialysis is a process of removing dissolved substances from the patient's body to maintain the chemical balance of the blood when the kidneys have failed. There are two types of dialysis: hemodialysis, in which the blood is pumped through a machine that "cleans" it and then returns it, and peritoneal dialysis, in which a solution is put into the peritoneal cavity and removed taking with it the accumulated toxins. Each hemodialysis treatment requires a minimum of several hours, often three to four times a week. Approximately 82 percent of Medicare ESRD beneficiaries use hemodialysis, which is primarily given in outpatient facilities. About 18 percent use peritoneal dialysis, which is given in the home.

Transplants--or grafts--are becoming increasingly common, but are still relatively rare due to a shortage of available organs. The operation is expensive, and patients are required to take immunosuppressive drugs for the rest of their lives to prevent organ rejection. Transplant recipients who are under 65 and are not otherwise disabled lose Medicare entitlement 36 months after a successful transplant. However, only 50 percent of successful transplant recipients actually leave Medicare after 36 months; the 50 percent who remain retain entitlement on the basis of age or disability.

PROGRAM HISTORY

Treatment of ESRD requires expensive advanced medical technology. In 1972, Congress enacted legislation[1] that extended Medicare eligibility to ESRD patients. Thus, the ESRD program is the only portion of Medicare in which eligibility is based on the presence of a medical condition.

In terms of saving lives, the program has been enormously successful. Currently over 200,000 Americans are either on dialysis or have a functioning kidney transplant. Without Medicare-financed coverage, it is unclear how the vast majority of these people would have been able to afford this life-saving treatment.

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[1]Social Security Amendments of 1972 (P.L. 92-603, section 299(I))

ESRD beneficiaries account for approximately one-half of one percent of the total Medicare population (183,000 in CY 1991) and four percent of total Medicare expenditures ($6.1 billion in CY 1991).

ELIGIBILITY REQUIREMENTS

To qualify for Medicare under the renal disease provision, a person must be diagnosed with ESRD and be either (a) entitled to a monthly Social Security benefit, (b) fully or currently insured under Social Security, or (c) the spouse or dependent child of a person who meets at least one of these requirements. There is no minimum age for eligibility under the renal disease provision. For beneficiaries who are not otherwise entitled to Medicare, entitlement for the ESRD program ends 36 months after a successful transplant or 12 months following the last dialysis treatment (unless the beneficiary receives a transplant or begins a new course of dialysis during these periods).

About 93 percent of all ESRD patients meet requirements for Medicare entitlement. The remaining seven percent are covered through other sources, such as Medicaid, the Department of Veterans Affairs or private insurance.

ESRD BENEFICIARY PROFILE

Although the typical ESRD beneficiary is middle-aged, the largest and fastest growing age group of the ESRD population is persons age 65 and older, and census projections show that the "graying" of the ESRD population will likely continue into the foreseeable future. Slightly more men than women are diagnosed with ESRD: In 1991, 54 percent of new ESRD cases were men and 46 percent were women.

The ESRD population displays a great deal of diversity and important age-race-disease interactions. For example, although most patients are white, black persons and Native Americans are over-represented in the ESRD population as compared to the overall US population. Black persons have more than three and a half times the risk of renal failure than white persons; they are also more likely than white persons to experience renal failure as a result of hypertension or non-insulin dependent diabetes. Native Americans, Asian Americans and some Hispanic Americans also have markedly higher risks of renal failure than white Americans.

The number of beneficiaries with ESRD has grown rapidly since the beginning of the program. Original estimates were that 10,000 persons would begin treatment each year out of a potential pool of 20,000. Yet, in 1993, approximately 60,000 persons began treatment, which reflects an increase averaging nearly 10 percent a year since 1978. From 1978 to 1991, the total number of persons enrolled in the program grew more than 400 percent, from nearly 45,000 to approximately 183,000. This unanticipated growth has primarily been caused by a change in medical practice that resulted in extending dialysis to persons whose primary disease is not renal, but who experience renal failure as a result of other diseases (primarily diabetes and heart disease). For example, before enactment of the ESRD program, diabetes was a medical contraindication to dialysis treatment; now, however, diabetes is the most common co-morbidity within the ESRD population. Other factors that contribute to the growth in the ESRD population include the general aging of the population, longer life expectancy, and improved survival rates among the sick.

CHART A shows new ESRD enrollees over time and the cause of their renal failure. Overall, the three most common causes of ESRD are diabetes, hypertension and a type of kidney disease called glomerulonephritis.

From 1978 to 1992, the proportion of ESRD beneficiaries with a functioning transplant doubled from 11 percent to 22 percent. Recent improvements in technology and immunosuppressive drugs, which are used to prevent organ rejection, have increased the survival of transplant patients. In general, transplants

are desirable because beneficiaries have a better quality of life and because associated expenditures for health maintenance are much lower than those for dialysis. Unfortunately, kidneys available for transplant are in short supply. In 1993, more than 23,000 persons were on the transplant waiting list; of this number, fewer than half (10,000) received kidney transplants.

Due to additional health complications in the aged, elderly patients tend not to be good candidates for transplantation. As a result, transplants are generally performed in the younger population. In 1987, 45 percent of the ESRD population under age 35 had a functioning graft, compared to 25 percent of those aged 35 to 64, and only two percent of persons over age 65.

EXPENDITURES AND PAYMENT METHODS

In 1991, total expenditures in the ESRD program were just over $6 billion. This total includes all Medicare payments for inpatient hospital care, outpatient services (mostly dialysis), physician services, skilled nursing care, and home health care. Program outlays have been increasing annually at an average of more than 14 percent. This is primarily attributable to increases in the ESRD population.

Although ESRD is expensive to treat, HCFA has successfully contained per capita costs. In the mid-1970s, the average cost per ESRD beneficiary was 30 times as much as the average for all Medicare beneficiaries; by 1991, the difference in average per capita costs had shrunk to nine times (CHART B).[2] Thus, while inflation has greatly increased the costs of the Medicare program generally, the combination of increased transplantation and cost controls on both dialysis and physician care have tempered per capita increases.

Chart C shows the breakdown of ESRD expenditures by category. Several payment methods are used in the ESRD program. Renal facilities are paid a prospective composite rate for outpatient and home dialysis treatments. The average payment per treatment is $126 for independent facilities and $130 for hospital-based facilities. Renal facilities that meet certain regulatory exception criteria (e.g., atypical patient population, isolated essential facility) can receive a higher composite rate. Because these treatments are covered under Part B of Medicare, Medicare pays 80 percent of the composite rate and the beneficiary pays the remaining 20 percent, either out-of-pocket or through a supplemental insurance policy.

Except for two statutory changes that resulted in a net decrease of $1 per treatment, payment rates have remained constant since August 1983. The number of independent renal facilities, however, has continued to increase to meet patient demands: from 1983 to 1994, the number of these facilities has nearly tripled (from 627 to 1,795). Moreover, independent facilities, which account for 71 percent of all renal facilities, continue to have positive margins, on average, on their Medicare business.

Patients who dialyze at home are able to select from two payment methods: Method I, in which supplies are obtained from a provider, and the provider bills Medicare as if the dialysis were received in a facility; or Method II, in which the beneficiary purchases the supplies directly from a supplier and is reimbursed the provider rate from HCFA. In 1991, approximately 25,000 beneficiaries dialyzed at home; about 16,000 selected Method I and 9,000 chose Method II. Expenditures for outpatient services, which are primarily dialysis related, totaled more than $2 billion and accounted for 33 percent of the total ESRD program costs in 1991.

As a result of a regulation in 1994, physicians providing dialysis-related services are now paid under Medicare's physician fee schedule. The capitated monthly payment is now approximately $190. Total expenditures for physicians and

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[2]In 1974, the average annual per capita expenditures for a Medicare beneficiary and an ESRD beneficiary were $530 and $16,200, respectively; by 1991, they were $3,250 and $32,700.

suppliers in 1991 were $1.3 billion, or 21 percent of total ESRD costs. In addition to office visits, surgeon fees and other physician-related services, supplies for home dialysis patients who elect Method II for payment are included in this amount.

As with the rest of the Medicare program, payments for hospital care are based on the hospital prospective payment system and are predetermined, depending on the diagnosis and/or procedure associated with the hospital stay. At 44 percent of total ESRD costs, inpatient expenditures totaled almost $2.7 billion in 1991.

Approximately 90 percent of ESRD dialysis beneficiaries use a drug called erythropoietin (EPO) to combat anemia. Payment for EPO is made on a per unit basis, set by law at $10 per 1,000 cc's. The average dose is now just more than 4,700 cc's. In 1994, Medicare expenditures for EPO were $736 million, which translates into an annual amount of $5,600 per patient (based on average use).

Medicare Secondary Payer (MSP)

Under OBRA 93, Medicare is the secondary payer to specified group health plans for the first 18 months in which a beneficiary is entitled to Medicare on the basis of ESRD. This provision is scheduled to expire at the end of FY 1998. The President's budget proposed making it permanent; as you know, this provision was recently marked-up and reported out by this Committee. This estimated savings from this proposal are $50 million in FY 1999 and $70 million in FY 2000.

ESRD NETWORKS

HCFA contracts with 18 private ESRD Network Organizations that cover the US, the District of Columbia, Puerto Rico, the Virgin Islands and the Pacific Trust Territory, Guam and American Samoa. The Networks are organized groups of Medicare-approved ESRD providers in a designated area that collectively furnish the necessary care for ESRD patients in the area. Networks were established to ensure that Medicare beneficiaries receive high quality ESRD-related care. They monitor the quality of care provided to Medicare patients by reviewing items and services furnished in dialysis and transplant facilities. In particular, the Networks are responsible for:

- encouraging the use of treatment settings that are most compatible with the successful rehabilitation of the patient;
- encouraging patients, providers of services, and ESRD facilities to participate in vocational rehabilitation programs;
- developing Network goals for the placement of patients in self-care settings and undergoing or preparing for transplantation;
- developing criteria and standards related to the quality and appropriateness of patient care;
- evaluating the procedures used by Network facilities and providers to assess the appropriateness of patients for the proposed treatment modalities;
- implementing procedures evaluating and resolving patient grievances;
- using standards of care established by the Network to conduct on-site reviews of facilities and providers as necessary;
- collecting, validating and analyzing data for the preparation of reports on the ESRD program;

- providing data on the ESRD population to the US Renal Data System for analysis by Department of Health and Human Services; and

- identifying facilities that do not meet Network goals, assisting those facilities in developing corrective plans, and reporting to the Secretary those who are not providing appropriate medical care.

HCFA and the Networks have worked well together in a public-private partnership and we feel that the Networks are fulfilling their statutory mission.

QUALITY IN THE ESRD PROGRAM

Survey and certification of facilities

A facility becomes "certified" (and therefore eligible for payment) in the ESRD program through an initial survey to determine if the facility meets health and safety standards. Periodic follow-up surveys are conducted to monitor compliance with regulations. If a complaint about poor health and safety practices is received about an ESRD facility, a focused complaint survey is conducted. The surveys are conducted by State health departments, under contract to HCFA.

Conditions for Coverage

Providers and facilities must meet the requirements for institutional dialysis services and supplies established by the Secretary of Health and Human Services in order to be covered by Medicare. These participation requirements are called "Conditions for Coverage." The current regulations are primarily process-oriented and do not adequately support the outcome-oriented approaches to quality management that HCFA is initiating. Last year, HCFA determined that a thorough revision of these conditions was necessary.

In March 1994, we met with representatives from the ESRD industry to begin discussing these changes. We envision that the new standards will reflect current standards of practice and support a comprehensive outcomes-oriented approach to quality management. It will emphasize the total patient experience and actual organizational performance. Specifically, the proposed revised regulations will include standards for evaluating the adequacy of dialysis. Last November, a first draft of the proposed revised regulations was informally distributed to industry representatives for comment; we hope to have the Notice of Proposed Rulemaking published for public comment by the end of the year.

ESRD Health Care Quality Improvement Program (HCQIP)

HCFA is focusing on outcomes-oriented research to respond to the need to improve the care of Medicare ESRD patients. This approach has been named the ESRD Health Care Quality Improvement Program (HCQIP). HCQIP is based on the principle that HCFA can help improve the quality and cost-effectiveness of care by helping the facility bring typical care in line with best practices. The project's goal is to improve care provided to ESRD patients by establishing benchmarks for care and documenting improvements.

As part of the program, we have identified four core indicators for dialysis care that will be tracked over time. The indicators chosen for the project were adequacy of dialysis, anemia, blood pressure control, and nutritional status. The adequacy of dialysis measures are based on the Renal Physicians Association's guidelines and on the findings of an NIH consensus conference. The first measurements of these indicators was completed in October 1994 and focused on outpatient hemodialysis care. Measurements will be repeated in 1995 and 1996 and expanded to include peritoneal dialysis.

A second part of the HCQIP concentrates on improving the management of anemia for in-center hemodialysis patients by educating facilities about clinical data analysis and by providing information on trends of national, regional and facility-specific hematocrit levels and EPO usage.

We are very excited about our HCQIP and believe it has the potential to continue to improve the care provided to ESRD beneficiaries. As in other parts of the Medicare program, the HCQIP is a cooperative effort between renal providers and HCFA. We appreciate the support that the renal community has provided in this effort and look forward to their continued active participation.

ESRD AND MANAGED CARE

Attention has focused lately on the potential for managed care to provide savings in the Medicare program. However, as we look to expand managed care options for Medicare beneficiaries, we are clearly faced with challenges in figuring out how to care effectively for Medicare beneficiaries in systems that were originally designed to care for relatively healthy people.

In the current Medicare program, beneficiaries who already have ESRD may not enroll in Medicare managed care plans. This legislative exclusion resulted from apprehension about the ability of managed care plans to effectively treat ESRD patients and from concerns about financing and liability. However, Medicare beneficiaries who are already enrolled in managed care plans may not be involuntarily removed from the plan if they develop ESRD. As a result, approximately 6,300 ESRD beneficiaries are currently enrolled in managed care plans.

Quality

Generally, managed care plans that have ESRD beneficiaries have found it easier to contract out for dialysis and other services rather than incorporate these services into their existing health systems. Consequently, the managed care industry has only limited experience in caring for this special population. Moreover, although managed care programs and their participating facilities must meet quality certification requirements that are similar to those in the fee-for-service market, the unique needs of ESRD beneficiaries raise concerns about access issues in a restricted provider network.

In March 1995 the Inspector General of the Department of Health and Human Services found that beneficiaries with disabilities or ESRD who disenrolled from managed care reported more access problems in several crucial areas of their care than did aged beneficiaries who disenrolled. This group also was the most likely to believe that cost-containment was more important to the providers than providing the best medical care possible and most likely to seek out-of-plan care while still enrolled in the HMO. In addition, and perhaps more telling, 66 percent of beneficiaries who are disabled or have ESRD and are enrolled in managed care report wanting to leave their HMOs. We find these concerns distressing and plan further examination of the situation.

Payment

We also need to address the adequacy of our payments to managed care plans. In health care discussions, there is a tendency to equate high cost with uninsurability. However, while dialysis costs are high, they are actually fairly predictable. The real issue here is the calculation of an actuarily fair payment rate

The adjusted average per capita cost (AAPCC), which is used to determine the payment amount to managed care plans that contract with Medicare, does not currently account for the difference in expenses associated with the different treatment options. Maintenance costs for dialysis patients are about $44,000 per year, compared to $7,400 per year for beneficiaries with a functioning transplant.

Thus, the average of the two results in a rate that underpays plans for dialysis patients and overpays them for transplant patients.

Upcoming demonstration

We are hopeful that an upcoming demonstration will lead relatively quickly to improvements in the payment methodology. In an effort to further explore issues related to ESRD and managed care, we commissioned the RAND Corporation to study concerns relating to the incorporation of ESRD patients in a managed care program. The study dealt with payment amounts, reinsurance provisions, barriers and incentives. We have used this information to design a demonstration that will test a new payment methodology for capitated systems. We expect to solicit proposals for sites within the next four months and estimate that service delivery could begin in the second half of 1996.

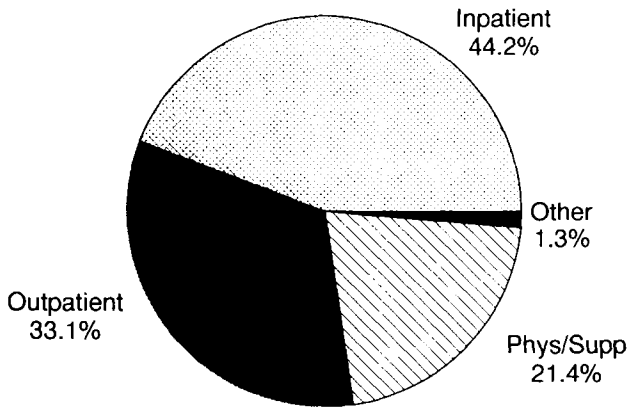
CONCLUSION

Medicare's ESRD program provides life-saving coverage to many who would otherwise be unable to afford necessary treatment. With more than 90 percent of persons with ESRD on Medicare, Medicare is by far the largest payer of ESRD-related services and supplies. We have a strong interest in the quality of care provided to our beneficiaries and close working relationships with our partners in the provider and advocacy communities. HCFA will continue to seek ways to increase the efficiency of the program without compromising patient care or access.

I hope this has been informative. I am happy to answer any questions you might have about the ESRD program.

Medicare Program Expenditures

for ESRD, by Type of Service: 1991



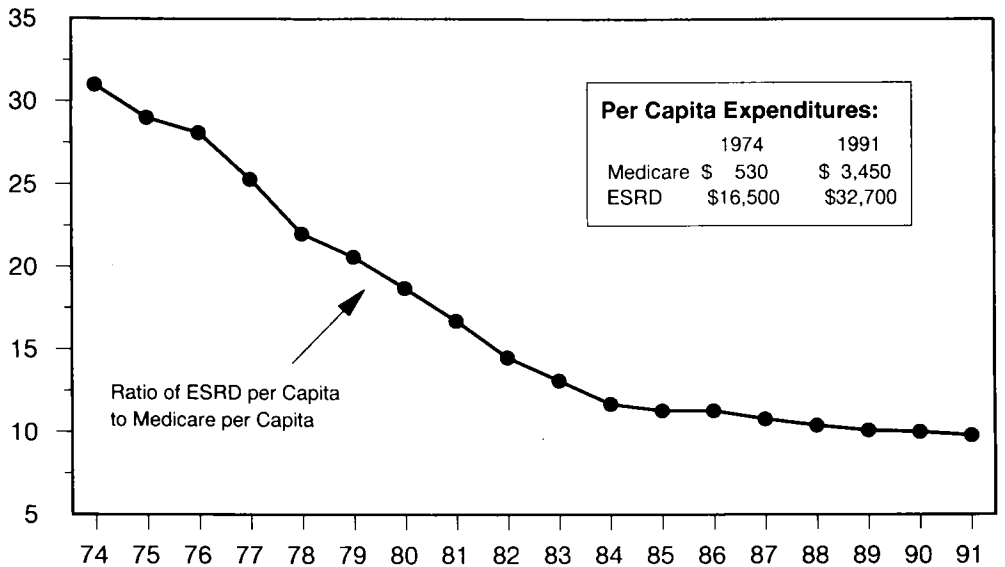
1991 - $6.1 Billion

Inpatient = Hospitalizations	Outpatient = Dialysis
Phys/Supp = Physician Services and Home Dialysis Supplies	Other = Home Health/ Skilled Nursing

P78 AS330A

Source: HCFA, ESRD, PMMIS

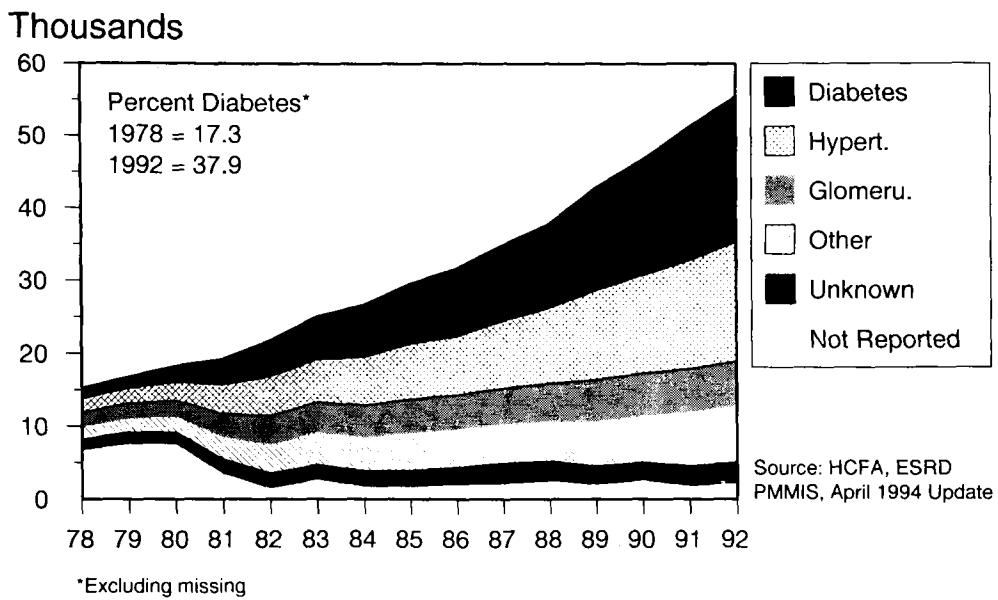
Medicare Expenditures per Person (74-91)
Ratio of ESRD to Total Medicare



Source: HCFA, BDMS, PMMIS, April 1992 Update

P78 AS330C

New Medicare ESRD Enrollees by Cause of Renal Failure: 1978 to 1992



P78 AS330B

Chairman THOMAS. Thank you very much, Dr. Smits.

Before I recognize my colleague from Nebraska, since we had several charts up there and you made some statements, some folks may want an answer to some of the statements that were made.

For example, in terms of the distribution of the types of patients on ESRD, you indicated, I believe, that there was some surprise that the diabetes and hypertension group was larger than anticipated. Why?

Dr. SMITS. We got better at dialyzing them. Again, you have to remember, when I was in training, there were a few dialysis slots available. We tended to give them to the youngest and healthiest. There actually—we had successful transplantation at about the same time, so in some cases you were dialyzing only those people you had hope of taking to transplantation.

Once you began to get broader experience, in the first years of the program, those people came on, people with end-stage renal disease and no other medical problems, but we then began to recognize that patients with controlled diabetes, for example, shouldn't be denied dialysis simply because, in the past, we hadn't had enough to go around and we had kept them out.

Young diabetics, especially, have done quite well on dialysis and to a certain extent with transplant, which is something we didn't anticipate. The severe hypertensives often do very well on dialysis, so frankly, we are much, much better at providing the service than we were in 1973.

Chairman THOMAS. You indicated on a line chart that initially the program was about 30 times more expensive. Now it is down to 10 times. Is that through significant changes in this program, more high technology being applied to a broader Medicare universe, or a combination of both?

Dr. SMITS. Actually, you see the same thing if you look at per capita costs and correct it for inflation. Part of it is efficiencies from doing it on a large scale, better understanding of how to do it well. The large facilities now have great economies in the purchase of equipment, building facilities, in the way they purchase and handle the supplies that go into it, better handling of staff, some shortening of dialysis time over the ones I knew in the very early seventies. Although it has stayed pretty stable for well over 10 years, a whole series of factors contribute to simply doing it better because it is being done on a planned, large scale.

Chairman THOMAS. So efficiencies—economy of scale as well?

Dr. SMITS. Yes.

Chairman THOMAS. On the pie chart, which was a 1991 representation of inpatient versus outpatient, 44 percent inpatient, 33 percent outpatient, with a 21 physician support, 21 percent physician support piece of pie. Ten or twelve years ago, what would that pie chart have looked like, inpatient versus outpatient?

Dr. SMITS. I am sorry, Mr. Chairman. Ten or twelve years ago I was running a hospital in Nancy Johnson's district and I don't know. I would be glad to submit it for the record.

Chairman THOMAS. I understand, the huskies had never been heard of. I was just going to try to get people who might be looking at that to get a feel for the changes between inpatient versus outpatient, but if we don't have it, that is fine.

Dr. SMITS. I think, yes, you will definitely see a ratio change with the outpatient becoming smaller and the inpatient larger, but we would be very glad to submit that for the record.

[The following was subsequently received:]

The distribution of Medicare payments from the past twenty years is shpwn below:

	1974	1984	1991
Reimbursements in Millions	$264	$2,341	$6,070
Percent Distribution:			
Total	100%	100%	100%
Inpatient	38.0	43.3	44.2
Outpatient	51.4	38.6	33.1
Physician/Supplier	10.5	17.7	21.4
Other	0.2	0.5	1.3

The shift in payments has occurred for a number of reasons. The major shift is due to the fixed payment rates for dialysis, which accounts for almost all of the outpatient category. The second factor has been the gradual shift of the patient population off of dialysis and on to a functioning kidney graft status.

In 1978, 11 percent of the ESRD population had a functioning kidney transplant. By 1991 this had increased to 22 percent. This shift of patients not only decreases the share of ESRD Medicare program going to dialysis, it also helps to restrain the overall increase in ESRD per capita costs.

Chairman THOMAS. I just wanted to try to indicate that I believe that was the case, and therefore, that portion of the expense has grown significantly. That was my guess, but if we don't have it, that is OK. I was just trying to bring some context to the charts that you had presented.

Thank you very much.

The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Ms. Smits, what percentage of ESRD beneficiaries are already eligible for Medicare because they are disabled or aged?

Dr. SMITS. Over one-half are already aged and the other one-half become eligible through the process of ESRD. I would estimate that the number who qualify for disability first and then for ESRD is quite small.

Mr. CHRISTENSEN. Would it be possible to get an accurate number on that?

Dr. SMITS. Oh, yes.

[The following was subsequently received:]

In the four year period 1990 through 1993, there were 206,000 persons who experienced renal failure and entered Medicare's ESRD program. The distribution of these patients by initial entitlement status is shown below:

- Old Age: 38.1 %
- Disability: 20.2 %
- Renal Only: 41.7 %

Mr. CHRISTENSEN. The second question I have is: Would a more preventive approach to care in the Medicare Fee-for-Service Program help reduce the numbers of people who develop ESRD, more of a preventative approach to this problem?

Dr. SMITS. That is a very interesting medical question. My sense is that the prevention ought to be as early as possible and that with respect both to diabetes and hypertension, the period of really effective prevention may have been before they aged into Medicare. These are long-term chronic effects on the kidneys. So, again, I would have to bow to the very sophisticated renal physicians who are following me.

But, yes, everyone believes you could have less ESRD with better prevention, but whether you could do it starting at 65 is an interesting question.

Mr. CHRISTENSEN. I have an additional question. I was talking with a constituent this week in Omaha about the drug EPO, Epogen. Are you familiar with whether HCFA bundles the payments to local providers on this drug?

Dr. SMITS. Yes. We don't bundle. We pay—we make a payment for the drug, yes.

Mr. CHRISTENSEN. In the past, I am told that out of nearly two-thirds of all developed countries in the world, we reimburse at a significantly lower rate for Epogen than most of all western developed countries; is that correct?

Dr. SMITS. I don't know the international comparisons. We are buying it in very large—in much larger volumes than anyone else, so the ordinary pressures of the market would suggest we probably ought to be paying less for it, but, I again, would be glad to get you the international figures for the record.

[The following was subsequently received:]

Current information on international prices is hard to find. Anecdotal reports show that the United States pays less than Western Europe. A JAMA article published on July 10, 1991 by Sisk, et al included a table of EPO prices from 18 countries as of December 1989 which use currency rates from June 1990.

At that time, the United States was listed as paying $41 per 4,000 unit vial. Other countries ranged from a high of $130 in Greece to a low of $36.13 in Finland. According to these listings, the United States is in the lower third of these countries.

In early 1992, an informal study of dialysis facility nurse administrators in the United States suggests that EPO prices has dropped. The list price was $10 per 1,000 units but many units got "volume" discounts that dropped the price to $9.25 to $9.50 per 1,000 units or $37 to 38 per 4,000 unit vial. We have heard rumors that the price has dropped further since 1992.

Mr. CHRISTENSEN. Is there any evidence to show whether bundling, instead of paying as you go on Epogen, would cost the taxpayer more money rather than the other alternative method? Is there any evidence to show that we could do it at a cheaper rate, providing better health care coverage, providing better treatment of illnesses?

Dr. SMITS. That is a very difficult question. Epogen, as I am sure you know, is a biologic that is currently—it is not technically patented but it is currently under exclusive licensing. That exclusivity will expire next year. I think when you have essentially one very large buyer and one seller, you have a very odd market. I certainly think it is appropriate, as other manufacturers come into the business, to look into different ways of paying for Epogen.

Mr. CHRISTENSEN. OK, thank you, Doctor.

Chairman THOMAS. The gentleman from California will inquire.

Mr. STARK. Just to follow up, we pay about $10 for a thousand cc's for EPO now, is that about right?

Dr. SMITS. I have all these figures.

Mr. STARK. Somebody behind you is nodding on your staff. And if they use 4,700 cc's 3 times a week, it is good money. When we figure it probably costs 50 cents to manufacture 1,000 cc's, so that your idea of some other manufacturers coming in could lower our costs even more, could they not? It would be a great savings, I think.

Would you say that much of the inflation in the ESRD Program has come from items that we don't cover in the composite rate?

Dr. SMITS. Well, as you can see, it is not inflating as fast as the rest of Medicare. The items that we don't cover in the composite rate, the big one is hospitalization, where we do control the rates paid for the hospitalization. It is hard to talk about this as a program suffering badly from inflation. Whether you could contain the costs still further if you had a composite rate for everything, including hospitalization, is certainly an important question.

Mr. STARK. We are going to hear testimony from somebody, I suppose that has an interest in an HMO, that the ESRD Program

is probably the most extreme example of immense human and economic waste caused by Medicare fee-for-service. I think they are suggesting that we should put everybody in an HMO.

But if you have looked at the charts in the testimony on HMO versus non-HMO patients, it occurs to me that they are not really comparable. My guess would be that there is a difference in the composite of the HMO patients from others. Can you enlighten me there as to whether I am——

Dr. SMITS. I have looked at the charts but I haven't seen the tables behind them. It doesn't seem very likely that the small number of patients in HMOs are particularly similar to the average in Medicare as a whole.

Mr. STARK. Younger?

Dr. SMITS. Probably younger, yes. Probably healthier, and this is, I think—some of your questions about prevention are ones we ought to be asking the HMO industry because this is a setting where, over time, the care should, in fact, reduce the total rate of the onset, at least in certain categories.

Mr. STARK. What kind of penalties—you mentioned this 1.2 on a Kt/V and I don't know what that is except I guess you divide V into Kt, and if you get more than—if you get less than 1.2, we are not doing it right.

How do you punish or how do you encourage or what do you do to get these dialysis centers to hit the goal?

Dr. SMITS. Well, Kt/V is really a mechanical function, it is a measure of how effectively the clearance took place. The standard used to be 1. The profession itself upped that standard very recently to 1.2. When the standard was 1, more than 70 percent of all patients were meeting it. As soon as the standard became 1.2, that same measurement showed that only 40 percent of the patients were meeting it.

I think the challenge here is first to look very carefully at what that really means. I respect the professional standard. It is a useful one, but we need to look at what kind of benefits, does this really make a dramatic difference in quality of life or survival, which would mean we ought to——

Mr. STARK. Do you think there could be a minimum standard, that we ought to say, hey, if you don't hit this standard, you are out of the game or we don't pay you?

Dr. SMITS. I think there could be a minimum standard. I wouldn't want to have it the benchmark standard that everybody is working toward, but I certainly think there should be a minimum standard.

Mr. STARK. There isn't one now?

Dr. SMITS. No, we don't have one now, but we are looking very carefully at focusing the regulations much more on outcomes and that is one of the areas we——

Mr. STARK. Some kind of interim punishment or penalty or—if they don't hit it, I would gather.

The renal administrators and physicians want a repeal on the ban for referral to hospital facilities, and it is my understanding that physicians get about $15 a treatment in a dialysis center and closer to $180 per visit when they visit a patient in the hospital; is that correct?

Dr. SMITS. I believe so.

Mr. STARK. Which would give some incentive, would it not, or would it not appear to treat somebody in the hospital setting rather than the dialysis setting?

Dr. SMITS. Yes. In fairness, some hospital dialyses are much more complicated. Some are done when the patient is often sick with other problems and the rate would also apply to a patient who is newly in renal failure who is often quite difficult to dialyze at the beginning.

Mr. STARK. But it would also apply to routine dialysis in the hospital?

Dr. SMITS. Yes.

Mr. STARK. Thank you.

Chairman THOMAS. Before I ask the gentleman from New York to inquire, why is there such a significant discrepancy on reimbursement between inpatient and outpatient, $15 to $180?

Dr. SMITS. The physician on the outpatient side is——

Chairman THOMAS. If they were driven by money, you wouldn't have a more significant inpatient versus outpatient ratio here.

Dr. SMITS. You mean that if the doctors were all trying to get the patients into the hospital in order to get the higher fee?

Chairman THOMAS. Yes.

Dr. SMITS. I think the incentives are much more complicated than that. They are paid on a flat rate in the facility per month. They don't have to see the patient every dialysis. Many of them see the patients once or twice a month, sometimes in big facilities.

The group as a group will round on every patient every time. It really varies considerably. I think the settings where the doctor really does try to overcome Medicare's pressures not to admit and pick the patient out of the dialysis facility and put them in the hospital in order to get the extra money is unlikely.

Chairman THOMAS. Thank you.

The gentleman from New York, Mr. Houghton, will inquire.

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

Dr. Smits, I have a specific question and then a more general one. The specific question is, How about the administration's support increasing the number of months during which Medicare would be secondary to ESRD beneficiaries' employer-based coverage?

What do you feel about that?

Dr. SMITS. I think that——

Mr. HOUGHTON. It would save quite a bit of money.

Dr. SMITS. Yes, it certainly would. I think there is some anxiety that in the absence of comprehensive health reform, you might see perverse effects, particularly the elimination of dialysis as a benefit from private plans.

Mr. HOUGHTON. Yes, but is the administration thinking about this?

Dr. SMITS. We have considered it in great depth and the President made the recommendation that he has made and that you have supported, which is to preserve the current timeframe.

Mr. HOUGHTON. The more general question I guess keys from the issue that Mr. Stark brought up about prevention, and you have talked about in some of your comments.

Now, we all talk about wellness programs, but when you take a look at something like dialysis and the cost, it is something like 5 percent of all Medicare costs. I mean, it is just extraordinary. Do you have anything that you can do in terms of not just the dietary issue, but other things which can eliminate some of these huge costs later on?

Maybe you have some charts and maybe you have some ideas on this thing, but when we are talking about saving money and helping people have a longer life, it doesn't seem to me there is almost any area which sponges up funds and real tragedy more than this one.

Dr. SMITS. Again, that is a very interesting question. I am not entirely sure, if you looked at it carefully, that you would save money. You can prevent renal failure, or at least delay it significantly in diabetics, if they are under very tight control. That is expensive. That means—there have been some recent trials looking at very frequent doctor or nurse visits, very frequent blood testing, very tight monitoring to hold blood sugars to something similar to the blood sugars that the rest of us manage normally.

That costs over years in order to prevent the end-stage renal disease. It is better. It is better for the patient, but whether it is less expensive than dialysis I think is an interesting question. Similarly with hypertension.

Mr. HOUGHTON. But have there been any tests on this? There must have been some examples where people have tried this type of process to try to find a way of cutting costs.

Dr. SMITS. You have to go disease by disease. Some of the recent work in diabetes certainly suggests it is manageable there. We do know that if hypertension is detected early and controlled rigorously, it is also manageable there. Again, although I would be glad to submit comments for the record, I think probably the best people to discuss this with are the renal physicians who follow me.

[The following was subsequently received:]

To the best of our knowledge, there have been only a few clinical trials to test mechanisms to slow or retard the progression of chronic renal disease into end stage renal disease. Nothing has been shown to work.

The largest study was the Modification of Diet in Renal Disease (MDRD). It failed to show that progression could be altered by diet. More recently there was a trial on the control of diabetes. The basic aim was to prevent blindness in diabetic patients, but it did give some weak evidence of beneficial renal effects as well. However, at this time there is no evidence that renal failure can either be prevented or even slowed. Needless to say, if no one knows how to prevent ESRD, it is difficult tc project what types of prevention efforts would be be cost effective.

Mr. HOUGHTON. Thank you very much.

Chairman THOMAS. The gentleman from Georgia, Mr. Collins, who is not a Member of the Subcommittee, but I believe has an interest in this area, might like to inquire.

Mr. COLLINS. Thank you, Mr. Chairman, yes, and I do appreciate your allowing me to participate in this hearing this morning. I wanted to respond to a constituent who had a daughter who was being treated by a center in Georgia and she died in January 1993, and I would like to submit for the record, Mr. Chairman, a statement by me and also a statement from that particular person.

[The prepared statement follows. The letter from the constituent was not available at the time of printing.]

SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS
END-STAGE RENAL DISEASE PROGRAM
MAC COLLINS
APRIL 3, 1995

Mr. Chairman, I appreciate the opportunity to participate in this morning's hearing of the Subcommittee on Health to discuss issues surrounding the Medicare End-Stage Renal Disease Program.

I have many concerns about this program. Last year I introduced the Elizabeth A. Greeson Dialysis Coverage Act that provided additional protections for patients who receive treatment through dialysis clinics that receive funds from the Medicare program. Mrs. Greeson was an end-stage renal disease patient receiving treatment through a dialysis clinic in Atlanta. Tragically, Elizabeth Greeson lost her battle with the disease in January of 1993. She was a patient at a clinic that was cited for several health and procedural violations. Additionally, the Georgia Department of Human Resources recommended to the Health Care Financing Administration that the facility be terminated from the Medicare program within 90 days. To this date, the facility remains open, operating business as usual.

As legislators, I believe that it is our responsibility to review the standards of these programs to ensure that we are providing the necessary protections that will prevent needless losses such as these.

Currently, American taxpayers pay $8 billion per year through Medicare to ensure that care is provided for some 200,000 end-stage renal disease patients. These funds go to private dialysis treatment clinics, entrusted with the responsibility of providing good care and treatment.

My legislation requires that private medical facilities, offering medicare-financed end-stage renal dialysis kidney treatment, make necessary arrangements to ensure these services are available on a 24 hour basis.

Currently, federal regulations require renal dialysis centers and facilities have an affiliation agreement or arrangement in writing for the provision of inpatient care and other hospital services. My legislation would essentially codify this regulation by requiring renal dialysis centers, as a condition of receiving Medicare funds for these procedures, either provide dialysis treatment on a 24 hour, "on-call" basis, or make an arrangement with a local facility that has the capacity to provide these services during periods when the facility is not open. Additionally, patients that receive care at the private clinics should be notified of this arrangement so that they are fully aware that emergency services are available at an alternate local facility.

The primary purpose of this bill is to stress to privately-owned facilities that their responsibility includes the well-being of the patient, and not merely monetary profit. These facilities provide fundamental treatments for patients who cannot live without them. Consequently, these private facilities should be accountable for treatment when it is needed for the preservation of life -- 24 hours a day; not merely during business hours.

I believe it is necessary to codify this condition and clarify in law that private renal dialysis clinics, receiving tax payer funds, provide for this type of arrangement.

I appreciate the opportunity today to participate and hear testimony about the program and its effectiveness; as well an opportunity to pose questions to officials about the legislation I am working on again this Congress.

For Elizabeth Greeson who battled kidney disease, legislative improvements come too late. But by legislatively strengthening the program, we will improve how we provide end-stage renal disease treatment and enable other families to avoid tragic loss due to failures of the health care system.

Thank you Mr. Chairman.

Mac Collins

Mr. COLLINS. But my question is about reports by the Georgia Department of Human Resources who conduct investigations and certifications of dialysis facilities. Once those reports are made, and if the recommendation is made to HCFA for termination of such facility as far as delivery of service, what is the normal procedure after such a determination is made and recommendation is made by HCFA?

Dr. SMITS. We then proceed to—if we agree that the conditions in the facilities jeopardize the life and health of patients, we can and do terminate.

Mr. COLLINS. Well, I want to refer to this particular center, which seems to be twice in 1 year that the Department of Human Resources actually recommended termination, but, however, this facility is still in operation. Is that kind of normal procedure or is——

Dr. SMITS. How many times—first of all, I can't comment on that facility——

Mr. COLLINS. I am using that facility as an example. Would that be normal procedure, if you had two such recommendations in 1 year, they could still continue to provide the service?

Dr. SMITS. I don't think that is particularly common. We have terminated a number of facilities. How many times we have received recommendations and not acted on them, I don't know.

Is the facility in a remote area?

Mr. COLLINS. No. Atlanta.

Dr. SMITS. So it is not a question of access.

Mr. COLLINS. No. Do you have a record of termination? How many facilities—do you have off the top of your head how many facilities may have been terminated in, say, a 12-month period using calendar year 1993?

Dr. SMITS. They gave it to me in my book and I am afraid I can't remember it. Can I submit it for the record?

Mr. COLLINS. I would love to see those numbers.

[The following was subsequently received:]

In Calendar Year 1993, 28 facilities were terminated (1 involuntarily). In 1994, 32 facilities were terminated (5 involuntarily). In 1995, 2 facilities were terminated (none involuntarily).

In addition I would like to discuss the specific center you have referred to as an example. There were three complaints made to the Georgia Office of Licensure and Regulation against Peachtree Dialysis Center in Atlanta, Georgia in 1993. One complaint was made by the father of a young woman, who was a dialysis patient at the facility and had died. Also, in November 1993, two other patients at this ESRD facility filed complaints against the facility. One of these complainants made 16 allegations against the facility.

An on-site investigation was completed on November 30, 1993, by the Georgia Department of Human Resources, Office of Regulatory Services. The investigation revealed that one Condition for Coverage was not met and substantiated some, but not all, of the allegations. The facility developed acceptable plans of correction for all of the deficiencies and compliance was confirmed on a follow-up visit on January 26, 1994. Since the facility met all of the conditions of coverage and met additional criteria it was not terminated from the Medicare program.

In addition, the ESRD Network serving the area received a complaint about the ESRD facility from the father of the patient who died. The network reviewed the medical record of the patient in question and referred the case to the Georgia Professional Review Organization (PRO), which also conducted a review of the case. Neither the Network nor the PRO found that care was inappropriately rendered. They completed their investigation on June 9, 1994.

A review of this facility's compliance history reveals that a January 29, 1992 complaint investigation found that the facility was not in compliance with the Condition for Coverage relating to staffing requirements. The facility corrected this problem as well. Also, the facility was found out of compliance with the Patient's Rights Condition for Coverage on the August 1991 survey, but subsequently corrected its deficiency.

In conclusion, Peachtree Dialysis Facility has been found to be out of compliance with some basic conditions on at least three occasions since 1991. Patient complaints have been brought against the facility, and some of the complaints have been substantiated. However, in each case, the facility developed a Plan of Correction and corrected its deficiencies. Consequently, the facility remains Medicare certified.

At this time, there are no outstanding issues between the State Survey Agency or the ESRD Network and the Peachtree Dialysis Facility. However, I would be happy to discuss this case further if there are any additional questions you may have.

Mr. COLLLINS. Any restrictions in the Medicare rules or regulations pertaining to profit centers by physicians who may be treating a patient and have profits or investment within a center?

Dr. SMITS. The recent self-referral law, which would apply to some aspects of renal disease, and those regulations are not yet written, but in the past, no, there was no prohibition on a physician referring for dialysis to a center in which he or she also had a financial interest.

Mr. COLLINS. But you are in the process, if I understood right, of new regulations being written to address that situation?

Dr. SMITS. Yes.

Mr. COLLINS. OK, good.

The particular area where we have some legislation that we are introducing pertains to emergency care, such as weekend care for dialysis where a center would be required to have an affiliate agreement with a hospital or someone else to take care of a patient and to notify the patient that such agreement is in place.

Do you have any comment on such as that so that we can assure, even in a place like the city of Atlanta, that a patient who depends on a dialysis center would be covered on a weekend?

Dr. SMITS. I would certainly expect that the physician who is being paid a capitation rate for that patient should always either be available or have an arrangement, have a call arrangement, that it isn't just having a hospital available. It is having someone available who has access to your personal records and knows you. I have not heard of that previously as a problem. That is certainly something we will be glad to look at.

Mr. COLLINS. Could I request that you have a member of your staff contact my office where we can further discuss this particular case and this particular center and try to come to some kind of resolution on it?

Dr. SMITS. Yes, sir.

Mr. COLLINS. See if there have been any updates or changes made that will help the people in this area?

Dr. SMITS. Yes, we would be very happy to.

Mr. COLLINS. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. You mentioned earlier the method of payment between dialysis, transplant, postoperative, and followup may cause some problems for HMOs. You mentioned that we should examine the way we pay, but we really, I don't think, discussed in any meaningful way, the relative costs, for example, of a successful kidney transplant. We hope all the transplants will be successful.

I have a friend who died of kidney failure who had several kidney transplants. They were all temporarily successful, none of them permanently successful, so I am acquainted with the problems when the transplants are not successful.

I am interested in the cost of the transplant, postoperative costs, how long that might be, the long-term costs of maintaining someone who has had a successful kidney transplant versus a path of dialysis and continued dialysis for that same period.

Dr. SMITS. Successful transplantation is much more cost effective.

[The following was subsequently received:]

In fact, an analysis can be found in the May 1992 publication of Seminars in Nephrology (Volume 12, No. 3). The article is "Comparison of Treatment Costs Between Dialysis and Transplantation" by Paul Eggers who works for the Office of Research and Development at the Health Care Financing Administration. I would be happy to send a copy of this article to this Committee. To summarize briefly, the article shows that the high initial costs of transplantation are recovered in avoided dialysis costs in about 4.5 years. The net savings per transplant over a ten-year timeframe was estimated to be about $41,000. This "payback" period is shorter for living related donor (LRD) transplants than for cadaver transplants due to the higher rates of graft survival among LRD transplants. Similarly, aggregate ten-year savings are greater for LRD transplants than for cadaver transplants.

The analysis was conducted based on 1989 reimbursement patterns.

At that time EPO was just beginning to be used to treat anemia in dialysis patients. Since 1989, dialysis patient care has become more expensive because of EPO (there is very little off-setting savings). In addition, transplant success rates continue to improve. Consequently, a recent analysis of pediatric transplant recipients (not yet published) suggests that the payback period is now closer to three years and the ten-year cumulative savings is closer to $100,00 per transplant. Although not yet analyzed separately, the payback period is likely to be somewhat longer for adult transplant recipients and the cumulative savings somewhat less.

Dr. SMITS. The limiting factor there to a great extent is the availability of kidneys. The technology—or success rate in this country with transplantation is really very good. But kidneys become available in the situation of tragedy, and we certainly don't want to be in the position of encouraging more automobile accidents in order to have more kidneys.

Chairman THOMAS. I think you would get agreement from the Subcommittee on that. Is it a problem of matching up as much as it used to be, or are we able to maintain a functioning kidney now easier than we used to?

Dr. SMITS. We are much better at the match. We understand the immunology a great deal better than we did 15, 10, or 5 years ago.

Chairman THOMAS. Do we provide a successful rate roughly in terms of all transplants?

Dr. SMITS. The current success rate?

Chairman THOMAS. Yes, ballpark. Is it 60, 80?

Dr. SMITS. It is over 90, isn't it?

Chairman THOMAS. Over 90 percent?

Dr. SMITS. I am told 80 percent for cadaver—over 80 percent for cadaver, over 90 percent for living related donors.

Chairman THOMAS. So it is the condition of the donor as well.

Mr. CRANE. Mr. Chairman, would you yield?

Chairman THOMAS. Certainly.

Mr. CRANE. After a transplant, what is the annual cost, roughly, of the immunosuppressive drugs?

Dr. SMITS. I am sorry. I don't remember that specific figure individually. I will be glad to give you that for the record. It is probably one of the highest elements of cost posttransplant.

[The following was subsequently received:]

The Batelle Corporation conducted a study for HCFA on immunosuppressive protocols for kidney transplantation in 1989. The results of that study showed that yearly immunosuppressive costs, after the initial period following a transplant, were between $3,200 and $4,000 per patient. Although we have not had an update to this study, we assume that annual costs are about $4,500 per patient.

In 1994, Medicare spent $55 million on immunosuppressive therapy. The Omnibus Reconciliation Acts of 1993 extended the coverage period for immunosuppressive therapy from 12 months to 18 months. Although costs will increase significantly for immunosuppressive therapy but still be less than dialysis. We estimate that we will spend $80 million for immunosuppressives in 1995.

Secondly, as I mentioned earlier, the use of immunosuppressives after transplantation is certainly more cost-effective than dialysis in the long-term treatment of the ESRD patient. In fact, the May 1992 edition of Seminars in Nephrology, Volume 12, Number 3 contained an analysis entitled "Comparison of Treatment Costs Between Dialysis and Transplantation." This analysis has definitely proven the cost effectiveness of immunosuppressive therapy.

In short, our estimates show that in 1995 Medicare will spend approximately a total of $42,000 per patient annually on dialysis, while after transplantation, Medicare will spend $4,500 per patient annually for immunosuppressive therapy. Clearly immunosuppressive therapy is cost effective in the treatment of ESRD.

Mr. CRANE. Thank you.

Chairman THOMAS. Obviously, quality of life would be significantly improved as well. We have been looking not only at dollars and cents, but obviously, the ultimate goal is to provide——

Dr. SMITS. The fact is that one-half of the people after transplant leave the program because they are able to go back to work.

Chairman THOMAS. Very good.

Dr. SMITS. Let me just mention again that because we have this demonstration coming, the RAND Corp. has worked out detailed rates for us for potential HMO payment. I think we should put those in the record so you can inspect them in detail.

[The following was subsequently received:]

The exact payment rates will be determined based (1) partially on analyses conducted by Brandeis University of ESRD expenditure data and (2) through negotiations with potential bidders on the demonstration. However, it is very likely that there will be two basic payment rates, one for dialysis patients and one for patients with a functioning kidney transplant.

In 1991, the yearly cost to Medicare for a dialysis patient was about $44,000; for a functioning graft patient, was $7,400. A monthly equivalent of these amounts would be a rough approximation of what would be paid. In addition, both of these amounts are likely to be adjusted for patient case-mix, such as age and the presence of diabetes. Finally, it is expected that a special one-time payment will be needed to pay for the cost of the transplant.

This question was asked of a different panel and th information given was incorrect. This is the correct answer:

o **When does Amgen's exclusivity to market erythropoeitin expire?**

A: Amgen's exclusivity to market EPO is protected by the Orphan Drug rules under the FDA. The Orphan Drug Act gives Amgen exclusive rights to market EPO for the treatment of anemia associated with ESRD for seven years. During this time, the FDA will not consider applications from other companies for the same basic product. The FDA granted this protection to Amgen specifically for this medical condition. This protection ends on December 31, 1996. Amgen also has Orphan Product protection for the marketing of EPO for the treatment of anemia associated with HIV. This was granted on December 31, 1990 and expires on December 31, 1997.

These protections under the Orphan Drug Act are distinct from the patent Amgen holds on the organism that produces EPO. The patent is distinct from FDA approval. It expires on October 27, 2004.

Chairman THOMAS. Very good. Thank you.

The gentleman from California.

Mr. STARK. Two issues that are just very difficult to deal with. At one point a year or two ago, I had suggested that we do something like a congressional commendation, a medal or something like that for people who would donate organs—wouldn't cost much and it would be a symbolic gesture to encourage it. We tended to run into lots of problems with postage stamps and other things we have.

Is there anything that might be considered, or perhaps the Secretary might have a secretarial commendation, on the theory that sometimes it is just an omission of someone who has died, and people are in shock and really need a little encouragement to perhaps make the donation? That is one thing I would like you to consider.

Second, the question that certainly none of us like to discuss and ought not to be the subject of legislation, but whether you have thought about it, there is some indication, and I think Dr. Rettig is going to testify later, that we are dialyzing folks who, for other reasons, are so ill that whether or not the dialysis is successful, they are going to die from something else.

We certainly don't want to be setting standards to say, no, let Uncle Joe die, but on the other hand, could we educate—is there something we could do to educate either the patients or those who would hold the proxy for the patient in cases of extreme illness where there are other complications that might serve the patients and their families better?

I don't know. It is an area which I have always hesitated to think about legislating, but encourage the people who disseminate information to allow families to make a better informed choice. I don't know whether you have a program like that or whether you are any more interested in doing it than I would be as a legislator.

Dr. SMITS. Let me answer both questions with personal experience. First, I have been there in the room asking families to donate organs. That is a very tough job, and any support there is, any publicity, any general knowledge that the families come to that meeting with is helpful to us.

We try continuously to remind people about the benefits, and it is possible that some kind of public acknowledgment, particularly to the families who agree to cadaver donation, would be very welcome. A living related donor is a much more personal decision and does not usually face the same problems.

In the question of who we dialyze in this country, I have worked in nursing homes and I have seen patients—I have cared for patients on dialysis where it made me very uncomfortable that dialysis had been started and that it was being continued. At the same time, I would not like to see the government try to make that decision or to hold facilities to some sort of standard.

The private sector has developed essentially advanced directives for dialysis, a way of looking at that decision. What happens sometimes is you begin dialyzing in the hope that the other elements of the illness will improve and they don't, and then it is very hard to stop. There is an advanced directive that helps the doctor and the families go through what is, by rights, their joint collective decision, and once that had been developed, we did distribute it to all dialysis facilities in the country and encouraged them to use it.

We would certainly be very pleased to work in any other collaborative way with providers if we can help with this but, again, there are times when families absolutely want dialysis, no matter what you and I believe about the quality of life.

Chairman THOMAS. I think if we will work toward simplification, computerization, and continued collection of data for outcomes, that we can begin to develop some profile analysis in which we can either encourage or discourage based upon very solid evidence which allows us to lead people to the proper decision with some data that might be helpful, even in a difficult family time.

Dr. SMITS. When you raise the question in most settings of shouldn't we stop for this patient, what you have is a whole lot of people who say, Oh, no, no, we can't, there is absolutely no way to; we have started, we must keep on. And I think simply distributing the advanced directive and helping people think through the process will at least send some message that it isn't necessarily terrible to stop if it is appropriate for that patient's circumstances.

Chairman THOMAS. Now I think it is appropriate to turn it over to the gentlewoman from Connecticut whose women yesterday were not very gentle but very, very good.

Mrs. JOHNSON. Top notch. Just to welcome you, Dr. Smits, and say that I regret that I wasn't able to hear all your testimony, but I do appreciate the good work you have done for us in Connecticut, and I particularly appreciate your opening your testimony by recognizing the accomplishments of our women's basketball team in their come-from-behind victory. It is really important for women's success to be recognized, and particularly when they demonstrate the discipline, courage, and concentration that coming from behind takes. Nice to have you.

[Discussion off the record.]

Chairman THOMAS. The next panel is Dr. Rettig, Dr. Powe, and Dr. Blagg, please. Thank you, doctors.

Any written testimony that you have will be made a part of the record and you can inform us, educate in any way you see fit, in the 5 minutes you have. We will start with Dr. Rettig and then move across the panel.

STATEMENT OF RICHARD A. RETTIG, PH.D., SENIOR SOCIAL SCIENTIST, RAND CORP.

Mr. RETTIG. Thank you, Mr. Chairman. My name is Richard Rettig. I am a senior social scientist at the RAND Corp. where I have been since February of this year. Previously, I worked there from 1975 to 1981. I was not part of the ZAND group that did the recent capitation study. From 1987 until early this year, I was at IOM, the Institute of Medicine of the National Academy of Sciences. In that capacity, I was study director for the study of the institute called forth in OBRA, the Omnibus Budget Reconciliation Act of 1987.

My remarks today do not necessarily represent the views of either the Institute of Medicine or the RAND Corp.

I have submitted a longer statement for the record, as well as a number of background materials, and two papers that deal with the legislative history of this program and how it came to pass in 1972, which may interest the Members.

OBRA 1987 asked the IOM to study the program. I served as director of that study. My remarks pertain mainly to that 1991 report, a copy of which you have, including a summary which is available for all Members, and to an initiative that the IOM took in 1993 and 1994 as a followup.

I should echo the comments of several Members that the program has been very successful in saving lives that would have ended abruptly or prematurely. It has also been successful in holding down the per treatment cost of dialysis. The aggregate cost is high because treatment is expensive and the patients are growing rapidly in number.

I have five points to make today, Mr. Chairman, and Members. First is epidemiology. You saw Dr. Smits's charts. The program has been growing very rapidly in the elderly patient population. Those 65 to 74 and 75 years of age and above constitute 44 percent of all new enrollees in 1992. Diabetes and hypertension provide a major source of new patients, and it may be that as we treat these dis-

eases better, we increase the pool of individuals who then experience kidney failure.

The population also includes a large portion of minority patients. Twenty-nine percent of all new patients in 1992 were African Americans: they have a failure rate four times that of the white population.

During the IOM study in 1991, we asked Dr. Eggers of the HCFA to project the ESRD patient population to the year 2000. He did so and made three estimates: a slow growth resulted in 210,000 patients, moderate growth reached 240,000 patients, and 270,000 patients was the rapid growth estimate.

It is clear from HCFA data that the actual numbers in the year 2000 will exceed the high, rapid growth estimate made in 1989. My point is that there is no escape from the epidemiology of this program as the fundamental driver of the costs. That ought to be very clear in everybody's minds as the Subcommittee searches for cost reductions. It is that underlying epidemiology that drives costs.

Reimbursement is my second point. This is important because total program costs are very high and the beneficiaries are few in number relative to the total Medicare population.

At the level of outpatient dialysis per treatment reimbursement, the ESRD Program has been a great success. Historically, the rate was unchanged for 10 years, was reduced in 1983, was modestly reduced again in 1986, and has had no adjustment for inflation during the entire 20-plus years of this program. Congress added $1 to the composite rate in 1990.

In our study, the IOM analyzed the real dollar decrease in per treatment payment from 1974 through 1989. The result of the analysis was that the 1989 payment rate was approximately 40 cents on the 1974 dollar. A recent update of that analysis showed that payment today is closer to 30 cents on the 1974 dollar.

Reimbursement and quality are my third point. The IOM found in its study that reductions in quality, as measured by the outcomes of hospitalization and mortality, could not be correlated with reimbursement reductions. Staffing changes could be, but these changes couldn't be correlated with outcomes. That is as much a problem of measurement as it is of the phenomenon which we have heard from the others.

In perspective, two trends are occurring. Epidemiology continues to add to the patient population; second, there is a continued reimbursement decline on the outpatient treatment side. These two trends can't go on forever. Either quality will decline or reimbursement must be increased. Fourth, what is needed is a system of quality assessment. The community has been concerned with mortality and adequacy. In addition, at a conference in 1993 and a workshop in 1994, the IOM strongly urged the adoption of functional status, health status, and health-related quality of life measures of quality.

Mr. RETTIG. There are good instruments to obtain such data. They can be derived from patients. They ought to be derived from patients. Only as we get such data, in my judgment, will we really begin to put in place a system in which the quality implications of cost reduction are firmly understood.

Fifth, let me end by saying the 1972 legislation called for a medical review board to screen "the appropriateness of patients for the proposed treatment procedures." The meaning of that term has not been defined. The IOM report had a chapter on ethics that specifically asked whether too many patients were accepted for treatment.

The existence of an entitlement has often been interpreted by clinicians as an obligation to treat, regardless of other complicating medical conditions and the prognosis for patient benefits. The willingness of some clinicians to accept for treatment, for example, elderly demented patients, a persistent vegetative state patient, or a blind diabetic amputee is widely recognized and discussed, if not well documented.

The Subcommittee recommended that guidelines for patient acceptance be developed involving patients and professionals. Thus, we raised an issue, but did not resolve it. My personal conclusion today is the slow pace of guidelines development reflects the great difficulty physicians and others have in dealing with this issue. Although we concluded that this issue was not one on which legislation was appropriate, I conclude it is not an issue on which the Congress should continue to remain silent.

The time has come for Congress to ask the patient and provider communities to address the issue of appropriateness of patients for treatment with respect to developing guidelines for patient acceptance criteria. Congress need not and should not consider legislation. It can and should clearly indicate to the public and all interested parties the importance it attaches to discussing and addressing this hard issue.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF RICHARD A. RETTIG, PH.D.
RAND CORPORATION

Mr. Chairman, Members of the Committee. My name is Richard Rettig. I am a Senior Social Scientist at the RAND Corporation, where I have been since mid-February of this year; I previously worked at RAND from 1975-81. From 1987 until early this year I was a Senior Staff Officer at the Institute of Medicine of the National Academy of Sciences. In both organizations I have done work related to the Medicare End-Stage Renal Disease program. Most recently, at the Institute of Medicine, I was the responsible staff officer for a major study, a conference, and a workshop related to the ESRD program.

I am pleased to testify today before this committee, which has been involved in all legislative aspects of this program.

Some time ago, I wrote a legislative history of how Section 2991 (the kidney disease entitlement amendment to the Social Security Amendments of 1972) was adopted. That amendment authorized treatment for permanent kidney failure, by both dialysis and kidney transplantation, as a near-universal entitlement covering an estimated 92-93 percent of the United States population. More recently, I wrote a related paper, with the help of the Congressional staff who were involved in the 1972 legislation. Both papers have been supplied to the committee staff and Members may find them useful analyses of the political background to this program.

I should say at the outset that the Medicare ESRD program has been very successful, especially for those individuals for whom it was originally intended. Thousands and thousands of individuals whose lives would otherwise have ended prematurely and abruptly due to kidney failure have had those lives extended and have pursued productive activities of benefit to themselves, their families, and the society. The program has also been very successful in holding down the per treatment costs of dialysis. However, the aggregate cost of the program, estimated to be $8 billion in this year, is a function of the patient population, which continues to grow, and the per patient per year treatment cost, which is very high.

The Omnibus Budget Reconciliation Act of 1987 called for an Institute of Medicine (IOM) study of certain aspects of the ESRD program. That study, conducted by an expert committee for which I served as study director, was published in 1991 by the National Academy Press as Kidney Failure and the Federal Government. A single copy of that very thick report has been provided to the Committee. In addition, twenty-five copies of the report summary have also been provided, as have multiple copies of a 1991 paper in the New England Journal of Medicine by Dr. Norman G. Levinsky, the IOM committee chairman, and myself, that also summarizes the study.

My remarks today pertain mainly to the 1991 IOM report and to a follow-up initiative that the Institute took in 1993 and 1994. In addition, I will share with you some of my personal views about the program for your consideration. I should emphasize that my remarks do not necessarily represent the views of either the Institute of Medicine or the RAND Corporation.

In OBRA 87, the Congress asked the IOM to consider the following five issues:

- The epidemiology of the ESRD patient population
- Access to treatment, especially for those not covered by Medicare
- The effects of reimbursement on quality
- The measurement of quality
- Data

DATA

In my remarks today, I will comment only in passing that the data for the ESRD program are probably the best there are in the Medicare data system. This is due to the dedication and competence of several key professionals at the Health Care Financing Administration (HCFA) and to the work of the United States Renal Data System, now housed at the University of Michigan and supported by contract by the National Institute of Diabetes and Digestive and Kidney Diseases (of the National Institutes of Health) and HCFA. There are some opportunities for making more creative use of these data, in my judgment, about which I will comment below.

EPIDEMIOLOGY

The growth of the ESRD patient population has been the single most important cost driver. For some time, the patient population has been growing increasingly older. For example, in 1992, of nearly 56,000 new patients enrolling in the program, 20% were in the 55-64 years-of-age group, 26% were 65-74 years old, and 18% were over 75. Nearly two-thirds (64%) of the new patients were over 55 years of age and 44% were over 65 years old. Moreover, in the 1987-92 period, the *average annual growth* of new patients over 65 years was 11.6% and those 75 years and older grew at a rate of 15.7%.

Patients are also presenting in large numbers with primary diagnoses of kidney failure of diabetes and high blood pressure. In 1992, 36% of all new patients had a diagnosis of diabetes as the primary cause of kidney failure; and for 29 percent of new patients, hypertension was identified as the primary cause of kidney failure.

The patient population is also includes a large proportion of minority patients. For example, 29% of new patients in 1992 were African-American; for whom the rate of kidney failure is nearly four times that of the white population.

The IOM, in conducting its study, asked Dr. Paul Eggers of HCFA to project the ESRD patient population to the year 2000. Using actual data through 1988, and using three different assumptions of slow, moderate, and rapid growth, the estimates were 210,000 patients (slow growth), 240,000 (moderate growth), and 275,000 (rapid growth) by the end of the decade. Total program enrollment in 1992 had already reached 200,000 patients, indicating the difficulty of estimating the growth of the patient population and that year 2000 actual numbers are likely to exceed the earlier high estimate.

I dwell on these numbers for one simple reason. Whatever the Members of this Committee think about this part of Medicare, there is no escape from the fact that the growth of the patient population is the primary factor driving cost increases. I will return to this later.

ACCESS

The kidney failure treatment entitlement is as close as we come in the United States to universal coverage of any condition. Individuals are eligible for entitlement if they are currently or fully insured under Social Security, have been diagnosed as having permanent kidney failure, and have applied for benefits, or are the spouse or dependent child of such an individuals. Thus, over 90% of the U.S. population are covered by Medicare for permanent kidney failure.

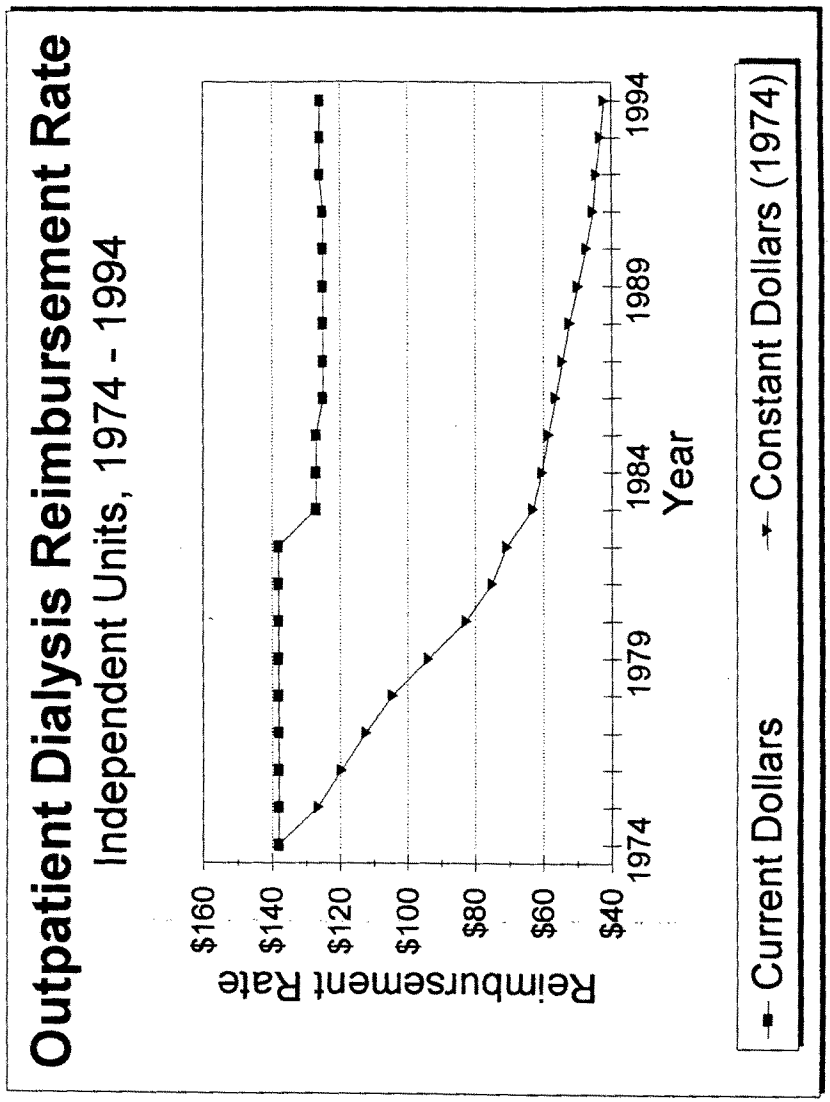
The IOM committee made basically two recommendations regarding access. First, it recommended that there be universal coverage of all American citizens and resident aliens. If the nation is prepared to insure more than 90 percent of the population, the committee r easoned, it ought to complete the task and insure the entire population. It is safe to say that the Congress greeted this recommendation with studied indifference.

Second, with respect to kidney transplantation, the IOM committee recommended that coverage for immunosuppressive drugs be made coterminous with the duration of coverage for the transplant patient. The 1972 legislation had limited coverage for the procedure to 12 months, which Congress extended to 36 months in 1978. The rationale for the recommendation about immunosuppressive coverage was that the most cost-effective treatment and the one with the highest quality of life on average should not be jeopardized by a failure of Medicare to pay for the necessary drugs. As a result of the Omnibus Budget Resolution Act of 1993, coverage of immunosuppressive drugs has been extended from 12 months to 18 months effective January 1 of this year; it will increase to 24 months in 1996, to 30 months in 1997, and to 36 months on January 1, 1998 and thereafter.

REIMBURSEMENT

Reimbursement for ESRD treatment is important for a simple reason: total progam costs are very high and the beneficiaries are few in number relative to the total Medicare population, perhaps one-fourth of one percent.

At the level-of-per-treatment reimbursement, the ESRD program has been a great success. The IOM committee analyzed the real dollar decrease in per treatment payment from 1974 dollar through 1989. A combination of an unchanged reimbursement rate for 10 years, followed by a downward revision in 1983, a more modest downward revision in 1986, and NO ADJUSTMENT FOR INFLATION at any time during the program's history, resulted in a 1989 payment rate that was approximately 40 cents on the 1974 dollar. A recent update through 1994 puts the figure closer to 30 cents on the 1974


Outpatient Dialysis Reimbursement Rate
Independent Units, 1974 - 1994
Reimbursement Rate
$160
$140
$120
$100
$80
$60
$40
1974
1979
1984
1989
1994
Year
Current Dollars
Constant Dollars (1974)

dollar. (The 1989 adjuster used was the GNP implicit price deflator; the more recent figures uses the Consumer Price Increase--Urban deflator (CPI-U).)

In 1991, the IOM committee recommended no further explicit reimbursement reductions and also that the payment rate be updated annually, consistent with the rest of Medicare. Congress did add $1 to the composite rate in 1990.

REIMBURSEMENT AND QUALITY

The OBRA 1987 charge directed the IOM to examine the effects of reimbursement on quality of care. We did so, using mortality and hospitalization as outcome measures and treatment unit staffing as a measure of input use. The findings were as follows: (1) the relation of reimbursement reductions to increases in patient mortality were suggestive but not conclusive; (2) the relation of reimbursement reductions to hospitalizations were also suggestive but not conclusive; and (3) the relation of reimbursement reductions to reduced staffing were -- not surprisingly -- clear, but these effects could not be related clearly to changed patient outcomes.

To be sure, every clinician (physicians, nurses, social workers), administrator, and patient representative to whom we spoke believed that quality had suffered in response to reimbursement reductions. The IOM committee saw no reason to doubt them. But the problem of measuring the relation of aggregate data on reimbursement to quality of care, especially outcomes, is very difficult and, in my judgment, there is no inconsistency between what practitioners see and what aggregate data fail to capture.

Regarding patient outcomes of care, mortality is the measure that has preoccupied the U.S. nephrology community. This concern for mortality is appropriate but it is not enough. It is noteworthy that the United States Renal Data System has reported improved survival among all groups of patients and for all modalities of treatment in recent years, during which there has been no improvement on reimbursement.

In the past five years or so, the "adequacy" of dialysis has become the primary clinical measure of quality of care for the dialysis patient population. Adequacy is a complex clinical measure of the appropriate "dose" of dialysis for a given patient. A good deal of progress has been made in recent years with respect both to the measurement of adequacy and the delivery of adequate dialysis care. Measuring adequacy is very important, but, in my view, not enough.

It is worth noting, both with respect to mortality and adequacy, that large administrative data bases are increasingly being used to generate data on local treatment unit performance, then these date are fed back to these units, allowing them to compare their performance to other units in their region and to all units in the nation. This emerging system, or set of systems, of data acquisition, analysis, generation of information on national and regional performance, and feedback to local treatment units is very promising.

QUALITY ASSESSMENT

The 1991 IOM report had a rather general, conceptual chapter on the measurement of quality, appropriate for the time but limited in many ways. As a follow up, the IOM held a conference in September 1993 on "Measuring, Managing, and Improving Quality in the End-Stage Renal Disease Treatment Setting." The proceedings of that meeting were later published in the August 1994 issue of the American Journal of Kidney Diseases. A copy of that proceedings issue has been made available to the staff.

The conference concurred in the importance attached to mortality and adequacy of dialysis as measures of quality, but also •lent strong encouragement to going beyond these measures to include measures of functional outcomes, health status, and health-related quality of life. The organizing committee believed that systematic measurement of how well patients were doing, not just the measurement of laboratory and clinical values, was very important in a chronic disease patient population.

In a December 1994, the IOM held a related workshop to answer the question of how to measure functional outcome, health status, and health-related quality of life. Four well-validated measurement instruments were examined: the Duke Health Profile, the Dartmouth COOP charts, the Medical Outcome Study 36-Item Short Form, and the RAND Kidney Disease Quality of Life instrument. The results of that workshop are being prepared for publication.

Dr. Robert Brook testified before this Subcommittee several weeks ago, saying that measurement of quality was possible. Indeed it is and it is certainly possible in the data-rich ESRD program. But neither the Health Care Financing Administration nor the nephrology community have been very quick to exercise leadership regarding the measurement of quality. There are two areas in particular that the Committee might consider asking for more vigorous action.

The first of these is in relating cost data to outcomes of treatment at the facility level. Although there has been a marked improvement in attitude,orientation, and competence of personnel in the Health Standards and Quality Bureau in recent years regarding the assessment of quality in the ESRD program, there appears to me to be little or no discernible interest in the Bureau of Policy Development (which is responsible for reimbursement) in relating cost data to information about quality. The IOM committee, in 1991, recommended that this issue be taken up and systematically addressed. It is long past the time that a good faith start on this matter be undertaken.

To do so requires that HCFA link several existing data bases that have yet been linked. It is currently possible with existing data bases to identify high reimbursement and low reimbursement treatment units (both ends of the spectrum) and to examine high and low mortality rates (both ends of another continuum) and to initiate the systematic examination of the relation between resource inputs and outcomes of care. This endeavor should be done. This Committee should provide clear guidance to HCFA and the nephrology community on this point. Absent the systematic analysis of the relation

of cost to quality, we will continue to be subjected to a series of anecdotes that serve the purposes of the user but do not help policy makers. It is also the case that the USRDS was barred by the National Institutes of Health in its first five year contract from considering reimbursement and clinical issues together, even though the data permitted such examination. It appears that that problem has been remedied in the second five-year contract. But this Committee should make clear to NIH and to HCFA that the public interest is not served by the failure to examine cost and clinical data together.

The second area in which HCFA and the nephrology community might be asked by this Committee to be more forthcoming is in the development of a system for the acquisition of data on the functional status, health status, and health-related quality of life of the ESRD patients. In a chronic disease patient population, it is entirely reasonable to ask about patients' physical functioning and limitations, their social functioning, bodily pain, general mental health, vitality, and general health perceptions. Well-validated instruments exist for acquiring such data. Several of these are deliberately short, to ease the costs of data collection and analysis and to facilitate their use in busy clinic settings.

Resistance to the use of functional and health status and quality-of-life measures stems, in my view, from several sources: (1) these instruments have been developed by health services researchers and are unfamiliar to many clinicians; (2) the utility of these instruments has yet to be demonstrated for patient monitoring and patient management; (3) functional and health status data have yet to be correlated with clinical outcome data; (4) measuring these factors adds to the cost of treatment; (5) systematically-acquired patient data may challenge physician authority; and (6) these data may provide the basis for limiting what HCFA can do with respect to reimbursement reduction (direct or indirect).

Some of these reasons for resistance have merit, others do not. If improving the outcomes of patient care is an objective shared by the Congress, HCFA, the provider community, the general public, and -- above all -- by patients, this Committee should encourage greater progress in this area than we have seen to date.

EPIDEMIOLOGY, COST, AND ETHICS

Mr. Chairman, Members of the Committee. Let me return to the epidemiology of the ESRD program. It should be clear that the growth of the patient population drives cost growth of the ESRD program. It should also be clear that cost containment has been extraordinarily successful on a per treatment basis, largely through the absence of adjustment for inflation. But the two trends of the increasing treatment requirements of an increasingly older and medically complicated patient population and a relentless reduction of reimbursement cannot persist indefinitely without either quality suffering or expenditures increasing. Obviously, it is impossible to calibrate the appropriate relationship between epidemiology and cost without the systematic acquisition of data about quality of care. This is one implication of the epidemiology of the ESRD patient population.

A second implication is the need to examine the major clinical contributors to kidney failure of diabetes and hypertension. As the nation improves its treatment of these diseases, it may simultaneously be increasing the pool of prospective patients destined for kidney failure. Consideration should be given to the progress of medical research, to the implications for behavioral change by individuals, especially related to diet, and to the probable costs of a health care system that fails to provide adequate primary care to many low income citizens early in their lives only to reap the costs of providing very expensive treatment for the failure of a major organ system later in life.

Finally, I should note that the IOM committee in its 1991 report included a chapter on ethics that was specifically concerned with whether too many patients were accepted to treatment. The existence of an entitlement has often been interpreted by clinicians as an obligation to treat kidney failure, regardless of other complicating medical conditions and the prognosis of patient benefit. The willingness of some clinicians to accept for treatment, for example, an elderly demented patient, a persistent vegetative state patient, or a blind diabetic amputee is widely recognized and discussed, if not well-documented.

The IOM committee recommended that "patients, professionals in adult and pediatric nephrology, and bioethicists develop guidelines for evaluation of patients for whom the burdens of renal replacement therapy may substantially outweight the benefits." We thus raised, but did not resolve, a very hard question, and encouraged a discussion that continues to the present.

Although the IOM committee concluded that this issue was not one on which legislation was appropriate, my personal conclusion today is that the slow pace at which guidelines development has progressed reflects the great difficulty that physicians and others have in confronting this issue. I have also concluded that this is not an issue on which the Congress should continue to remain silent.

The 1972 legislation that authorized this entitlement included the following paragraph:

- "The Secretary is authorized to limit reimbursement under Medicare for kidney transplant and dialysis to kidney disease treatment centers which meet such requirements as he may by regulation prescribe: *Provided*, That such requirements must include at least requirements for a minimum utilization rate for covered procedures and for a medical review board to screen the appropriateness of patients for the proposed treatment procedures [emphasis added]."

I believe the time has come for the Congress to ask the patient and provider communities to address the issue of the "appropriateness of patients" for treatment with respect to developing guidelines for patient acceptance criteria. It need not and should not consider legislation. It can and should indicate to the public and to all interested parties the importance that the issue be responsibly addresssed.

Mrs. JOHNSON [presiding]. Dr. Powe.

STATEMENT OF NEIL R. POWE, M.D., M.P.H., M.B.A., ASSOCIATE PROFESSOR, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

Dr. POWE. Thank you, Members of the Subcommittee. I am an associate professor of Medicine at Johns Hopkins University. I am currently directing an End-Stage Renal Disease Patient Outcomes Research Team or PORT funded by the U.S. Agency for Health Care Policy and Research. The work focuses on defining the effectiveness and cost of treatment for individuals with end-stage renal disease.

I previously led a national study for HCFA of the effectiveness of erythropoietin, a relatively new and expensive treatment for anemia of ESRD. This study included an evaluation of the impact of different payment methods on access, outcomes, and cost.

In my testimony today I will address the issue of how payment methods to reimburse providers will affect cost, access to care, and quality of care.

The first issue is cost. The medical care of ESRD patients is expensive. Persons with ESRD consume 8 to 10 times more medical resources on an annual basis than the average Medicare beneficiary. Total Medicare expenditures for ESRD are likely to grow due in large part to the continuing increase in the population of older adults who are experiencing ESRD. The large costs suggest that there is an opportunity to develop and implement clinical, organizational, and payment innovations that will help reduce the cost of ESRD care.

Both renal physicians and facilities are paid a fixed payment for treatment for medical services related strictly to dialysis. This partial capitation method of payment has been viewed as an effective means of controlling program costs. Evidence for this is that expenditures for nondialysis, noncapitated care, have grown at a faster rate than expenditures for dialysis care. The extension of provider responsibility to manage the total care of the ESRD patient using capitation methods that encompass all services is therefore very attractive as a means of continuing cost containment. Capitation has the potential to impose discipline on medical spending through more predictable outlays. Furthermore, capitation methods reward efficient providers and have the potential to promote better coordination of care because a provider is made fully accountable and encouraged to provide more comprehensive care.

Capitation payments are often constructed with the assumption that all patients are average. However, patients with ESRD are heterogenous; heterogenous with regard to other medical conditions and the resources necessary to provide their care. For example, persons with ESRD and diabetes or age greater than 65 years have higher expenditures than persons without these attributes.

Other conditions such as heart disease, bone disease, and bleeding disorders are frequently present. If Medicare were to pay an average fee to providers who take care of less severely ill patients, the program might pay more than necessary. On the other hand, if a provider were to care for patients who are more severely ill and consume more necessary medical resources, it might lose money

and become economically inviable under a system which pays only an average capitation rate. Thus, it is essential that a program of full managed care and capitation incorporate risk-adjusted payments for comorbid disease. Risk-adjusted payment rates account for the fact that all patients are not average.

The second issue is access to care. Medicare payment for ESRD since 1972 has allowed and maintained access to care for over a half a million individuals. Because the number of providers of ESRD care now exceeds 2,000, most individuals have a choice of providers from which to receive care.

In a move to comprehensive managed care of ESRD, an organization choosing to participate must be able to provide the full range of services that these patients require; outpatient dialysis care, outpatient nondialysis care, inpatient care, and transplantation services which offer persons with ESRD the possibility of resuming a near normal life. Some organizations may not have these capabilities. Thus, in some areas of the country under a mandatory full capitation program, choice of providers could be restricted. Furthermore, a new payment system must permit choice and access to likely cost-effective ESRD technologies such as peritoneal dialysis, transplantation, and medications.

My last issue and equally important issue is quality of care. Payment for capitation must recognize that while there is a financial incentive to use resources more wisely, there is also the potential that providers might cut back on necessary and expensive medical care that is beneficial to patient well-being. Therefore, it is prudent that a reformed system of fully managed and capitation care implement more careful oversight. This includes monitoring and enforcement of quality standards.

Unfortunately, much work needs to be done to develop appropriate quality standards such as clinical practice guidelines for the care of the ESRD patient. Our patient outcomes research project will help in this regard.

Thank you.

[The prepared statement follows:]

TESTIMONY OF NEIL R. POWE, M.D.
JOHNS HOPKINS UNIVERSITY

Thank you Mr. Chairman and members of the Committee. My name is Neil R. Powe, M.D., M.P.H., M.B.A. I am an Associate Professor of Medicine at the Johns Hopkins University. I am currently directing an End-Stage Renal Disease Patient Outcomes Research Team (PORT) funded by the U.S. Agency for Health Care Policy and Research. My work focuses on defining the effectiveness and cost of treatment for individuals with End-stage Renal Disease who now number over 150,000. I previously led a national study for the Health Care Financing Administration of the effectiveness of recombinant human erythropoietin therapy, a relatively new, effective and expensive treatment for anemia of End-Stage Renal Disease. This study included an evaluation of the impact of different payment methods on access, outcomes and costs.

In my testimony today, I will address the issue of how payment methods to reimburse providers who care for individuals with ESRD will affect costs, access to care and quality of care.

The first issue is cost. The medical care of individuals with ESRD is expensive. Persons with ESRD consume eight to ten more medical resources on annual basis than the average aged Medicare beneficiaries. While ESRD beneficiaries account for only 6 tenths of a percent of the Medicare population they disproportionately account for over 4 percent of Medicare expenditures. Epidemiologic studies suggest that total Medicare expenditures for ESRD are likely to grow due in large part to the continuing increase in the population of older adults who are experiencing ESRD. The large per patient costs and rising total Medicare costs suggest that their is opportunity to develop and implement clinical, organizational and payment innovations that will help reduce the cost of ESRD care.

Since 1983 providers of dialysis care, both physicians and facilities, have been paid by HCFA under the composite rate methodology, which pays a fixed payment per treatment for medical services related strictly to dialysis. This method of payment has been viewed as an effective means of controlling program costs. Evidence for this is that expenditures for non-dialysis, non-capitated care for dialysis patients have grown at a faster rate than expenditures for dialysis care. These non dialysis, noncapitated services include care for other health conditions and hospitalizations. The extension of provider responsibility to manage the total care of the ESRD patient using capitation methods that encompass all services is therefore very attractive as a means of continuing cost-containment. Capitation has the potential to impose discipline on federal medical spending for ESRD patients through more predictable outlays. Furthermore, capitation methods reward efficient providers and have the potential to promote better coordination of care because a provider is made fully accountable for comprehensive care.

The second issue is access to care. Medicare payment for ESRD care since 1972 has allowed and maintained access to care for over a half a million individuals. In addition, because the number of providers of ESRD care has doubled over the past 15 years and now exceeds 2000, most individuals with ESRD have a choice of providers from which to receive care. Private-sector for-profit and non-profit organizations versus government-run facilities comprise most of the centers that provide care. In a move to comprehensive managed care of ESRD, an organization choosing to participate in care for ESRD persons must be able to provide the full range of health care services that these persons require. This includes outpatient dialysis care, outpatient non-dialysis care and inpatient care. In addition, transplantation services which offer persons with ESRD the possibility of resuming a more normal life must also be available. Some organizations may not have these capabilities. Thus, in some areas of this country under a mandatory full capitation program, choice of providers for individuals with ESRD could be restricted if not enough providers are capable of organizing the complete care of these patients. Furthermore, a new payment system must permit choice and access to likely cost-effective ESRD technologies such as peritoneal dialysis, transplantation and medications (such as recombinant human erythropoietin and cyclosporine) that enhance the quality of life of the ESRD patient.

Capitation payments are often constructed with the assumption that all patients are average. However, persons with ESRD are heterogenous; heterogenous with regard to other medical conditions and the resources necessary to provide their care. For example persons with ESRD and diabetes or over the age of 64 years have higher expenditures than persons with

ESRD without these attributes. Other comorbid conditions such heart disease, bone disease and bleeding disorders are frequently present. A system of full capitation for individuals with ESRD must recognize the differences in disease severity and resource use between patients. If the Medicare program were to pay an average fee to providers who take care of less severely ill patients, the program might pay more than necessary. On the other hand, if a provider were to care for persons with ESRD who are more severely ill and consume more necessary medical resources, it might lose money and become economically inviable under a system which pays only an average capitation rate. Thus, it is essential that a program of full managed care and capitation incorporate risk-adjusted payments for comorbid disease. Risk-adjusted payment rates account for the fact that not all patients are average.

The last and an equally important issue is quality of care. Payment for capitation must recognize that while there is a financial incentive to use resources more wisely, there is also the potential that providers might cut back on necessary and expensive medical care that is beneficial to the well-being of individuals with ESRD. Most health indicators in the ESRD population are already below that of the general population. For example, on average, approximately one out of five ESRD patients dies each year in the United States. There is the risk that if payment levels to providers are not adequate, providers might reduce care to the point of negatively impacting patient outcomes. Therefore, it is prudent that a reformed system of fully managed and capitated care implement more careful oversight. This includes monitoring and enforcement of quality standards. Much work needs to be done to develop appropriate quality standards such as clinical practice guidelines for the care of the ESRD patient. Our PORT project will help in this regard.

In summary, innovative payment approaches should be explored for the care of persons with ESRD. However, the methods should be carefully selected to control costs, maintain access to care, allow choice of providers and enhance the quality of care.

Thank you.

Chairman THOMAS [presiding]. Thank you.

STATEMENT OF CHRISTOPHER R. BLAGG, M.D., EXECUTIVE DIRECTOR, NORTHWEST KIDNEY CENTERS

Dr. BLAGG. Thank you. I am Christopher Blagg. I am executive director of the Northwest Kidney Centers in Seattle, which is a large community-based, nonprofit corporation, the oldest freestanding dialysis unit in the world. I have been asked to talk about the capitation study because I was one of the consultants to the study that was completed by the RAND Corp.

My written testimony contains an outline of the issues, and I don't propose to go through them except to say that I think it was a successful study. It identified payment methodology based upon a rate for dialysis, a rate for the patient with a functioning transplant, specific lump sum payments for a kidney transplant, or for a kidney transplant failure, both of which are expensive events, and as Dr. Powe mentioned also, risk adjustment for sick patients who may be outliers, and so forth.

I included some of the cost data from the study in my written testimony. The problem is how to contain costs for patients with a disease that requires very expensive treatments and for whom the costs can vary widely, depending upon patient characteristics, complications, and the treatment the patient receives.

I would reverse the order of the things Dr. Powe has just said and say the most important thing, I believe, is quality of care. It is most important if we are going to go to capitation that we ensure we have good measures of quality of care first.

Several years ago we became concerned because the mortality rates in U.S. hemodialysis patients were significantly higher than for patients in Europe, Australia, and other Western countries. It is only as we have collected more data and started to do some things looking at quality that this has begun to change.

I believe that at this point in time we are not going to be able to get much economy by cutting the costs of dialysis. This is because as we are trying to provide better dialysis, we are going to use more expensive dialyzers, and are probably going to increase the length of time we dialyze patients. Where we can contain costs is in terms of hospitalization, physician services, access surgery services, and so forth. Those are the areas where capitation would give the opportunity to reduce costs. So, if we are going to go to capitation, first we must ensure we have good quality control; that any capitation program deals with the problem of selection so we don't get selection bias and skimming off of the better patients to capitation.

Second, we must make sure that whatever the system is, it does not skew patients' choices. Patients need to have access to transplantation and to various forms of home dialysis. It is possible to skew things, depending how you set up the system. I think you need to find ways of encouraging patients to enroll in managed care if this is what we are going to do, because right now I believe it is true to say that Medicare continues to have problems in getting patients generally to enroll in managed care.

I think you also have to take into account geographic variations in costs in different parts of the country. You certainly must also

take into account the occasional patients for whom costs can be extremely high.

You also have to take into account the fact that the population is changing. As you have heard, the number of patients is increasing, increasing faster than was anticipated. Not only that, the population that is increasing is changing and becoming sicker, so you have more complex patients who, again, are going to cost more money.

Managed care would have the advantage of providing better coordination of care, but I would emphasize that at a time like this when we are just beginning to get a handle on quality in the ESRD Program, it is not the time to go to capitation. We need to do the demonstration studies that HCFA is proposing and learn from these, because here we are dealing with a disease in which all the patients are sick. This is a different situation to the general HMO situation where you have the whole population to select from, and a lot of people who are not sick. Here you have a sick population with a chronic condition that is very expensive to treat, and we need more experience with capitation before we go to this generally.

One final comment. Mr. Stark at the beginning of the hearing made a comment about home dialysis only being useful in exceptional circumstances. I disagree with that. We in health are particularly enthusiastic with the idea that home hemodialysis eventually may come back into wider use. There is data from the U.S. Renal Data System which is not yet published, but was mentioned at a meeting 2 weeks ago. This showed that not only is the quality of life better with home hemodialysis, but the survival of patients, when adjusted for all the factors that may affect survival, is significantly better than survival for patients who are on in-center hemodialysis. That is my little plug from Seattle.

In summary, I think capitation could well prove a fruitful approach to containing costs in the ESRD Program, but I do not believe this is the moment to look at it generally. Let's do a demonstration project first.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF CHRISTOPHER R. BLAGG, M.D.
EXECUTIVE DIRECTOR
NORTHWEST KIDNEY CENTERS

Testimony to House Ways and Means Health Subcommittee, Monday, April 3, 1995:

My name is Christopher Blagg, I am a nephrologist from Seattle, and Executive Director of the Northwest Kidney Centers and Professor of Medicine at the University of Washington.

Northwest Kidney Centers (NKC) is a non-profit, community-based organization that provides dialysis services throughout Seattle and most of King County, Washington, as well as serving as the Organ Procurement Agency for Western Washington and the states of Alaska and Montana. NKC has six dialysis facilities that provide outpatient hemodialysis for 600 patients. A further 124 patients are treated by home hemodialysis, and 93 by CAPD and other forms of peritoneal dialysis at home. Currently, 59.2% of all NKC patients either have a functioning kidney transplant or are treated by home hemodialysis or peritoneal dialysis. NKC serves a medical staff of 37 nephrologists from private practice, the University of Washington, and Group Health Cooperative, a large HMO.

I have been involved with dialysis for more than 30 years, and with the NKC for 23 years. During that time I have also been involved in various ways with legislative activities, consulting with the Health Care Financing Administration (HCFA), with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), with planning of end-stage renal disease (ESRD) services at the state level, and with various professional organizations.

I have had an interest in the concept of capitated reimbursement for ESRD treatment for a number of years, and served as a member of the advisory committee to the Rand Study "Designing a Capitation Payment Plan for Medicare End Stage Renal Disease Services". I also met with congressional staff in the past to support inclusion of a demonstration project on capitation for ESRD in HCFA's Social HMO demonstrations. At this time, I am waiting for publication of the Request for Proposal from HCFA for this demonstration project. NKC will then consider whether or not to respond with a proposal to participate in this.

THE RAND CAPITATION STUDY:
This research project, funded by HCFA, evaluated the options for a capitation payment system for patients with ESRD that would combine payments for hospital and outpatient services, including physician services. Medicare claims data from 1990 for all part A and part B services for ESRD patients were analyzed and used to estimate total payments, including Medicare and copayments and deductibles. Monthly payment amounts were standardized to national averages. The study used 1990 data from 136,047 patients who used dialysis services only during the year, 27,740 patients who only had a functioning kidney transplant, 6,185 patients who received a transplant, and 1,773 patients whose transplant failed during the year.

Capitation Program Principles:

- Control cost by an appropriate mix of services and their efficient delivery;

- Promote quality of care in terms of appropriate care and outcomes and patient satisfaction;

- Promote equity for patients, including free choice of both treatment modality and health plan;

- Provide equity for health plans by payment methods that take into account differences in patient resource needs and ability of plans to compete for patients.

Components of a Capitation Plan

1. **Benefits package** that includes all part A and part B services. This could also include additional benefits or reduction in copayments as incentives for enrollment.

2. **Marketing and enrollment** that allows any Medicare ESRD beneficiary with part A and part B entitlement to enroll at any time. Enrollment and disenrollment must be monitored to detect bias in patient selection.

3. **Delivery systems** comprised of health plans contracting with HCFA and with dialysis providers, hospitals, laboratories and physicians. Contracts between health plans and providers should be flexible in such matters as risk-sharing and profit-sharing agreements.

4. **Payment methods** based on monthly capitation amounts for patients on dialysis or with a functioning kidney transplant. Payment must take into account patient characteristics, including age and a diagnosis of diabetes, as well as extra costs in preparation for a kidney transplant and following transplant failure.

5. **Quality assurance** provisions.

6. **Monitoring and oversight** of the quality of health care services and the financial viability of health plans on behalf of the government in order to protect the interests of Medicare ESRD beneficiaries.

Payment Methodology Recommendations

- Monthly capitation payments for patients on dialysis, risk-adjusted for differences in costs related to patient characteristics;

- Monthly capitation payments for patients with functioning transplants;

- A fixed lump sum payment for each kidney transplant and for each transplant failure to cover the incremental costs of these infrequent and expensive events;

- Separate payments for Medicare part A and part B benefits;

- Use of multiple linear regression models to risk-adjust for additive payment adjustments. While they explain only about 3% of total variation in average monthly payments, there are a few extremely expensive dialysis patients. Separate sets of risk adjustments for part A and part B payments are recommended to take into account age, sex, diabetes as cause of ESRD, and previous graft failure. An important adjustment for part A payments is a one-time payment for patients in their first month of treatment if Medicare is already primary payor. Other risk factors also should be evaluated.

- A fixed loss outlier payment policy as one means to mitigate health plan risk from unusually expensive patients. Outlier payments would be paid for cases with medical expenses during the calendar year exceeding the capitation payment plus $50,000;

- Care must be taken to avoid incentives for health plans which would discourage the use of transplantation or home dialysis as options;

- There are clear rural and urban differences to be taken into account.

AVERAGE 1990 MONTHLY STANDARDIZED PAYMENTS

	Part A	Part B	Total	Annual
Dialysis	$ 1,334	$2,049	$ 3,393	$40,716
Transplanted	$ 472	436	908	10,896
One-Time Payment				
For Transplant	$33,971	$3,948	$37,919	
One-Time Payment	$ 8,958	$3,167	$12,125	

Table 1 illustrates some of the data from the Rand study. It is important to note that these estimates are based on 5 year old data from 1990. Any demonstration will require careful updating of the financial estimates used to set reimbursement rates.

COMMENTS

Patients with ESRD are expensive to treat, and the 1995 estimate of $8 billion for Medicare is only part of the cost. The total cost of ESRD treatment to Medicare and other sources in 1995 will be some $11.2 billion, based on a methodology used to estimate cost in the United States Renal Data System 1994 Annual Data Report. The problem is how to contain costs for patients with a disease requiring very expensive treatments and for whom costs can vary widely, depending on patient characteristics, complications, and the treatment, while at the same time maintaining or improving the quality of care.

Quality of care is particularly important, as some years ago it became clear that dialysis patients in this country had a significantly higher average mortality risk than patients in other western countries. At that time, U.S. patients were receiving some 20% less dialysis than those elsewhere. To improve the adequacy of dialysis requires use of either larger more expensive dialyzers or of a longer dialysis time which is also more expensive. Thus, it seems unlikely the cost of dialysis treatment itself can be reduced much, if at all. Any costs

saving in the Medicare ESRD Program must come from other economies involving hospitalizations, access surgery, physician services, and other items. Capitation is certainly worth exploring as a potential means of controlling these costs.

Nevertheless, the Rand study does not go into detail about how the implementation of capitation for ESRD should be carried out. This is a significant problem because, on the one hand, dialysis providers and nephrologists in general are not yet experienced with a capitation approach and, on the other hand, existing health plans have relatively limited experience with ESRD patients. Thus, it is most important that the next step towards capitation for ESRD be a demonstration project or projects to gain experience with this for a very expensive chronic disease with widely varying costs for some patients. Another reason for such a study is that by the time it is concluded and the results assessed, physicians and providers will have had much more exposure to managed care generally, and so will be more open to innovative changes in reimbursement.

Several concerns are important in devising a capitated health care system for the ESRD program. First, and most important, measures of quality control are essential in any such scheme in order to avoid risk to patients. In addition, methods must be developed to deal with several other issues:

- means to prevent selection bias so as to deal with the problem of health plans enrolling an overlarge proportion of less expensive patients;

- means to address the influence of health plan and provider financial incentives on the choice of treatment modality. The Rand study shows how payment subsidies can be created by the choice of time cutoffs. Subsidies could be used as incentives, for example, to encourage transplantation and possibly home hemodialysis - the treatments with the best survival and quality of life. In any case, it is important that patients are educated fully about, and have access to, all modalities of treatment;

- means to encourage beneficiaries to choose to enroll in a managed care plan. Slow enrollment continues to be a nagging problem with Medicare managed care options generally.

- payments must also take into account geographic variation. For example, hospital days and hospital costs vary widely by region, by urban or rural location, and are higher in teaching hospitals and disproportionate share hospitals. Thus, geographic differences in reimbursement are common now, and can only be adjusted over time;

- means to deal with health plan risk that might occur as a result of inclusion of an unexpectedly high proportion of patients with extremely high costs. This problem could be minimized by adjustment of payments if appropriate, or by use of outlier payments;

- means to adjust the capitation rate to match the changing ESRD population. The number of patients continues to increase, with an ever larger proportion of complex

cases that require more services and have only a limited ability to improve their health status.

The cost containment potential with capitation relates particularly to the opportunity to manage the individual patient much more closely. Dialysis costs and the costs of a kidney transplant are relatively fixed, but better and more coordinated care using a case management approach could improve care, reduce the frequency of hospitalization and access surgery problems, and consequently reduce costs. More coordinated management would also allow opportunity to reexamine the frequency of physician visits and the frequency and number of laboratory studies, both of which help to drive costs in the fee-for-service setting. This becomes important as the incidence rate for new ESRD patients continues to grow by some 8% annually, while the number of practicing nephrologists is expected to decrease in the near future.

In summary, a capitated approach to the ESRD program has potential merits in terms of cost containment and improving adequacy of dialysis and quality of care. The Rand study dealt in detail with financial issues but not with the details of implementing such a program. The next step should be the demonstration project under development by HCFA which will give the opportunity to learn the issues and problems in implementing capitation. A time when the quality of dialysis treatment in the U.S. is only beginning to improve as a result of monitoring of facilities and physician and patient education, is not the moment to radically change reimbursement without further experience with capitation. Nevertheless, I believe this approach will prove fruitful and will be the next major innovation in funding of the Medicare ESRD program.

Thank you for considering these comments.

Chairman THOMAS. I thank the panel very much. The gentlewoman from Connecticut will inquire.

Mrs. JOHNSON. Dr. Powe, do you agree with Dr. Blagg that if we go to capitated rates they need to be adjusted for severity, that their needs to be more than one rate?

Dr. POWE. I thoroughly support that. I am concerned that, as I said, Medicare might pay more if a provider were to select rather healthy ESRD patients and vice versa, that if providers took care of the very sick, they may not be viable as organizations.

Mrs. JOHNSON. We appreciate the danger of that. In the past have there been problems with oversight of quality?

Mr. RETTIG. I think what has happened in the past 10 years is great attention to mortality as an outcome measure; next, a great attention to adequacy of dialysis, accompanied by hematocrit, blood pressure, and nutrition.

The argument that emerged from the IOM conference held in 1993 is that there is a marvelous opportunity in this chronic disease patient population of 200,000, who present three times a week, to get data on how well the patients are doing. There are instruments for doing that. They are called questionnaires and they are filled out by patients.

Sometimes patients find it easier to respond to a questionnaire than they do to talk to their physician. I think it is long past the time when this program should have been collecting data on physical function, bodily pain, social and role function, general health perception, and general mental health. A complete quality assurance system, whether capitated or not, needs all those elements—mortality, adequacy, functional and health status.

Mrs. JOHNSON. I think that is an excellent comment. Has there been any problem in the past with quality? Because if we are going to build quality in, and some of you have suggested that one of the dangers is that we tend to build that in through regulatory systems that also affect costs and not necessarily in a way that improves quality. I want to know whether there are any past problems with quality and that is not to say that the kind of questionnaire that you recommend would be costly, but wouldn't be very useful.

I am not sure from Dr. Blagg's comments that he isn't envisioning a proper controlling form of government oversight of quality. Have there been problems in the past?

Mr. RETTIG. I think there have been, but they are documented extensively on mortality and about the same on hospitalization. There are very good data systems that have begun to generate data on adequacy of dialysis. But you don't have a complete picture. You have anecdotes. That is part of the problem in responding to the question.

I am arguing the need for putting a systematic mechanism in place to acquire such data.

Dr. BLAGG. I agree. I am not suggesting that the government should be applying strict sanctions in this area. Rather, the information should be available to both patients and to physicians and also to the public in general so that by peer pressure we can improve quality. I agree there was a problem. It is now beginning to get better, and that is why I say now is not the time to change the reimbursement system.

Mr. RETTIG. Let me extend that if I may. There are very good data systems. They can generate data on a facility-specific basis on some outcomes and then those data can be compared to regional and national data. They can be fed back to the facility and potentially they can be made available to patients. I think they should be made available to the patients, and that would be much more powerful than any system of sanctions.

Dr. POWE. I agree that there have possibly been isolated problems with quality in different areas of the country. I think on a broad scale, the care of ESRD patients is excellent. I think that we need to understand more how to measure quality of care. It can be measured in a variety of ways and we need to get better at doing that, and then setting some standards by which we all can work to achieve.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. The gentleman from California.

Mr. STARK. I am sure that Mr. Collins is going to be recognized again, and he has a case of quality that doesn't seem to have much to do with medical training to me. It is just providing the service and it could be in fashion to Members. I will let him go on about it.

Dr. Blagg, in the very round figures when you talk about capitating ESRD dialysis, for most people it is three times a week, $47. The dialysis itself is about $20,000 give or take $1,000, regardless of who the patient is, isn't that——

Dr. BLAGG. I agree.

Mr. STARK. Capitating that we are not going to change a thing. It is the other stuff, and here is where the cheese binds, that many of these people on whom we are spending $20,000 a year for dialysis which may vary in its quality, for hospital—we are spending an equal amount for hospital admissions 15 days a year hither and yon because they get an infection from a poorly run facility, because they are not checked at the facility to see whether or not they need a better dietary control, so that the cost that we are trying to control isn't the dialysis center as much as problems that might have been prevented if the dialysis center was more holistic in its approach to caring for people. Am I on the right track?

Dr. BLAGG. I agree, except it involves the physician as well as the dialysis center.

Mr. STARK. Dialysis, we are not going to save money one way or the other. We could go about that by having tougher standards, really enforcing inspection and getting rid of the bad operators——

Dr. BLAGG. I am not sure that would make that much difference to costs. In my testimony, I said that as far as dialysis is concerned, it would be a mistake to try to cut costs there.

Mr. STARK. I am not saying cut the cost. I am saying we are doing about everything we can do there——

Dr. BLAGG. Things are changing, going the right way there. What may be the way we can save money is by better coordination of patient care and making patients have fewer hospitalizations perhaps, by——

Mr. STARK. You can't make them do that, but there might be some incentives, it seems to me, to get extra fees for peripheral services—that is an accusation, so I don't know that. But the big

cost variance, it seems to me, is this 1 to 15 days in the hospital to fix something or because somebody gets much sicker than just the routine dialysis.

Dr. BLAGG. A significant part of that relates to blood access surgery. That accounts for one-quarter of all hospitalizations.

Mr. STARK. Shouldn't we do these test programs first before we jump into that? I don't know that all HMOs are qualified to jump into this—a very small number of our population have it and I am inclined to agree. We pretty much have a capitated rate for dialysis.

The question is how do we take care of these peripheral things and I think all three of you—I wish I could talk more with you about the programs, but it does seem to me that we are not talking about dialysis, but other treatments that people receiving dialysis get.

Dr. BLAGG. I agree. I feel strongly. Do the demonstrations, and see whether capitation works, see what the problems with it are before making any radical changes in the reimbursement system.

Mr. STARK. Thank you.

Chairman THOMAS. The gentleman from Nebraska.

The gentleman from New York.

Mr. HOUGHTON. I would like to ask a couple of questions. Maybe, Dr. Blagg, you could sort of break this down a bit—you are for capitation, yet you are not for it on a short-term base. That always can be so, that there have been innumerable tests on this and I don't know why we can't move forward on it with full confidence.

Dr. BLAGG. I am concerned that at this point we are only learning the ways to really manage quality control in this program, and that to disturb the whole system by going to full-scale capitation now would cause more problems than it would solve.

I would like to see us really in control of quality first and seeing that we have a capitation system that will do the things I mentioned like ensuring that patients have appropriate access to different treatments, ensuring that patients have access to choose capitation in a way that prevents, if you will, skewing of the patient population, and so forth.

The RAND study gave good information on the financial implications of capitation as of 1990. What it did not do was spell out in detail how to do the mechanics of the process.

Mr. HOUGHTON. I understand that, but I want to push you a little bit on this because you will have one study, develop studies. You will have something you feel is reasonably satisfactory. You will have a policy and move into it and then something else will come along. It is inevitable. It is not an end result. It is a process of constantly understanding what the quality is. Why isn't the quality sufficient now?

Dr. BLAGG. I think there are a number of reasons why there are problems with quality, but it is a lot better than it was 5 years ago. At that time, American nephrology in general was concerned about shortening the time that patients were on dialysis, and Americans don't like to sit around longer in the dialysis unit than they need to. This helped in terms of costs. It helped to cut the costs so there were more profits, more margin if you are a nonprofit organization.

At that point, we didn't know enough about what were the right measures to judge quality. We now have some handle on this and things are improving. But I would be very concerned to make a big change to capitation at this time.

Mr. HOUGHTON. I would respect that. Let me get into another area with some of the big economic forces involved, because you have the balancing of care and cost. It is going to be a constant issue. But our job now is to try to make sure we are doing the right thing for the next 20 years rather than just sticking with a system which has been pasted together and is certainly not very efficient and enormously costly.

What are those things which we can impact here? There is capitation, competition, early detection in terms of wellness programs, and basic knowledge about families and lifestyles. If there were one or two big economic thrusts that we could make assuming that the care was going to be there, what would you focus on? Maybe the other gentlemen would like to comment also.

Dr. POWE. I think the issue of prevention of this problem is an area that has been neglected. Although we know that diabetes and high blood pressure cause kidney failure, we don't have a clue as to why some individuals with diabetes or hypertension go on to develop kidney failure. We need to understand that better so that we can develop interventions that will have an impact on that.

Mr. RETTIG. I demur slightly from that. I don't think there are major opportunities for prevention. That issue has been on the table for 30 years and is dependent on medical science making a big bite into hypertension and diabetes.

At the present time, the way we are controlling those diseases we may be increasing the pool of individuals who live with those problems and who then have extended lives during which their kidneys fail. I don't think there is a big economic bang for the prevention buck to be had until medical research gives us far more knowledge.

Mr. HOUGHTON. If we had a system, which we don't have and probably will never have, that required everybody to take a medical examination every year, and we understood not only the obvious results of that, but also delved in a little bit about eating, lifestyles, drinking, smoking, and elements of the family background which might be conducive to certain things, that wouldn't help? That wouldn't help in the prevention?

Mr. RETTIG. If it were massive and controlling.

Mr. HOUGHTON. But I mean——

Mr. RETTIG. Sure it would help, but at the margins. You are talking about behaviors that have to have changed 20 years before somebody manifests kidney failure. What do you do——

Mr. HOUGHTON. Or basic family knowledge.

Mr. RETTIG [continuing]. When you reason with your young daughter about the cost of smoking, if you haven't been through that, I can tell you I have, about the long-term cost of smoking. When somebody figures that one out, how to be persuasive, then come back to diabetes 20 years before the presentation of kidney failure.

Mr. HOUGHTON. It just seems to me that there are an awful lot of innocent people out there who try to live a decent life and ulti-

mately pick up the check for people who could have been helped earlier if some detection and wellness program had been out there for them.

Mr. RETTIG. The intersection with the low-income population of this country suggests to me primary care and universal coverage in that area would cut deeply into manifestation of problems that need expensive treatment down the line. That is my personal view and I can't document it, but I think we have to begin to think along those lines.

Dr. BLAGG. I am in agreement with Dr. Rettig. I believe that if we were to give better care before these patients come to dialysis, we might make marginal savings. The patients might not be as sick when they start dialysis, might not need as much hospitalization at that time. But even if we can slow the onset of dialysis by diet and the other efforts we make, patients are still going to end up getting kidney failure. So, you slow the process but the end result is the same.

Chairman THOMAS. It is always tough wrestling with mere mortals. We are talking about an organ that is kind of like a fuel filter and eventually it simply fails. It is not like smoking-lung cancer. You don't have that kind of a connection.

I agree with you, the value expended certainly would create quality of life in a number of other areas, but it wouldn't necessarily change the fact that at the end they would wind up with kidney failure.

Dr. BLAGG. If we all live to be 150 we will all get kidney failure.

Chairman THOMAS. Eventually that part is going to wear out.

The gentleman from Texas.

The gentleman from Illinois.

The gentleman from Georgia.

Mr. COLLINS. I am not going to take but just a moment, Mr. Chairman. My concern is in the area of quality of care. You probably heard when I was questioning Mrs. Smits about the particular situation of a center in Georgia. The Rand study was based on Medicare recipients; did I understand that right?

Dr. BLAGG. That is correct. They took the financial data on all Medicare recipients for the year 1990.

Mr. COLLINS. Are all kidney dialysis patients under Medicare?

Dr. BLAGG. Dialysis and transplant patients for 1990. They excluded a very small number of patients for lack of information or other reasons, but it was something on the order of 190,000 patients as I recollect it.

Mr. COLLINS. But are all patients with this problem under Medicare or are they private pay?

Dr. BLAGG. The estimates they made included the private pay portion, too. They calculated that.

Mr. COLLINS. You did include private pay?

Dr. BLAGG. Yes.

Mr. COLLINS. Are there any variances in the private pay versus Medicare?

Dr. BLAGG. I can't tell you the extent of this. There would be differences, because dialysis facilities may charge private payers more than they charge Medicare.

Mr. COLLINS. That is—what about in the area of service? Quality of service; would you say there is a difference in private pay versus Medicare in quality of service?

Dr. BLAGG. I don't think so because the same facility may be billing primarily private payers for some patients and billing Medicare for other patients. I don't think there is any difference there.

Mr. RETTIG. If I could interject, 92 or 93 percent of the American public are covered for kidney failure under Medicare under the Social Security statute. The remaining less than 10 percent are those with no work history. They are not fully or currently insured under Social Security.

Private pay, in effect the Medicare secondary payer is a cost-shifting mechanism. One rationale is to take the cost of the ESRD Program off the Federal budget and put it on private pay in the expectation that the private payment rate is higher. But it is the same set of facilities doing it and it is a time-limited thing on private pay. One comes back to the issues of measuring quality in precisely the same way that one began.

Mr. COLLINS. Ninety-two percent you say are under Medicare. That is an interesting——

Mr. RETTIG. Fully or currently insured.

Mr. COLLINS. That is an interesting shift from private insurance to government so-called insurance.

Mr. RETTIG. The ESRD entitlement is the nearest thing we have to universal health insurance in this country—fully or currently insured under Social Security, diagnosis of chronic renal failure, and you apply for benefits.

Dr. BLAGG. In 1973 when the legislation was passed, many patients either didn't have insurance or their insurance didn't cover renal disease, and Americans were dying from a disease that was potentially treatable. That is why Congress, in its wisdom, decided to fund this program not realizing what a Pandora's box they were opening.

Mr. COLLINS. Yes, it did open quite a Pandora's box, because if you take that $40,000 annual figure that is per patient under Medicare and you extend that by an average annual earnings of around $50,000, at 3 percent you are talking about 5.2 million working people earning $50,000 a year to cover the cost of those 200,000. An interesting figure.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. I have questions that have been presented in other testimony. Dr. Blagg, you indicated that you thought there should be more hemodialysis at home. Has there been a change in technique, equipment, or knowledge that would lead you to believe that?

Dr. BLAGG. There is a potential for new equipment that I think will become available for testing within the next couple of years. This will enable patients to do hemodialysis at home without an assistant. We continue to do a lot of home hemodialysis in Seattle because we actually use our surplus funds to pay for assistance for patients to do hemodialysis at home. We think this is the best treatment. I think that 5 years from now we will see a significant increase in the use of home hemodialysis with new technology.

Chairman THOMAS. On the first page of your statement you indicated you are waiting for publication of the request for proposal from HCFA for this demonstration project before you decide whether or not you are going to respond to try to participate in it. What are you looking for in the proposal?

Dr. BLAGG. I want to see what HCFA is going to require. I don't know what they are going to propose. I have to look at a study from the point of view of a large dialysis program working with a lot of physicians. We have a large HMO, Group Health in Seattle. I have to look at the whole picture before deciding that I want to recommend to our board of trustees that we take part in this study. It is very interesting, but I don't want to do anything that would jeopardize our program in any way.

Chairman THOMAS. I understand HCFA is responding to a 1993 requirement for the demonstration project. Are we late in this? Should we have done this 4 or 5 years ago or is the timing pretty good because of changes that have been made? How good is this timing?

Dr. BLAGG. I think the timing has been reasonable. It has taken HCFA some time to actually put together its request for proposal. But perhaps time is important so they can do this properly.

Chairman THOMAS. My problem with demonstration projects is that once you start them you have to wait until they are concluded, then you have to examine the evidence and make some timid decisions. I was shocked, yesterday I was turning the channel and came on CNN in which there was an interesting news piece on patients suffering from ALS and that apparently there has been a secondary benefit from perhaps a drug given to hemophiliacs, but a drug that was not necessarily prescribed directly for ALS and they had been communicating with each other over the Internet and had begun some self-experimentation on dosages not run directly through doctors.

One of my worries is, I was listening to the discussion about demonstration projects and producing information and moving in an old-fashioned way in a slightly different world, that we may lose control if we do not move more rapidly. What I heard several times was we ought not to go into attempting to finance in different ways the clear need for a different financing structure until the demonstration project has concluded.

I guess my answer is, why not, if we have some minimum evidence that we can make a shift, we can make that shift and can then change later. I am not naive in thinking that we can't just go in and out of a structure, but it seems to me we are going to have a clear indication of the direction we need to move and we ought to begin moving in that direction. Perhaps we should begin moving and utilize the demonstration project as a finalizer in terms of the ultimate relationship between the new funding mechanism. Any reaction?

Dr. BLAGG. The Medicare ESRD Program to this point has probably been the most cost effective of all Federal programs as shown by the data that Dr. Smits presented and ratio of the cost of the end-stage renal disease population to the general Medicare population. I am sure there aren't any other programs that have been as effectively, so I don't see the urgency that you do capitation. If

you start the demonstration project, say, in 1996, maybe by the end of 1997 or 1998, you are going to at least know where it is going and what the problems are.

Chairman THOMAS. I don't feel a sense of urgency in terms of need to move, but this seems to be one of those in which it ought to lend itself more to a managed care structure and it doesn't in part because of the financing. If we could make some adjustments there, we might, in fact, get better quality for the same dollar.

Dr. BLAGG. I think that is correct. The more managed coordination of care is what will improve this, but capitation is an innovation to most of the ESRD population and their physicians, and we need time to get used to it.

Dr. POWE. I think we need to learn from this demonstration and learn to do this right, and I think the demonstration is going to be very useful in regard to how to construct a fully capitated program from an organizational perspective across this country. I am concerned it may not work in some areas of this country and things could be bad.

Chairman THOMAS. Dr. Powe, if you will comment briefly on the question of drugs versus mechanical intervention. Has it limited the ability to move more toward drugs because of the cost? Or, is it the treatment question? What is the cost effectiveness in terms of use of drugs versus dialysis?

Are dollars and cents because of the cost of drugs affecting that at all, or is it that it is very limited range treatment capability?

Dr. POWE. I should make this clear; the drugs that we are referring to are not used to dialyze the blood so they are not a substitute for dialysis. These are drugs——

Chairman THOMAS. There could be a maintenance aspect to it.

Dr. POWE [continuing]. These are drugs to maintain other conditions which occur in association with kidney disease.

Mr. RETTIG. Mr. Chairman, I have two comments in response to your question. I am not a big fan of demonstrations. I wrote a paper that demonstrations are anecdotes for action quite often and your concern for not wishing to wait seems to me quite appropriate. However, it is possible to conceive of the ESRD Program with this chronic population as a marvelous test bed for doing lots of things conceptually, doing a probe in the managed care environment here and doing something else there. That takes a certain amount of organizational skill and some efforts, but you can theoretically approach that.

Practically, I yield to others on how feasible it is to use the program in this way. I will say, regardless of the financing mechanism, you need a quality assessment, quality assurance system in place. I was here 2 weeks ago when Dr. Brook testified before this Subcommittee on quality and said quality can be measured, quality can be measured.

The arguments that I have made this morning are, I believe, the direction I think the quality system has to evolve regardless of whether it is financed by capitation or an extension of the current program.

Chairman THOMAS. Last, because some people may not fully appreciate the difference between the heart and a kidney, one is a pump and the other is a filter and we have been much more suc-

cessful in artificial hearts than we have in artificial kidneys. In fact, we have those, except the machines are so large they aren't very portable.

Are there any opportunities from your folks' perspective in the next 5 to 10 years to have breakthroughs, technology or combination of drugs and technology to get people away from a triweekly need to tie themselves to a machine? Are we looking at where we are going to be for perhaps the next decade or so? What is the cutting edge on kidneys?

Dr. BLAGG. I think there are several things. New equipment will make home hemodialysis more practical, which will be very beneficial to some patients. I suppose it is feasible that within the next 5 to 10 years we may have a wearable artificial kidney. It isn't necessarily a bad thing to dialyze longer or more frequently. There is a study in Canada going on in which patients are dialyzing themselves every night with wonderful results. A very small number of patients are doing this at home.

Of course, when you get down to it, the real answer is to have more kidneys donated and do more transplants. We are also waiting for this xenotransplantation—taking kidneys from other species, probably pigs, and using these for transplants. It may take 5 or 10 years before this becomes practical. But when it does, the whole situation changes.

Dr. POWE. Peritoneal dialysis is a form of dialysis that doesn't require the patient to go to the facility three times a week. Currently, only about 17 percent of patients in this country receive peritoneal dialysis. We don't understand the reasons for that. Some are medically unsuitable for peritoneal dialysis, but this is a modality that should be explored in greater detail.

Chairman THOMAS. Any other questions? I thank the panel very much.

The next panel would come forward, Dr. Latos, Mr. Sims, Ms. Wish, Mr. Bowden, and Dr. Ludin, I believe.

Any written statement you have will be made a part of the record. We will start with Dr. Latos and move across.

STATEMENT OF DERRICK L. LATOS, M.D., PRESIDENT, RENAL PHYSICIANS ASSOCIATION

Dr. LATOS. Thank you. Good morning, Mr. Chairman and Members of the Subcommittee. I am Derrick Latos. I have been a practicing nephrologist in Wheeling, West Virginia, for 18 years and currently serve as president of the RPA, Renal Physicians Association.

I would like to thank you for the opportunity to testify, and I welcome the Subcommittee's interest in reviewing the ESRD Program. I would like to offer the RPA's resources in assisting you in drafting policy designed to improve an already excellent program.

I had prepared something more specific for my oral testimony, but much of what I had prepared has already been discussed in detail. What I think I would like to do is to highlight some issues and leave what time is available to address some comments and questions from the panel.

One interesting feature of the Medicare ESRD Program that is unique among all other programs for Medicare is that this program

provides comprehensive care, which includes specialized dietician and social work services for both patients and their families.

One of the concerns that the Renal Physicians Association has as well as others is that in privatizing the Medicare system, we are very concerned that various health plans may consider some of these services as extras and not really germane to the specific medical therapy. There is considerable data already in existence in the published literature that shows the valuable input of appropriate and timely nutritional intervention.

In response to some of Dr. Rettig's comments, we would agree that the quality assurance programs in the Medicare ESRD Program are very unique, and it is our feeling that they have not been and probably cannot be replicated by private industry.

A big concern that we have heard discussed many times today is how do we save money yet assure the quality of care that we are trying to deliver today. It is clearly realized that much of the growth in ESRD expenditure is due simply to the increase in the number of people receiving this lifesaving therapy, which is both dialysis and transplantation, but at the same time it is incumbent upon the provider community, as well as Congress, to maximize efficiencies while continuing to improve the quality of the program.

We have heard ample testimony this morning attesting to the very high cost of hospitalization for this generally sick, older, and complex population of individuals. There is no question that many hospitalizations for dialysis and transplant patients may be preventable, and many cannot. One of the major reasons for hospitalization has to do with vascular access complications.

People undergoing chronic dialysis need to have a way of circulating their blood into the artificial kidney. I would point out for the record that several months ago the Renal Physicians Association met with staff from HCFA and presented data that suggested that considerable savings could be realized if the use of a therapy to dissolve clots in some of these vascular grafts, if that were made available and then reimbursed as an outpatient service, then many hospitalizations could be shortened and sometimes prevented.

We don't have data to show what has happened yet, but we certainly appreciate the position HCFA took that changed the reimbursement policy. We think that will clearly improve the outcomes for patients in the sense of decreasing their hospital time. We also believe that there will be data to show that costs have been substantially decreased with that.

Another critical issue, we believe, is that there must be strengthened efforts to educate renal physicians and other providers regarding issues that assure the delivery of cost-effective dialysis and transplant care. The use of practice guidelines such as those recently developed by the Renal Physicians Association, which deals with the adequacy of hemodialysis, will in fact have a measurable beneficial effect on patient outcomes.

Other guidelines already in development will help to assist practitioners in selecting patients for renal replacement therapy which is very much needed, as well as in the appropriate use of expensive, but necessary technological advancements.

We are aware of the growing interest in utilizing managed care programs for Medicare beneficiaries, including those with end-stage

renal disease. The nephrology community has had 20 years experience in dealing with a capitated approach to health care and the RPA is conducting an extensive analysis of the effects of current and proposed capitation systems for nephrologic care, including dialysis and transplantation. We will be developing additional innovative approaches and look forward to sharing our views with the Members of this Subcommittee and others.

We feel there are other areas for important potential cost savings for the ESRD Program and that some of these need to be examined in much more detail. We have not heard a lot yet, but we need to identify and enhance the identification of basic mechanisms of diseases that cause kidney failure.

There needs to be improvement in the detection and management of renal disease in its early phases, and I would be remiss if I did not comment on the role of the nephrologist and the other members of the renal health care team in early intervention and involvement.

The issues of managed care that sometimes tend to keep the specialist, including nephrologists, away from the patients until an advanced stage when clearly dialysis is the only option, needs to be examined, and we have in fact published some information on this and would look forward to further testimony.

Finally, the development of more effective strategies in the treatment of ESRD needs to be examined. There are already studies doing that, but we think there needs to be more.

Last, I offer a suggestion that programmatic improvements must also provide stronger rehabilitation initiatives since excellent dialysis care and successful renal transplantation are only the bare essentials for restoration of an individual with ESRD to a healthy productive life, and that is the kind of life envisioned by Congress 20 years ago when they put this program together.

That concludes my oral comments. I would be happy to answer questions.

[The prepared statement follows:]

STATEMENT OF DERRICK L. LATOS, M.D.
PRESIDENT
RENAL PHYSICIANS ASSOCIATION

April 3, 1995

INTRODUCTION

Good morning, Mr. Chairman, members of the Subcommittee. My name is Derrick L. Latos, MD. I am a practicing nephrologist from Wheeling West Virginia and I am the President of the Renal Physicians Association (RPA). RPA is a professional organization of nephrologists whose goals are: to insure the optimal care under the highest standards of medical practice of patients with renal disease and related disorders; to act as a national representative for physicians engaged in the study and management of patients with renal disease and related disorders; and to serve as a major resource for the development of the national health policy concerning renal disease. The RPA would like to thank the Ways and Means Subcommittee on Health for this opportunity to provide written and oral testimony. RPA's written statement will focus on many of the issues that are currently affecting the renal community, especially in light of the increasing expenditures and numbers of patients in the ESRD program. We are very aware of the critical budget constraints that our country as a whole is facing. We also recognize Congress' function in examining the federal role in caring for ESRD patients as well as Congress' desire to promote competition among medical providers in order to cut costs and improve delivery of medical care. Because of this concern, we welcome this chance to provide the Subcommittee with our views on all facets of the ESRD program.

OVERVIEW

In 1991, more than 230,000 people were treated for end stage renal disease (ESRD), the vast majority under the Medicare program. Between 1984 and 1991, the number of ESRD patients doubled–to one patient per 1,387 U.S. residents–and the number of ESRD patients is expected to double again in the next seven years, according to an estimate from the United States Renal Data System (USRDS). The incidence of ESRD continues to rise at a rate of over 8% each year. The number of new program enrollees exceeds the number of deaths by an increasing amount: from +10,000 in 1982 to +17,000 in 1991. The prevalence of ESRD in elderly individuals has increased at a greater rate than in the population as a whole: Currently, more than 30% of all dialysis patients are over the age of 65. Minorities are four times as likely as non-minorities to develop chronic renal failure, and, on average, they are younger at the onset of disease than are non-minorities.

In 1991, the total direct cost of ESRD was $8.6 billion. Of this amount, the federal government paid $6.15 billion, or 72%. Medicare payments for ESRD are growing approximately 5% annually in constant dollars, with virtually all of the increase attributed to the increased patient population. Reimbursement rates paid to providers per dialysis treatment have actually declined when adjusted for inflation. The RPA believes that the greatest potential for reducing the high costs of chronic renal disease will be found by identifying basic mechanisms responsible for the disease and devising better, and more cost-effective strategies for treatment.

PRIVATIZATION OF THE ESRD PROGRAM

It is RPA's understanding that several Members of Congress, health policy analysts, economists, and even some members of the renal community, believe that the ESRD program should be "privatized". By privatization, we understand this to mean that the federal government could be charged with providing vouchers for patients with ESRD who would then be able to choose a health plan to take care of their renal-related needs. Under this scenario, the continued existence of the ESRD program would be in doubt.

Presently, the RPA has not take a position on this issue. However, we would like to point out some of the inherent difficulties this approach would face.

Although some managed care companies have stated that they would be interested in covering the health needs of the ESRD patient, we believe that at closer inspection, many insurance companies are likely to balk at the very high prices of covering the ESRD population. As a 1991 Institute of Medicine Report noted, according to 1987 data, the average annual expenditure for a

typical ESRD patient was $32,000. Estimates of the cost for caring for an ESRD patient today are more than $50,000. Assuming that health care companies still decide they would like to cover ESRD patients, it is reasonable to conclude that premium increases will have to be spread to other policy holders. These increases would differ by geographic area, thus penalizing some policy holders and not others. This would provide employers with a disincentive against hiring individuals with ESRD because of the extra cost of insuring the ESRD patient and the extra costs of insuring their remaining employees.

RPA fears that insurance companies competing for dialysis business would attempt to find the lowest common financial denominator, paying at rates below what Medicare pays today. Cost of care will become the predominant concern of the insurance company. Unlike the current ESRD format, where patients have the ability to choose their nephrologist, health plans would instead contract with nephrologists on a lowest cost-of-care basis. Thus, many patients would have to terminate existing physician relationships. Also, because health plans would contract with a limited number of physicians to provide dialysis, there would be a corresponding decrease in the number of dialysis facilities available to the patient for his or her dialysis treatments. Easy access to these facilities is critical to the successful treatment of the ESRD patient, who is often too sick to travel great distances. It seems doubtful that large health plans would take this geographic factor into account when enrolling physicians in their dialysis panels. ESRD patients are inherently different from other health plan enrollees. Individuals with renal failure are older and sicker than the general population and without access to dialysis treatment, they simply will die. Because of the life-threatening nature of their disease, ESRD patients can not be treated in the same manner as other health plan enrollees who are healthier and not in constant need of a physician's care.

RPA is also concerned that insurance companies could be tempted to develop treatment guidelines which would exclude coverage for ESRD patients with unusually complex comorbid conditions such as cancer or diabetes. This could lead to a situation similar to the period before the ESRD program began, when patients often were chosen for dialysis on the basis of their age, emotional stability, and chances of continued production to society. Before 1972, minorities, women, and low-income individuals were underrepresented in the dialysis recipient community.

Currently, Medicare is the only program offering comprehensive care for ESRD patients, including, in addition to, dialysis, nutritional counseling, psychological counseling, assistance in finding support groups, and other services. RPA is concerned that health plans, on the other hand, could place limits on the amount of dialysis treatments allowed, or place a monetary cap on the cost of care, similar to the way mental health benefits are treated. Such limits or caps would threaten medically necessary care for ESRD patients.

Also, under the ESRD program, the ESRD Network Organization and the United States Renal Data System (USRDS) exist to oversee the quality of care provided to ESRD patients and these groups work to improve health care outcomes. Under a system fueled mainly by private insurers, it would be very difficult to continue with such an effective oversight program. As is becoming increasingly clear, quality assurance systems are critical to the proper delivery of dialysis care. Insurance companies do not have the capabilities to provide the intensive quality agenda already being pursued by the ESRD program.

Current managed care practice encourages primary care physicians to "gatekeep" and may even have financial disincentives not to refer patients to specialists. Direct access to a nephrologist is essential to ensure quality care for patients with chronic renal disease, and patients with acute renal disease.

RPA also believes it is important to view "privatization" in the political sense. The ESRD population is one of the most vulnerable segments of the country. They are chronically ill, older, and in many cases, minorities. Very likely, a two-tiered system of care could result, with poorer patients enrolling in cheaper, and correspondingly lower quality health plans, while wealthy patients would be able to access fee-for-service plans. The ESRD program, on the other hand, has been very successful in keeping patients with ESRD alive, and has kept ESRD expenditures to a minimum. RPA anticipates that creating a nation-wide voucher system affecting this sick patient population would undermine the program's success and could have serious health ramifications in the future.

PATIENT POPULATION

The number of patients in the ESRD program has grown substantially over time, increasing from approximately 10,000 beneficiaries in 1973 to nearly 250,000 today. The ESRD population is diverse in age, sex, race, and has changed over the time span of the program. Increasingly

ESRD has become a disease of racial minorities and the poor in America. While African-Americans make up only 13 percent of the country's population, this group accounts for 35 percent of the dialysis population. An additional 5 percent of the patients are Latino or Native American. Further, many patients with ESRD are people who are financially disadvantaged even before they develop ESRD. Twelve percent of the dialysis population under age 65 has no insurance coverage at the time of ESRD, and 20 percent of the ESRD population depends on Medicaid for insurance coverage. Several investigators have shown a statistically significant correlation between renal failure and finances, such that increasing poverty is associated with an increased prevalence of ESRD. Complicating these trends is the limited access to medical care in rural areas. Five of the six ESRD Networks that report the greatest incidence of ESRD are composed of rural states, where geographic access to care may be problematic. These demographic trends are not simply persisting, but in fact worsening.

The ESRD patient population is becoming increasingly older. Before the creation of the Medicare ESRD program in 1972, candidates for dialysis and transplantation were selected for treatment based on subjective criteria. Due to limited resources and the financial barriers to dialysis and transplant care, candidates for ESRD treatment were generally under age 65. This is reflected in the fact that those over 65 accounted for only 5 percent of total enrollment in the program in 1974. However, this quickly increased to 11 percent in 1975, climbed to 18 percent in 1978, and by 1988, those over 65 made up 38 percent of the total ESRD population. Thus the incidence of treating renal failure is much higher among the elderly than the general population. The proportion of elderly patients among those being treated for ESRD continues to increase, perhaps in part because medical technology keeps patients alive longer than in the past. It should be noted that the growth among the very old ESRD population is also striking. Among those 85 and older, new ESRD patients increased by 18 percent annually between 1978 and 1988.

Elderly ESRD patients are also sicker than their younger counterparts. Diabetes and hypertension account for an increasing proportion of cases. In 1978, among new elderly ESRD patients with a specified diagnosis leading to renal failure, 16 percent were diabetic and 38 percent were hypertensive. By 1988, these proportions had increased to 29 and 42 percent respectively. Elderly patients generally arrive at permanent kidney failure with more comorbidity than younger patients, including unstable hemodynamics, vascular disease, and impaired function. In particular, elderly diabetics exhibit the comorbidities typical of that disease, including visual problems, neuropathy, and amputations.

In sum, the ESRD patient population has become increasingly older and sicker, and these trends are expected to continue throughout the 90's. The needs of these patients therefore are greater than ever before and provide nephrologists and their staffs with great medical challenges.

ROLE OF THE NEPHROLOGIST

Because of the increased penetration of managed care in the health system, defining the role of the nephrologist has become increasingly important. Primary care physicians have shown hesitancy to assume responsibility for the overall medical management of end-stage renal disease patients. They have, as a rule, relinquished this responsibility to the nephrologist who is specifically trained to address the unique technology related to dialysis and the unique medications related to renal transplantation.

Some managed care providers have tried to reduce the role of the nephrologist in the care of the end-stage renal disease patient. Most primary care physicians, however, are not trained to treat the complex multi-system medical problems usually seen in end-stage renal disease patients, are unfamiliar with the particular medications and technology prescribed for such patients. They would also prefer that the nephrologist provide general medical care, as the nephrologist is most likely to see the patient frequently on dialysis or in transplant follow-up, and address the patient's problems as a part of those interactions.

Furthermore, as a rule, the pre-dialysis patient requires interventions that are unfamiliar to primary care physicians. The role of the nephrologist for a pre-dialysis patient involves an initial consultation for diagnostic purposes related to the etiology and natural history of the patient's renal disease and global recommendations for management. The nephrologist is then re-consulted as the patient approaches end-stage renal disease so the patient can be "plugged into" the system for dialysis or renal transplantation. If care of the pre-dialysis patient is provided exclusively by the primary care physician, the nephrologist may not have an opportunity to evaluate the patient until the patient is near end-stage or, in extremis, thus requiring the urgent initiation of renal replacement therapy. When the opportunity to evaluate options for the treatment of end-stage renal disease is made available earlier, the patient can weigh alternatives while in a

healthy and stable condition, and perhaps with the intervention of the nephrologist, avoid or delay the eventual development of ESRD.

Early nephrology referral is consistent with increased emphasis on preventive care to improve outcome and to decrease costs. An early provision of nephrology care for the patient with chronic progressive renal insufficiency would yield great dividends in terms of quality of care, improved outcome, and cost containment.

Scope of Practice

The nephrology subspecialty may be defined as a hybrid discipline. Under certain circumstances, nephrologists function as primary care physicians, while in other circumstances they serve as uniquely skilled subspecialists, which includes active participation on pediatric or adult critical care units.

There are three categories of patients with renal disease for whom nephrologists serve as primary care physicians:

- children or adults who have mild or moderate chronic renal failure and are treated in an ambulatory setting prior to their entry into the ESRD Program; that is, for treatment by dialysis and/or transplantation. These patients with chronic renal failure may have renal disease from immune origin, as in many forms of glomerulonephritis; from infectious disease, as in chronic pyelonephritis; from heredity disease, most notably polycystic kidney disease; from hypertension or diabetes; and from other causes. The need for nephrologists' active involvement in patient care early in the course of renal disease is emphasized by a recent publication dealing with complications at the time of initiation of dialysis therapy. Those patients seen and followed by nephrologists early in the course of their renal disease had much better blood pressure control, were less anemic, and enjoyed better nutritional status than those referred late. All those referred late were in pulmonary edema, required emergency creation of vascular access, and the need for and length of hospitalization at the time of initiation of dialysis was two and six times greater, respectively, than for those referred earlier to nephrologists. This study underscores the critical need for a greater number of properly trained nephrologists to serve as primary care physicians or to provide care in collaboration with the referring physician to this expanding patient population.

- patients who have kidney or kidney-pancreas transplants are given long-term care by the nephrologist, particularly the transplant physician. There is very powerful evidence that, when these patients receive treatment from transplant physicians instead of non-experts, both patient and graft survival are positively affected.

- individuals receiving chronic dialysis, either hemodialysis or peritoneal dialysis.

The outpatient activities of nephrologists account for well over 90% of the billings of most nephrologists. However, in tertiary or referral medical centers, ambulatory nephrology practice may account for a smaller percentage of nephrology billings. Thus, the main portion of the nephrology practice is providing for the ongoing medical needs of patients with renal disease.

Nephrologists also serve as **subspecialty consultants**. The principal groups of patients for whom nephrologists serve as subspecialty consultants include:

- Patients who develop acute renal failure, often due to acute tubular necrosis, in an in-hospital setting.

- Hospitalized patients who develop electrolyte abnormalities.

- Hospitalized patients who develop hemodynamic imbalances either because of cariogenic factors, renal factors, or, in certain instances, iatrogenic factors resulting in a low urine output and reversible renal failure.

- Pregnant women who are at high risk -- most notably, those with pregnancies complicated either by urinary tract infection, hypertension or pre-eclampsia; patients who have chronic renal failure or who have received transplantation, who become pregnant; and diabetic patients, particularly those with Type I diabetes mellitus, who become pregnant.

- Patients who develop severe metabolic bone diseases as a complication of their renal disease or other factors.

- Renal stone disease

- Evaluation and treatment of edematous states
- Complicated hypertension, resistant to standard treatment
- Evaluation of hematuria and proteinuria

In all these instances, nephrologists provide either direct care or consultative care to patients with significant, and often life-threatening, illnesses. These patients are provided nephrologic care in various settings, including outpatient offices, acute care medical and surgical hospital beds, and critical care units.

Therefore, a nephrologist is a hybrid physician, who serves as a primary care physician in certain instances, and as a subspecialist in others. RPA believes that nephrologists should remain the primary care physicians for ESRD patients who are treated with dialysis or transplantation. Such an arrangement will provide for optimal patient care, better outcomes and likely less expense.

ERYTHROPOIETIN

RPA does not agree with the concept that reimbursement for Erythropoietin (EPO) should be bundled into the Medicare ESRD composite rate. It is RPA's belief that there is no clinical or quality-assurance reason to bundle EPO payments into the composite rate

EPO is a hormone produced by the kidney which is necessary for the body's production of red blood cells. Patients with kidney failure produce an inadequate level of EPO which results in anemia. Epotin, a bioengineered form of EPO, is administered to these patients in order to maintain the proper level of red blood cells. The EPO drug is currently reimbursed by Medicare at a rate of $10 per 1,000 units. This reimbursement policy is the most rational method available and the safest for the patient because it allows the nephrologist to prescribe EPO solely on the basis of the patient's need.

We believe that a primary motivation behind the proposal to bundle EPO into the composite rate is financial. Large volume providers of the drug can purchase EPO from the manufacturer at a discount. If EPO is bundled into the composite rate, large volume providers will be able to increase their financial return because of their buying power, thereby creating a disparity in financial returns between large and small distributors.

It is also our understanding that there is an interest in bundling EPO reimbursement into the composite rate in order to provide an economic disincentive against over-prescribing the drug. The perception that EPO is being over-prescribed is based on HCFA data which demonstrates that EPO dosing has continuously increased per patient while the average hemocrit (a marker of the degree of anemia) has remained flat. If this is the case, then the question of why patients are becoming resistant to the effects of EPO should be addressed by quality assessment and quality improvement methodologies, not economic disincentives.

Similarly, RPA is aware that anecdotal evidence exists regarding overdosing of EPO. However, a policy decision on bundling EPO into the composite rate should not be based on such assertions, rather, should be made after data has been collected and a scientifically accurate solution developed. The RPA is currently exploring different statistical models and other data driven studies regarding bundling and capitation of dialysis services, including EPO dosing, in order for the renal community and policy makers to come to such a solution. Additionally, the Health Services Quality Bureau and the renal Networks are planning a study on the quality and cost effectiveness of EPO. Therefore, RPA believes that a decision to bundle EPO into the composite rate would be pre-mature at best until proper data has been collated and analyzed. Once this has occurred, a scientifically accurate policy decision can be made.

PHYSICIAN OWNERSHIP/SELF-REFERRAL

As the Subcommittee is well aware, the Omnibus Reconciliation Act of 1993 (OBRA 93) contained language expanding the original self-referral prohibition to certain other designated health services. Among these designated health services was the listing "inpatient and outpatient hospital services". This language would prohibit situations where a nephrologist contracts with a hospital to provide its inpatient or outpatient dialysis services if the nephrologist (or group of nephrologists) had a financial interest in the dialysis service. This prohibition effectively hampers the continuum of care that nephrologists provide to their dialysis patients and it may have an adverse affect on a patient's access to inpatient dialysis. We ask that you work to fix this problem to ensure that dialysis care is not impeded.

The principal concerns underlying the self-referral prohibition language of OBRA 93, inflated charges and unnecessary utilization of services, do not apply to inpatient dialysis services. Most inpatient dialysis services are furnished to End Stage Renal Disease (ESRD) patients who are Medicare beneficiaries and are therefore covered by Medicare through the Prospective Payment System (PPS). Under this system, the hospital receives a fixed amount of reimbursement to cover all services furnished to an inpatient. Thus, opportunities for increased costs to governmental payors as a result of inpatient dialysis contracts involving nephrologists are virtually non-existent.

Similarly, over-utilization is not an issue. Again, most patients requiring inpatient dialysis have ESRD. Dialysis is a treatment that is prescribed for those with irreversible kidney failure who must receive regular dialysis to live. Dialysis is not an elective procedure for ESRD patients and its medical necessity cannot be questioned. Once diagnosed, most ESRD patients require dialysis several times a week, for two to four hours per session, for the remainder of their lives. Dialysis is always therapeutic and never diagnostic.

In addition, unlike situations where, for example, a referring physician has an ownership interest in an MRI facility, nephrologists are directly involved in the supervision and care to their patients receiving inpatient dialysis. Indeed, this provision of dialysis services is simply an extension of the nephrologist's practice.

Prohibiting large numbers of inpatient dialysis contracts involving nephrologists will have untoward, adverse patient care consequences: Given the fact that inpatient dialysis contracts are very common in the industry, the question will become: who will assume the responsibility of providing these services? Many hospitals do not provide inpatient dialysis and often lack the expertise and desire to do so. Non-nephrologist entities could assume a greater responsibility for providing this service. However, it is questionable whether these entities could assimilate all, or even a significant part of, the potential new arrangements. More importantly, it is undesirable from a patient perspective to bifurcate the responsibility of professional inpatient nephrological care and the technical components of inpatient dialysis, placing the latter in the hands of non-physician controlled entities.

Finally, it should be recognized that the training and support for the conduct of home dialysis is often integrated with inpatient services. Therefore, prohibitions on inpatient dialysis contracts are likely to have a broader negative impact extending to patients' access to dialysis in the home.

Congress agreed with RPA's views on this issue and drafted legislative language exempting nephrologists when they refer patients for any dialysis related services. This language was included in all the major health care reform bills originating in the House, including the Ways and Means bill, the Gephardt bill, and the Rowland-Bilirakis Bi-partisan bill. RPA, as well as many other medical societies would like to work with Congress in order to clarity and improve the OBRA 93 self-referral law. We look forward to this effort.

QUALITY ISSUES/NETWORKS

The RPA and all the members of the Renal Coalition are dedicated to quality delivery of dialysis care. The ESRD program has one of the finest and most comprehensive quality programs in medicine. The spearhead of this quality assurance process is the ESRD Networks.

The End-Stage Renal Disease Networks provide a cost effective mechanism to ensure the most efficient use of Medicare dollars for dialysis treatment and kidney transplantation through monitoring quality of care indicators and maintaining timely, complete data on the ESRD program. These functions are administered at the regional level, providing direct and immediate access from the provider to the Health Care Financing Administration through the ESRD Network.

The 18 Networks are in immediate contact with 2,642 dialysis providers and 241 transplant centers, serving approximately 245,996 patients in 1994. The ESRD Network budget is funded through dialysis payments to facilities.

History. For the first few years of the ESRD program, dialysis services were limited and dialysis programs were run autonomously with no coordination within the national Medicare system. In 1978, The ESRD Network program was designed to provide an oversight system to unite dialysis providers with the common goals of providing immediate access to treatment, treating patients with the quality care through medical standards developed by the scientific community, and helping the patient maintain a quality life which enables each individual to live as a functioning member of society.

Today, the United States is divided into 18 Network regions. Each Network is administered by a governing body made up of representatives of the local dialysis providers. A Medical Review Board, representing the providers, acts as the advisory group on clinical issues. In this way, the Networks benefit from the expertise and leadership of renal professionals, representing outstanding health care and academic institutions throughout the country.

Quality Improvement. RPA believes the effective way to impact care is through continuing examination and evaluation of practice. The Networks impact care by three methods: encouraging quality improvement for all providers, identifying providers in need of assistance in maintaining quality standards: and by conducting intensive special studies of practice areas, using the results to develop practice recommendations.

Continuous Quality Improvement. The 18 ESRD Networks have been involved since 1991 in implementing continuous quality improvement (CQI) concepts into the dialysis setting. These concepts encourage each provider to look at its own program and define areas for improvement, then design action plans to meet these goals. Networks are instrumental in the process by providing in-service training to dialysis staff members, including physicians, administrators, nurses, dieticians and social workers, on what CQI is, how it has worked successfully in industry and in other health care settings. Further, the Networks provide continuing resources and information for the facilities as they design their own CQI programs; and, provide comparative data profiles to allow each facility to assess its performance relative to other providers within the region, state, and nation, and identify areas for improved service. Rather than only seeking the outliers, CQI is employed for all providers regardless of the size of the patient base or quality of care being provided.

When problems are detected with a dialysis provider, the Network begins one-to-one evaluation of the center and its program to help pinpoint causes. The provider is mandated to develop its own plan of action to correct problems. The Networks serve a vital role as a catalyst for improvement by identifying the problem and assisting with solutions. The Networks have had a direct impact in improving these facilities, or in closing them when the providers were unable or unwilling to change.

Data Collection. The Network ESRD data base constitutes the most comprehensive disease specific registry in the world. Networks process and validate all patient data for the Medicare ESRD program. Beside Medicare beneficiaries, this data base includes non-Medicare patients, Medicare secondary and Veterans Affairs patients.

Patient Satisfaction. Patients are the ultimate benefactor of the ESRD Network Program. Working with dialysis providers to ensure quality care means healthier patients, with fewer hospitalizations. But the Networks also work directly with patients in many ways, serving as a clearinghouse of information, and encouraging patients to interact with the renal community.

Grievance Resolution. All Networks maintain a grievance process, enabling the patient to voice concerns about a dialysis provider directly to an objective third party. Monitoring grievances is one way the Network can tract facility performance or be made aware of problems which require further intervention.

Many grievances result from a miscommunication between a facility and a patient. With the Networks acting as an objective third party, most grievances can be resolved quickly.

Many complaints are resolved before they end in a formal grievance. Of an estimated 1,200 patient contacts during 1994, only 106 complaints resulted in formal grievances. This mark of success shows the Networks have developed an expertise in resolving these concerns at an early stage, avoiding major conflicts, and often litigation.

RPA Involvement in quality issues. RPA has been heavily involved in the quality improvement arena. Recently, RPA published clinical practice guidelines on the adequacy of hemodialysis. The RPA noted that in the 1980's, credible data documented a decrease in survival rates of patients undergoing maintenance hemodialysis for treatment of ESRD. This occurred despite advances in dialysis technology. The trend of unfavorable U.S. dialysis survival, documentation of extreme variability in the quantity of dialysis prescribed and delivered, and controversy concerning what constitutes an adequate quantity of dialysis were the stimuli which prompted the RPA to develop these practice guidelines on the adequacy of hemodialysis. The membership of the Practice Guidelines Committee was made up of experts from the entire renal community. The goals of the guidelines were to define parameters of hemodialysis having significant positive and negative effects on patient survival and defining the recommended quantity of hemodialysis delivered which is required for adequate treatment of ESRD so patients receive the full benefit of

hemodialysis therapy. These guidelines will hopefully serve to improve the survival rates of patients on hemodialysis and serve as an example of the renal community's mission to improve the quality of life of the ESRD patient.

MEDICARE SECONDARY PAYOR PROVISION FOR ESRD

The Renal Physicians Association would oppose legislative initiatives designed to extend the Medicare Secondary Payor provision for ESRD services beyond twenty-four months. Currently, Medicare is the secondary payor for ESRD services for eighteen months.

RPA believes that extensions beyond the already envisioned 24 months would have a detrimental effect on dialysis patients. Such an extension could lead to higher insurance costs to ESRD patients as insurance companies try to offset the price affects of the extension. Large price increases could lead to patients dropping their coverage altogether. Some health plans could drop their ESRD coverage completely. RPA is also concerned that such an extension would cause health plans to continue to lower the ESRD reimbursement rates. In addition, an extension beyond twenty-four months could provide employers with a disincentive for hiring ESRD patients or even those predisposed to ESRD, such as individuals with hypertension or diabetes.

BIOMATERIALS AVAILABILITY

As the Subcommittee may know, there is an impending threat to the availability of the raw biomaterials used in the manufacture of implantable medical devices. Because of massive class action suits over bodily injuries alleged to have been incurred from silicone breast implants, the providers of raw biomaterials to device manufacturers may withdraw entirely from the medical market. Possible medical and legal settlement costs reportedly cost in the billions while revenues to the suppliers often compare at less than $1 million.

The problem lies with U.S. tort law that allows an individual who has suffered bodily injury from a product to sue all participants involved in the manufacture of the product. In medicine, this applies to the suppliers of biomaterials for device manufacture.

Because of this liability situation, in 1992 suppliers of raw biomaterials informed medical device manufacturers that they were withdrawing from the medical device market for all implantable devices and some temporary devices. They would continue to supply these materials for up to 36 months to allow time for the manufacturers to develop alternative sources. The 36 month deadline ends on December 31, 1995. Disruption of this biomaterial source would prove disastrous for dialysis patients. Because of the suppliers withdrawal, teflon will no longer available for use in vascular access grafts. Without the use of these grafts, dialysis, quite simply, becomes almost impossible.

As a result of this situation, Senator Joseph Lieberman introduced the Biomaterials Access Assurance Act of 1995 which would eliminate raw materials liability when the raw materials supplied to the medical device manufacturer either meets the specifications as advertised by the raw materials manufacturers, or meets the specifications established by the medical device manufacturer. Without this liability relief critical biomaterials, like teflon, will be taken off the market leading to critical shortages of vascular access grafts as well as other implantable devices. We strongly urge the Subcommittee to work with Senator Lieberman and other members of Congress to ensure that patients continue to have access to needed medical devices critical to their care.

CONCLUSION

The RPA fully supports Medicare's ESRD program. The program is responsible for the lives of nearly 250,000 people. Despite the increasing age and sickness of the ESRD patient, the renal community has worked hard to make dialysis care both high quality and cost-effective. As a result, expenditures for the program have been kept to a minimum. However, RPA is concerned that further cuts could lead to quality problems. Nephrologists and other providers in the renal community are dedicated to serving the needs of our patients and to continually improving the delivery and outcomes of dialysis care. RPA welcomes the Subcommittee's oversight of the ESRD program and we offer our fullest assistance in helping members of Congress draft policy to improve an already superlative program.

STATEMENT OF TERRAN WARREN SIMS, B.S.N., R.N., C.N.N., IMMEDIATE PAST PRESIDENT, AMERICAN NEPHROLOGY NURSES' ASSOCIATION

Ms. SIMS. Good morning, Mr. Chairman and Members of the Subcommittee. My name is Terran Warren Sims. I am a registered nurse and I am the immediate past president of the ANNA, American Nephrology Nurses Association. Our association represents over 10,000 nurses who specialize in the care of patients with ESRD.

We have provided information on the ESRD Program to legislators and policymakers since the inception of the program in 1972. We applaud the Congress for establishing the ESRD Program and we support its continuation. It has demonstrated an ability to provide cost-effective care to an increasing number of older, sicker patients in light of a fixed reimbursement that has decreased in real dollars over time.

We believe this program is one of the most striking examples of a publicly funded, privately operated health care program that provides lifesaving medical care for a highly vulnerable, very sick population. At the same time, we are sensitive to the need to decrease the Federal deficit and reduce excessive health care spending, and we respect the mammoth task before the Congress. In keeping with your charge, ANNA comes before you to address issues in the ESRD Program that we ask you to consider.

First, we urge Congress to make the Medicare secondary payer provision permanent and to extend the provision to 24 months. In our written testimony, we address some concerns about extending the provision beyond that time period. Most of the concerns involve the response of the employer group health plans and employers themselves to significant cost shifting from Medicare. We urge you to take these concerns under advisement as you proceed with any extension of this provision.

Second, we support that epoetin continue to be reimbursed separately from the composite rate paid for dialysis services. We provide our rationale fully in our written comments, but our major concern is the incentive to underdose the drug that is inherent in such a fold in. The association has concerns about the impact such behavior would have on the health and rehabilitative potential of the dialysis population and the cost to the Medicare Program of such a scenario.

With regard to managed care, the association continues to support a nursing case management model of care delivery to this chronically ill population. We believe that such a model has the potential to assure the provision of high quality care and to control ESRD Program expenditures for several reasons, which we elaborate on more fully in our written testimony. We worked closely with this Subcommittee in the past to legislate an ESRD capitation study as part of the social health maintenance organization expansion in OBRA 1992.

We urge Congress to continue to support the social HMO project and the ESRD capitation demonstration so the nursing case management model can be more fully evaluated and so the appropriate risk adjusters can be determined for this highly specialized patient population.

In terms of transplantation, given the significant improvements in graft and patient survival in recent years, the number of patients on the waiting list continues to grow, as does the waiting time for a kidney. The gap between the supply and the need for donor organs is greater than ever.

ANNA and other members of the transplant community would be happy to work with the Congress to evaluate legislative measures that would increase the supply of donor organs in this country. We also support continued funding for research in this area, including the use of xenografts.

Finally, ANNA supports the continued partnership between HCFA and the renal community to evaluate and improve the quality of care delivered to the ESRD beneficiaries. We appreciate the Subcommittee's review of the ESRD Program. We have seen firsthand the benefits that this program has had on the beneficiaries and we are grateful for its continuation. We appreciate this opportunity to share our thoughts and observations and would be happy to answer questions when appropriate.

Thank you.

[The prepared statement follows:]

ANNA

American Nephrology Nurses' Association

TESTIMONY OF THE AMERICAN NEPHROLOGY NURSE S' ASSOCIATION PRESENTED TO THE SUBCOMMITTEE ON HEALTH HOUSE COMMITTEE ON WAYS AND MEANS

APRIL 3, 1995

The American Nephrology Nurses' Association (ANNA) is the professional organization representing registered nurses specializing in the care of patients with end-stage renal disease. In our 25th year as a professional society, and representing over 10,000 members, ANNA has repeatedly provided information on the ESRD program to legislators and policy makers since the inception of the program in 1972.

The end stage renal disease program has remained a success over the past 23 years, in part due to the commitment of the Congress to assure quality care to the beneficiaries. As this Congress considers both measures that improve health care delivery to the citizens of this country and methods to reduce overall spending in the Medicare program, we believe there is much to be learned from the successes and limitations of the ESRD program. Medicare entitlement has provided access to care for many patients who were previously denied treatment.

The initial reimbursement rates for outpatient dialysis were set arbitrarily; they were not based on costs. Established in 1973, they remained unchanged until 1983. They were lowered in 1983 and again in 1986, and no adjustments for inflation were allowed.

The estimated Medicare per capita payments for end-stage renal disease during 1991 averaged $38,400. When adjusted for inflation, the per capita costs are increasing minimally, or possibly decreasing. But, in fact, aggregate costs are increasing at over eight percent per year even with adjustment for inflation. This rise is almost totally driven by the increase in the number of patients, as the number of treated patients with kidney failure is increasing at over 9 percent per year.

ANNA is sensitive to the need to decrease the federal deficit and reduce excessive health care spending and we respect the mammoth charge before this Congress. However, we urge the Congress to maintain the ESRD program, one of the most striking examples in this country today of a publicly funded, privately operated health care program that provides lifesaving medical care for a highly vulnerable, very sick population.

EXTENDING SECONDARY PAYER PROVISION

Under current law, Medicare is the secondary payer for individuals with end stage renal disease who have coverage through employer group health plans (EGHPs). Medicare makes payments secondary to such EGHPs for the first 18 months of entitlement, after which Medicare becomes the primary payer.

ANNA supports that this provision be made permanent and that consideration be given to extending the secondary payer provision to 24 months. We have concerns about extensions beyond that time that we hope the Congress will consider.

- Such an extension could provide a disincentive for employers to hire ESRD patients, and ultimately individuals who are predisposed to ESRD, such as diabetics, hypertensives, and minorities.

- Such an extension could provide an incentive for EGHPs to eliminate coverage for ESRD in their plans altogether.

- Such an extension could provide an incentive for insurers to continue to lower their reimbursement for ESRD.

- Such an extension could serve to drive the cost of private insurance even higher, leading individuals to drop their coverage.

The GAO study, *Impact of OBRA-90's Dialysis Provisions on Providers and Beneficiaries*, reported in April 1994 that "as employer-sponsored plans react to increasing costs, they will have greater incentive to search for ways to reduce their expenditures."

If extensions to the secondary payer provision beyond the 24 month period are enacted, ANNA suggests that a provision to evaluate the effects of such a change be crafted into the legislation.

EPOETIN REIMBURSEMENT

ANNA has issued a position statement supporting that epoetin continue to be reimbursed separately from the composite rate paid for dialysis treatment for the following reasons:

1. There is no clinical, economic, or quality of care reason to change the current method for epoetin reimbursement.

2. The current methodology, paying a fixed rate per specified dose of the drug, is based on the number of units of epoetin per dose. This is the most rational method for reimbursement, and the safest for the patient because it permits physicians to prescribe the medication solely on the basis of the patient's need.

3. There are some concerns that folding epoetin reimbursement into the composite rate paid for dialysis services could provide a strong incentive to underdose the drug. The Association has concerns about the impact such behavior would have on the health and rehabilitative potential of the dialysis population and the costs to the Medicare ESRD program in such a scenario.

   The Office of the Inspector General of the Department of Health and Human Services issued a report in 1990 saying it found that lower than predicted average doses of epoetin were being administered, resulting in "a windfall profit of 44 percent to the facilities," when epoetin was reimbursed at a flat rate of $40 per treatment. (OIG Report, 1990, p. 4.)

   Further, an Office of Technology Assessment study reported in the Journal of the American Medical Association in July 1991 concluded that "paying a fixed rate per treatment...gave dialysis facilities a financial incentive to use low doses..."

4. There are no data presently available that suggest epoetin is being overprescribed based on the current reimbursement methodology.

MANAGED CARE

The Association worked with this committee to legislate an ESRD capitation study as part of the Social Health Maintenance Organization (SHMO) expansion in OBRA '92. We also worked with RAND in their short-term evaluation of a capitated payment methodology for this demonstration.

The SHMO project began in 1985 based on a mandate in the 1984 Deficit Reduction Act. The design of this project was to consolidate the acute and chronic care delivery systems and manage care across a full range of services, including acute care, post-acute care, and expanded community care. Initially developed as an integrated care system for the aged, OBRA-'90 amended the original authority to include four new sites and allowed for some important modifications in the demonstration.

One site that was considered was a specialty provider SHMO that would be created to serve a population suffering from a specific high-risk disease, such as end-stage renal disease. ANNA was successful in its efforts to have such a site included as an appropriate one for an ESRD capitation study which would integrate acute and chronic care management for patients with end-stage renal disease through a nursing case management model.

In a nursing case management model, the case manager serves as the principal coordinator of care for the ESRD patient across health care settings, and works with other health professionals involved in the patient's care. In addition, the case manager provides direct care within the legal scope of practice for advanced practice nurses. Such a model has the potential to assure the provision of high quality care and control ESRD program expenditures for several reasons. First, advanced practice nurses with experience in nephrology have the requisite knowledge and skills to monitor and intervene to prevent occurrence of some of the most common causes of hospitalization for the ESRD population. Specifically, aggressive, proactive care is likely to prevent many of the complications associated with vascular access and fluid and electrolyte imbalances. Additionally, nurses have strong preparation in health promotion and their focus on the individual within the context of the family enhances their potential to build on the patient's strengths and capabilities and to maximize the family role in care.

The nurse case manager is a health care provider who can serve as a substitute for physician providers in providing primary care to ESRD patients. In 1990 the National Kidney and Urologic Disease Advisory Board raised concern about the future supply of adult nephrologists, suggesting that current medical school and nephrology enrollment trends portend a future shortage. If this scenario develops, use of advanced practice nephrology nurses in case management roles will free up nephrologists from providing care that can be capably provided by these nurses and enable the nephrologist to focus on care that only they are prepared and qualified to give. Additionally, the case manager role is a mechanism to address one of the concerns raised by the Institute of Medicine study committee, that of lack of continuity of care among the various physician providers for individual renal patients (Rettig & Levinsky, 1991). The emphasis that the case management model places on care coordination and inter-professional collaboration is one means to address this concern.

Dianne Feeney, RN, MS, assistant vice president for care management of Health Services for Children with Special Needs, Inc., in Washington, DC, presented a specific example in a recent issue of the *Nursing Spectrum*:

> "Case managers with organ transplant expertise fill an important niche in managed care organizations. Mr. S, a 44-year-old recently diagnosed with

end-stage renal disease, enrolled in an HMO. Following his first acute care admission as a member, his case manager contacted him and his primary physician to discuss the treatment plan and orient them to plan providers. The case manager arranged a transplant workup with one of these participating providers and initiated discussions with the facility's transplant coordinator. The case manager reviewed benefits, including donor coverage, with all parties. Two months after enrollment Mr. S had a new kidney. The case manager monitored his progress throughout the hospitalization while arranging home infusion therapy as part of discharge planning. Follow-up continued after discharge including coordination of post-transplant medical care and helping Mr. S to obtain anti-rejection medicine, as well as arranging counseling services to enable him and his family to deal with the ongoing issues of chronic illness. The case manager also referred them to a transplant recipient support group."

We urge Congress to continue to support the Social Health Maintenance Organization project and the ESRD capitation demonstration so the nursing case management model can be more fully evaluated and so appropriate risk adjusters can be determined for this highly specialized patient population.

NEED FOR MORE DONOR ORGANS

According to the United States Renal Data System 1994 Annual Data Report, the number of cadaver and living related donor transplants have shown very little increase over the years. However, the kidney transplant waiting list continues to grow so that the gap between the supply and the need for donor organs is even greater than in previous years.

At the end of 1993, there were nearly 25,000 patients on the kidney transplant waiting list; in that same year slightly more than 8,100 cadaver transplants were performed. One year later the number of patients waiting for a kidney had increased to just under 27,500 patients and the number of cadaveric transplants performed was just over 8,300.

In 1992 the median days waiting time on the list for kidney transplantation was 621 days. This is the most recent data available However, in 1991 the median waiting time was 518 days. We can assume from this, and from the increased number of patients waiting, that the current waiting time is even longer than the 1992 figure.

According to one HCFA source, in terms of annualized costs, a dialysis patient dialyzing for one year has TOTAL costs to Medicare of $44,000. In the year he receives a transplant, that patient represents annualized TOTAL costs to Medicare of $88,000. However, in subsequent years as a "functioning graft" patient, TOTAL costs to Medicare average $7,400. (A certain percentage of the successful kidney transplant recipients loses Medicare entitlement at the end of three years following transplantation. Therefore, their costs are shifted from Medicare to other payers, whereas the alternative dialysis costs would have to be borne by Medicare.)

In a May 1992 article in *Seminars in Nephrology*, Paul Eggars notes that one of the basic questions facing any cost comparison of dialysis and transplantation is whether graft survival rates are sufficiently high so that subsequent dialysis cost savings offset the initial transplant costs. In a study conducted by Dr. Eggars on Medicare reimbursement data from 1979, he estimated that the high initial costs of transplantation were recovered in about 4 years for cadaveric transplants and in about 3 years for living donor transplants. Graft and patient survival estimates at that time

showed one-year graft survival rates of 51 percent for cadaver grafts and 75 percent for living donor grafts. This reflects the state of the art in the late 1970s.

Transplant graft survival rates have improved markedly since the estimates used in studies before the advent of cyclosporine as an immunosuppressive agent. In the 1994 United Network for Organ Sharing (UNOS) Center Specific Report, one-year kidney graft survival for a cohort of patients from 10/1/87 to 12/31/91 was 81.6 percent. One-year patient survival rates for the same cohort was 93.8 percent. Given these increases in graft survival, it can be assumed that the initial costs of transplantation are recovered in less than 4 years for cadaveric graft recipients today.

On the basis of this information, ANNA believes that it is in the patients' and the payers' best interest to promote transplantation as a cost effective modality of care for end-stage renal disease. The missing element, however, is an adequate supply of donor organs for the nearly 30,000 patients waiting.

ANNA and other members of the transplant community would be happy to work with the Congress to evaluate legislative measures that would increase the supply of donor organs in this country. We also support continued funding for research in this area, including the use of xenografts. Transplantation not only improves the quality of life of the recipient, but it is also the most cost effective modality of care for this patient population.

QUALITY OF CARE ISSUES

The ANNA applauds Mr. Stark's efforts to promote quality assessment and continuous quality improvement within dialysis facilities and to ensure the adoption, endorsement, and application of industry-wide standards for the benefit of the patients who are the beneficiaries of the ESRD program. We feel that mandating such standards in statute is inappropriate, however, for a number of reasons.

There are eighteen ESRD Network Organizations throughout the country that are currently under contract to HCFA to perform oversight activities to assure the appropriateness of services and protection for ESRD program beneficiaries.

HCFA, with input from ANNA and other members of the renal community, has reshaped the Network program's approach to quality assurance and improvement in order to respond to the need to improve the care to Medicare ESRD patients. This new approach has been named the ESRD Health Care Quality Improvement Program (HCQIP).

The Networks began implementing the HCQIP in July 1994 with the ESRD Core Indicators Project as one of its major projects. ANNA was part of a workgroup from the renal community that was established to provide guidance to HCFA in the development of the ESRD Core Indicators Project.

The purpose of the Project is to: assist ESRD care givers in assessing and improving the care provided to ESRD patients; to describe the prevalence of important clinical characteristics of adult, in-center hemodialysis patients; to identify opportunities to improve care for these patients; and to establish a consistent clinical database for these patients.

The quality or "core" indicators that were selected to describe several conditions of care for adult, in-center hemodialysis patients in the 1994 phase of the project were: adequacy of dialysis, anemia, blood pressure control, and nutritional status.

The most striking opportunity for improving care to in-center hemodialysis patients concerns the adequacy of dialysis. In the last quarter of 1993 only 43 percent of such patients received dialysis which resulted in a urea reduction ratio (URR) of greater than 0.65, the threshold for adequate dialysis recommended by the Renal Physicians Association and a NIH Consensus Development Conference Panel.

Previous studies by the United States Renal Data System have estimated that in 1986 and 1990 the percentage of patients with a prescribed Kt/V of 1.2 (equivalent to a URR of 0.65) was 20 percent and 30 percent, respectively. The 43 percent finding in 1993 suggests that progress is already occurring.

Publication of an educational brochure for patients concerning the adequacy of dialysis is currently under development by HCFA, with the assistance of ANNA and with publication scheduled for this spring. Other activities planned include the distribution of the 1994 Core Indicators Project Report to all dialysis facilities. The Networks will also develop intervention activities to assist dialysis care givers to understand the data report and how to use the information to identify opportunities for improving patient care. The next Core Indicators data collection effort will begin early this summer, looking at adult peritoneal dialysis patients.

In addition to participating in the HCQIP, ANNA has worked in the recent past with HCFA to revise the Chronic Disease Medical Evidence Report to enable HCFA to evaluate the appropriateness of ESRD therapy. We have worked with them on their revision of both the facility survey process and tool and we are actively working with the staff at this time in their review and revision of the conditions of participation.

While there is still much progress to be made, ANNA believes that the combined efforts of the renal community and the HCFA have led to improvements in the quality of care delivered to ESRD patients such that H.R. 1067 is not necessary at this time.

The American Nephrology Nurses' Association appreciates the committee's review of the Medicare End Stage Renal Disease program. We have seen firsthand the benefits this program has had on the beneficiaries and we are grateful for its continuation. We appreciate this opportunity to share our thoughts and observations with the committee and will be happy to meet with staff to discuss them further.

Chairman THOMAS. Thank you very much, Ms. Sims.
Ms. Wish.

STATEMENT OF DIANE WISH, EXECUTIVE DIRECTOR, COMMUNITY DIALYSIS CENTER, CLEVELAND, OHIO, ON BEHALF OF NATIONAL RENAL ADMINISTRATORS ASSOCIATION

Ms. WISH. Good morning, Mr. Chairman, and Members of the Health Subcommittee. My name is Diane Wish and I am the executive director of three freestanding, not-for-profit dialysis facilities in Cleveland, Ohio. I am appearing on behalf of the NRAA, National Renal Administrators Association, and am the current president of that association.

We are delighted to have the opportunity to participate in this important hearing on the Medicare ESRD Program. Our testimony will focus on a number of issues. We would like to begin by emphasizing that the Medicare ESRD Program has been highly successful in providing access to life-sustaining quality care to over 90 percent of individuals with end-stage renal disease in this country.

Thirty years ago, individuals who received a diagnosis of end-stage renal disease faced near certain death. This program has also been extremely cost effective as explained in the latest USRDS 1994 Renal Data Report.

According to this report, while real Medicare payments per year for ESRD continue to rise in response to a growing ESRD population, average payments per patient per year showed little or no growth in the last 5 years. The real level of reimbursement per dialysis treatment, determined through the composite rate schedule, has been declining for almost two decades. The USRDS also noted that the trend of little or no growth in real per capita Medicare payment for all ESRD patients is particularly surprising since Medicare coverage was expanded in 1989 to include EPO, which now is used in over 80 percent of patients.

For these reasons, we would strongly urge the Subcommittee to maintain the ESRD Program as it is currently structured because it has successfully met the objectives of the program in a cost-effective manner.

For the very same reasons and for quality assurance purposes, we also adamantly oppose privatizing the ESRD Program. Such a move would result in serious access to care problems for ESRD beneficiaries, significantly reduced patient choice, and would compromise the quality assurance programs currently in place. If the ESRD Program were privatized, the ability to obtain accurate, validated cost, and quality data would be seriously jeopardized.

HCFA's continuous quality initiatives, which are just beginning to make a significant impact, might be lost forever. We strongly recommend that no further action be taken to privatize the ESRD Program until the results from the ESRD capitation demonstration project are evaluated.

The NRAA can support the concept of managed care for ESRD patients; however, we would want assurances that patients have the option to sign up for a managed care plan or remain in the current ESRD system, and that there be multiple managed care plan choices.

Kidney patients themselves have expressed serious concerns with managed care plans according to an Office of Inspector General's report entitled, "Beneficiary Perspectives of Medicare Risk HMOs," released in March 1995. Until there is better data on quality of care in HMOs for ESRD beneficiaries, the NRAA supports the continuation of Medicare's rule that prohibits new ESRD patients from joining an HMO unless they are in HMOs when their kidney failure begins. Waiting for the findings of HCFA's ESRD capitation demonstration would make the most sense.

We strongly recommend that this Subcommittee seriously consider writing into law the same type of inflation adjustment for dialysis facilities like that provided to hospitals and other Medicare providers. This was an IOM recommendation. We must vie for labor and supplies with those who do receive updates in their payments.

For this year, we earnestly request the Subcommittee increase payments to dialysis facilities by 3.7 percent for fiscal year 1996 to reflect the projected price increases facilities will experience in the coming year and pay for quality improvements. The NRAA is greatly concerned that dialysis facilities will not be able to continue to provide quality care without an increase in payments.

We support HCFA's continuous quality improvement initiatives, including the national anemia study and the core indicator study which supports a 1.2 Kt/V adequacy standard. Those studies have provided benchmark data for dialysis facilities to improve their quality of care.

There is also special concern for low-volume rural facilities and inner city dialysis facilities that treat a kidney patient population which requires extra social services.

Our concern is, based on the fact that we have been doing everything we can to be cost effective during the past 20 years, the list of cost containment possibilities has been exhausted. The new Kt/V standard will only increase our costs. The only things left to cut will impact quality. Our membership strongly believes we are very close to that point.

We also recommend that the ESRD secondary payer provision should be expanded to 24 or 30 months, as it will save Medicare money and help fund the 3.7-percent increase. EPO should not be bundled into the dialysis payment as it will create incentives to underdose patients which would result in higher, rather than lower costs to Medicare, as these patients would require more medical care; in particular, more hospitalizations. The physician self-referral provisions which apply to physician-owned dialysis facilities, concerning the administration of prescription drugs in their facilities and contracting with hospitals for inpatient acute care, should be eliminated as they create unnecessary barriers to needed medical care.

Again, I would like to thank Chairman Thomas for allowing the NRAA to express its views on a wide range of issues before the Subcommittee. The task before you is enormous and the need to control costs is great. We hope you will remember that the ESRD Program is a true model of cost-effective care. Please do not hesitate to call on us for information and data concerning renal care and dialysis facilities as you formulate your recommendations for fiscal year 1996.

Thank you.

[The prepared statement and attachments follow:]

STATEMENT OF DIANE WISH, EXECUTIVE DIRECTOR
COMMUNITY DIALYSIS CENTER

Good morning Mr. Chairman and Members of the Health Subcommittee. My name is Diane Wish, and I am the Executive Director of Community Dialysis Center, which operates three free-standing not-for-profit dialysis facilities in Cleveland, Ohio. I am currently the President of the National Renal Administrators Association (NRAA).

The NRAA is a voluntary organization representing professional managers of dialysis facilities and centers throughout the United States. We represent free-standing and hospital-based facilities, which are for-profit and non-profit providers located in urban and rural areas. Our members manage approximately two-thirds of the dialysis units in this country which provide dialysis services to a majority of Medicare End-Stage Renal Disease patients. The association was founded to provide information and education to our members and to work with the Congress, the Administration, and other oversight organizations on the Medicare ESRD program. Our organization is dedicated to providing quality of care in the most cost effective manner.

We are delighted to have the opportunity to participate in this important hearing on the Medicare ESRD program. Our testimony will focus on: (1) the reasons to maintain the current ESRD program, (2) our concerns with managed care, (3) the need to establish an annual inflation update factor, (4) our recommendation for a 3.7% update for fiscal year 1996 to pay for quality improvements, (5) support for a 24 to 30 month ESRD secondary payer provision, (6) opposition to EPO being folded into the composite rate paid to dialysis facilities and, (7) recommendations for modifying the physician self referral bans as they apply to physician owned dialysis facilities.

MEDICARE ESRD PROGRAM IS SUCCESSFUL AND COST EFFECTIVE

The Medicare ESRD program has been highly successful in providing access to life sustaining quality care to over 90 percent of individuals with end-stage renal disease in this country. Thirty years ago, individuals who received a diagnosis of ESRD faced near-certain death. Dialysis and kidney transplantation were just then emerging as experimental procedures and were available in only a handful of medical centers. More importantly, these treatments were beyond the financial reach of most Americans. The Medicare ESRD program introduced hope where there was none, saving several hundred thousand Americans from premature death by making life-saving treatments financially possible. In fact, the Institute of Medicine, in its landmark study entitled, **Kidney Failure and Medicare Program**, concluded that, "It has been remarkably successful in fulfilling its intended objectives."

This program has also been extremely cost effective as explained in the latest United States Renal Data System (USRDS), **1994 Annual Data Report.** According to this report, "While real Medicare payments per year for ESRD continue to rise in response to a growing ESRD population, average payments per patient per year show little or no growth in the last five years. The real level of reimbursement per dialysis treatment, determined through the composite rate schedule, has been declining for almost two decades." The USRDS also noted that, "This trend of little or no growth in "real" per capita Medicare payment for all ESRD patients is particularly surprising since Medicare coverage was recently expanded to include EPO (9/89), which now is used in over 80 percent of center hemodialysis patients...."

The report further notes that, "With adjustment for the overall change in consumer prices, per capita Medicare expenditures for ESRD increased 1.3 percent per year from 1990-1991 and by an annual average of 0.3 percent from 1987-1991. When adjusting for medical care inflation, real Medicare ESRD expenditure per patient per year actually declined by 3.2 percent from 1990-1991 and 2.9 percent per year from 1987-91. Alternatively, the change in real per capita Medicare expenditures for non-ESRD beneficiaries adjusted for overall inflation, increased an average of 3.5 percent per year between 1987 and 1991."

These facts have led Stuart Altman, chairman of ProPAC to conclude that without the ESRD program Medicare would have paid far more for ESRD patients than it currently does.

For these reasons we would strongly urge the Subcommittee to maintain the ESRD program as it is currently structured because it has successfully met the objectives of the program and in a most cost effective manner.

OPPOSE PRIVATIZING THE ESRD PROGRAM

For the very same reasons and for quality assurance purposes we also adamantly oppose privatizing the ESRD program. We do not believe that sufficient numbers of insurers could be induced into accepting Medicare vouchers for ESRD beneficiaries. Given the costly nature of their care, amounting to over $38,000 per year, we find it extremely hard to believe that Medicare would risk adjust the vouchers high enough to attract significant numbers of insurers to accept these Medicare beneficiaries in their plans. We know ESRD beneficiaries already experience difficulty in purchasing Medigap policies because of pre-existing condition clauses and prohibitively high premiums due to their disease.

Privatizing the program could also result in eliminating the beneficiary safeguards built into the Medicare ESRD program. For example, patients currently have the choice of modalities and the location of where they dialyze. Privatizing the program would result in an unregulated environment in which access to care and patient choice could be negatively impacted. Some physicians could be disenfranchised in the process. Also, there could be a significant negative outcome for academic/hospital-based programs.

We strongly recommend that no further action be taken to privatize the ESRD program until the results from the ESRD capitation demonstration project can be evaluated.

If the ESRD program were privatized the ability to obtain accurate, validated cost and quality data would be seriously jeopardized. HCFA's continuous quality initiatives, which are just beginning to make a significant impact, might be lost forever.

CONCERNS ABOUT MANAGED CARE

The NRAA can support the concept of managed care for ESRD patients. However, we would want assurances: (1) that patients have the option to sign up for a managed care plan or remain in the current ESRD system, (2) that there be multiple managed care plan choices, (3) that access to nephrologist care before kidney failure be assured, and (4) that good consumer protections, including appropriate claims processing and appeal rights be required.

Kidney patients themselves have expressed serious concerns with managed care plans, according to an Office of Inspector General's Report entitled, **Beneficiary Perspectives of Medicare Risk HMOs,** released in March 1995. (See Table A which is a summary of ESRD/Disabled Beneficiary Perspective by enrollee and disenrollee.) For example, the study found that disenrolled ESRD beneficiaries were 41 times more likely than ESRD enrollees to say that medical care received through an HMO caused their health to worsen. The ESRD disenrollees were the most likely to report that their primary HMO doctors restricted access to needed Medicare covered services, did not refer them to specialists when necessary, and did not take their health complaints seriously. They were also the most likely to seek out-of-plan care while still enrolled in the HMO and to believe that holding down the cost of care was more important to primary HMO doctors and the HMOs than providing the best medical care.

NRAA members have also found that their patients are concerned about HMOs. ESRD patients have expressed concerns about having to change physicians, dialyze at a facility that is inconvenient and would require long travel times, or be unable to change dialysis facilities and physicians if not satisfied with the quality of care in the HMO.

NRAA member data, contained in Tables B through E, demonstrate that quality of care in HMOs is no better and by some measure worse. Our data, from 3 dialysis facilities with a total of 411 patients located in the Midwest, indicates that gross mortality rates are better for regular ESRD Medicare beneficiaries than those enrolled in Medicare Risk HMOs and standard mortality rates (i.e. adjusted for age, sex, race and diagnosis) are about the same for both. Comparing hospitalizations and days in the hospital, 3 dialysis facilities with 1047 patients in Ohio, found that the HMO patients had no fewer hospitalizations nor days in the hospital for 1994, than the regular ESRD

patients.

In light of the IG's study and our own data and experiences, to protect ESRD beneficiaries, the NRAA would urge the Subcommittee and Congress to spend more time studying the issue of ESRD beneficiaries and managed care. There is a real need to proceed with caution before creating incentives for these beneficiaries to join Medicare Risk HMOs. Until there is better data on quality of care in HMOs for ESRD beneficiaries, the NRAA supports the continuation of Medicare's rule that prohibits new ESRD patients from joining an HMO unless they are in an HMO when their kidney failure begins. Waiting for the findings of HCFA's ESRD capitation demonstration would make the most sense.

NEED TO INCLUDE A DIALYSIS INFLATION UPDATE IN THE LAW

Medicare's payment structure for dialysis facilities is unique in the Medicare system. Dialysis facilities are paid a prospective payment to cover the cost of providing all dialysis related services, including the cost of a dietitian and social worker. This prospective payment system has been called the first DRG. However, unlike hospital DRG payments, which are annually updated, there is no statutory automatic inflation update to this payment, as there for are hospitals, hospices, nursing facilities and other providers. Instead, payment to dialysis facilities can only be increased by the Congress or the Administration.

Without an inflation adjustment written into the statute, we know only too well that the Congress, in these tight budgetary times, will find it very difficult to increase payments to dialysis facilities, even when they are meritorious.

Because other Medicare providers have inflation adjustments included in their payment formulas, Congress can reduce the update factor, saving Medicare money, and still grant some inflation increase to these providers.

We cannot understand why the composite rate payment does not include a medical inflation adjustment when dialysis facilities must vie with hospitals and physicians, who do receive annual updates, for the same pool of labor and must pay similar amounts for medical supplies, health insurance and other overhead costs.

The Institute of Medicine (IOM), in its two year study of the ESRD program, also concluded that Medicare should provide annual updates for dialysis facilities. Concerned about quality of care, the IOM stated that annual updates were necessary in order to ensure that patients received all of the care they required.

We strongly recommend that this Subcommittee seriously consider writing into the law the same type of annual inflation adjustment formula for dialysis facilities like that provided to hospitals, hospices and other Medicare providers. Then each year the Congress can determine an appropriate update factor as it does for all other Medicare providers.

RECOMMEND A 3.7% UPDATE IN DIALYSIS FACILITY PAYMENTS FOR FY 1996

We strongly request the Subcommittee **increase payments to hospital-based and free-standing dialysis facilities by 3.7%, for fiscal year 1996, to reflect the projected price increases facilities will experience in the coming year and pay for quality improvements.**

ProPAC's Analysis of Increased Costs - ProPAC in its 1993 Report to Congress recommended a 2.5% increase in payments to hospital-based and free-standing dialysis facilities for FY 1994. We never received this update. In ProPAC's 1995 Report to Congress, the Commission's analysis indicated that the prices of inputs used in a dialysis treatment will rise by about 3.7% between fiscal years 1995 and 1996. At a minimum, dialysis facilities should be given an increase to reflect real cost increases. Instead, ProPAC decided to recommend no increase because they believe that free-standing facilities are still reimbursed more by Medicare than their costs. However, if ProPAC had not applied, what we believe was an erroneous 12 percent audit adjustment in calculating the costs of providing dialysis services for FY 1995-1996, they would have concluded that payments were less than 1 percent above costs for free-standing dialysis facilities. Based on our own membership data we actually believe that at least a 10 percent update is appropriate for FY 1996. The NRAA would be happy to share with the Subcommittee the data we provided ProPAC this year, which includes a detailed analysis of the true costs of providing dialysis services in free-standing dialysis facilities.

Medicare Payments Have Been Essentially Frozen - The prospective payment system established for dialysis facilities in 1983 was reduced $2 a payment in 1986 and only increased by $1 a treatment in 1990 for FY 1991. In other words, dialysis facilities did not receive any inflation updates, like other Medicare providers, throughout the 1980s and instead had their payments frozen for most of the decade. Following the dollar increase in 1991, payments have been frozen. No other Medicare provider has had to live without inflation updates for this long. With about 90% of revenues coming from Medicare, dialysis facilities have very little ability to cost shift, and therefore must depend upon adequate Medicare reimbursement.

Costs Continue to Rise - ProPAC projects a 3.7% increase in costs for dialysis facilities between 1995 and 1996. The costs of complying with CLIA, OSHA, and other regulations on water quality and dialyzer reuse, increased labor costs and other overhead costs are making it very difficult for too many dialysis facilities to provide all of the care older and sicker patients now require. Staff to patient ratios cannot be further lowered nor can the ratio of registered nurses to non-registered nurse staff be reduced. ProPAC's analysis confirmed our findings and discovered that staffing ratios and mix have remained flat for the past three years.

Cost of New Quality Standard - Further, the National Institutes of Health (NIH), and the Renal Physicians Association have recommended an increase from 1.0 to 1.2 adequacy of dialysis care standard, known as Kt/V. It is our understanding that this new quality standard will be included in HCFA's proposed changes to the ESRD Conditions of Coverage rules. As an association we strongly support this new standard and believe that dialysis facilities have been moving to meet it since November of 1993. In order to comply with this new standard, many dialysis facilities will have to incur additional costs for labor to dialyze patients longer and or purchase new equipment. ProPAC has concurred in our assessment and stated in its 1995 Report to Congress that, the Commission believes that payments must recognize the additional costs of meeting the new adequacy standards.

Quality May Be Compromised - The NRAA is greatly concerned that dialysis facilities will not be able to continue to provide quality care without an increase in payments. We support HCFA's Continuous Quality Improvement (CQI) initiatives, including the National Anemia study and the [illegible] adequacy standard. These studies have provided benchmark data for dialysis facilities to improve their quality of care. There is also special concern for low volume rural facilities and inner city dialysis facilities that treat a kidney patient population which requires extra social services.

Our concern is based on the fact that we have done everything we can to be cost effective during the past twenty years. The list of cost containment possibilities has been exhausted. The new Kt/V standard will only increase our costs. There comes a point when the only thing left to cut may impact quality. Our membership strongly believes that we are very close to that point.

EXTEND THE ESRD MEDICARE SECONDARY PAYER PROVISION

We urge the Subcommittee to permanently extend the ESRD Secondary Payer provision from 18 months to 24 or 30 months beginning January 1, 1996. Currently, unless the Congress approves President Clinton's FY 1996 budget proposal to permanently extend the 18 month ESRD MSP provision it will sunset in 1998 and then reverts back to a 12 month secondary payer requirement. Extending to 24 or 30 months saves $839 million over 5 years, according to a CBO estimate obtained in 1993 with a 1994 effective date.

Patients Are Not Negatively Impacted - A December 1992 GAO study entitled, **Medicare Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans**, concluded that very few dialysis patients were negatively impacted by the 18 month

secondary payer provision and that Medicare saved millions of dollars. A follow up study by GAO in April 1994 entitled, **Impact of OBRA-90's Dialysis Provisions on Providers and Beneficiaries** stated that, "Our review of payment rules indicates that only rarely will it matter to the beneficiary whether Medicare or the employer plan pays first. The extension should not affect most ESRD patients' out-of-pocket expenses, because specific payment provisions insulate ESRD patients with dual coverage from being singled out for increased out-of-pocket expenditures."

Medicare Will Save Money - The **Impact of OBRA-90's Dialysis Provisions on Providers and Beneficiaries** study also concluded that Medicare would annually save $87 million from the 18 month ESRD secondary payer provision.

The NRAA does not believe extending this provision by 6 or 12 more months will have any appreciable affect on ESRD beneficiary access to employment or health insurance. But it will save Medicare millions of dollars.

We would, however, oppose an open ended ESRD secondary payer provision as we believe this would create access to employment and health insurance problems for ESRD beneficiaries.

OPPOSE EPO BEING INCLUDED IN THE COMPOSITE RATE

It has been suggested by one or two organizations in the renal community that the payment method for EPO be changed to "bundle" the payment for EPO into the composite payment for dialysis. Under this proposal, facilities would be paid an additional amount whether or not EPO was furnished and regardless of the number of units administered.

The NRAA joins with the Renal Physicians Association and the American Nephrology Nurses' Association in urging the Subcommittee and the Congress to reject this approach because of the real potential for abuse. When Medicare initially set the reimbursement at a flat rate of $40 per treatment for most patients, regardless of the amount administered, the Office of Technology Assessment (OTA) and the Office of Inspector General (OIG) issued reports that found that lower than predicted average doses were being administered. Largely on the basis of the OIG report, Congress in OBRA 1990 changed the reimbursement methodology to $11 per thousand units administered. In OBRA 1993, the payment amount was reduced to $10 per thousand units.

There are now additional reasons to reject a flat rate or bundled payment. OTA in an article published in the **Journal of the American Medical Association,** in July 1991, concluded that "paying a fixed rate per treatment with the biologic agent gave dialysis facilities a financial incentive to use low doses ... and fewer than 45 percent of patients who had been treated for 6 months or more had ever attained the target hematocrit." In other words, a bundled payment would create strong financial incentives for some providers to withhold EPO or reduce doses which would result in the return of anemia and a sharp reduction in the health status and the quality of life of many dialysis patients.

Further, folding EPO payments into the composite rate would not result in reduced Medicare expenditures for ESRD patients. This is because dialysis patients receiving EPO have been found to develop fewer comorbid conditions that require inpatient hospital treatment. A recent study conducted by Johns Hopkins School of Medicine and HCFA found that patients on EPO are less likely to have heart failure, angina, myocardial infarction, depression, and strokes than patients not receiving the drug. The study also concluded that use of EPO may be associated with fewer overall hospital admissions and fewer days spent in the hospital.

If financial incentives to withhold EPO led to increased use of transfusions, Medicare would incur the additional costs of treating blood-borne infections and patients would risk development of antibodies, increasing their chances that a kidney transplant would be rejected. These additional costs would most likely wipe out any potential savings associated with bundling EPO payments into the composite rate.

The NRAA would also like to be on record in opposition to lowering reimbursement for EPO. The U.S. price of EPO is already the lowest in the world. The list price according to Amgen is on average 34.4 percent lower than the European price and 68 percent lower than the price in Japan.

EXEMPT PHYSICIAN OWNED DIALYSIS FACILITIES FROM THE INPATIENT HOSPITAL SERVICE AND OUTPATIENT PRESCRIPTION DRUG BAN INCLUDED IN THE 1993 SELF-REFERRAL LAW

As a result of the self-referral ban on "inpatient hospital services" included in OBRA 1993, as of January 1, 1995, physician owned dialysis facilities, group practices and solo practitioners can no longer provide hospitals with the staff and dialysis machines required to dialyze their inpatients, if they refer their own patients to the hospitals.

The NRAA strongly recommends that the Subcommittee explicitly exempt physicians who have ownership or arrangement agreements with hospitals to provide inpatient dialysis services from the ban for the following reasons.

The purpose of the exemption is to assure that hospitals will be able to provide acute dialysis services to their patients. Many hospitals cannot afford to provide 24 hour a day acute inpatient dialysis services and have therefore contracted with local dialysis facilities (solo practitioners, group practices and physician owned) to provide the staff and dialysis machines to dialyze patients with renal failure. Such arrangements result in continuity of care and better quality of care because the same staff is providing the patients with dialysis care in both the inpatient and outpatient setting. The patients also benefit greatly by having their treatments performed by highly qualified staff. If these hospitals had no other option but to hire their own staff, it is likely that the staff would not be as qualified. This would be due to the lack of experience and expertise especially when the volume of treatments they performed was low.

Smaller community hospitals and hospitals in isolated areas rely upon acute care contracts with physician owned dialysis facilities in the community to meet patient care needs that cannot be met in any other way. Without this proposal some hospitals that cannot afford to staff an inpatient dialysis unit may have to transfer their critically ill patients with renal failure to other hospitals. This could negatively impact and compromise these patients' health. It might also jeopardize the continuity of physician care, create additional hardships for the patients and their families and increase the patients' emotional stress.

Further, we do not believe these arrangements should be included in the self-referral ban because the dialysis services are actually an extension of the physician's practice. Also, hospitals already have oversight responsibility for utilization and admission reviews to ensure that patients are not dialyzed inappropriately.

In summary, our proposed correction would: (1) avoid reducing access to inpatient dialysis care; (2) help maintain continuity of patient care and; (3) allow hospitals to enjoy the most cost-effective means of providing inpatient dialysis services.

The NRAA would also urge you to eliminate the OBRA 1993 ban on outpatient prescriptions drugs being dispensed in physician owned dialysis facilities. Nephrologist owned dialysis facilities, like all other dialysis facilities, order a number of prescription drugs to be given to patients while on dialysis. These medications are covered under Medicare's Conditions of Coverage and are reimbursed by Medicare. Peritoneal dialysis, which is performed by a patient outside of the dialysis facility, is also categorized as a prescription drug for Medicare reimbursement. Prohibiting physician owned facilities from prescribing peritoneal dialysis would mean that patients of these physician owned facilities would be precluded from this form of dialysis. We do not believe even the authors of the self referral provision intended to ban the provision of prescription drugs when delivered within the physician owned dialysis facility. Such a ban would effectively deny patients of these facilities from receiving proper care and could endanger these patients' lives.

CONCLUSION

RECOMMENDATIONS

1. We strongly recommend that the Medicare ESRD program be maintained in its current form for now. We would urge that you not consider restructuring this program by *either* privatizing it or mandating managed care for the ESRD population until validated information is available from the ESRD capitation demonstration project.
2. We earnestly recommend that you establish in law an annual inflation update factor as exists for all other Medicare providers.
3. For fiscal year 1996, we urge a 3.7% inflation update, based on ProPAC's analysis of projected increased costs for 1995-1996 and which is now needed to pay for a higher standard of dialysis care.
4. The ESRD Secondary Payer provision should be expanded to 24 or 30 months as it will save Medicare money, not negatively impact ESRD patients, and help fund the 3.7% increase.
5. EPO should not be bundled into the dialysis payment as it will create incentives to under dose patients which could result in higher rather than lower costs to Medicare as these patients could require more medical care and in particular more hospitalizations.
6. We support the continuation of the prohibition on new ESRD enrollees in Medicare Risk HMOs *unless* they are already enrolled when their kidneys fail.
7. The physician self referral ban on physician owned dialysis facilities from administering prescriptions drugs in their facilities and the prohibition on contracting with hospitals for inpatient acute care should be eliminated, as they create unnecessary barriers to needed medical care.

Again, I would like to thank Chairman Thomas for allowing the NRAA to express its views on a wide range of ESRD issues before the subcommittee. The task before you is enormous and the need to control costs is great. We hope that you will remember that the ESRD program is a true model of cost effective care. Please do not hesitate to call on us for information and data concerning renal care in dialysis facilities as you formulate your recommendations for fiscal year 1996.

Table A: Beneficiary Perspectives by Medicare Categories of Aged or Disabled/ESRD

	Disenrollees		Enrollees	
	Aged	Disabled/ ESRD	Aged	Disabled/ ESRD
Medical care received through the HMO caused beneficiary's health to get worse.	20% (4,094)	41% (858)	2% (17,294)	1% (231)
For a scheduled appointment with their primary HMO doctors, usually waited:				
▸ 1 to 4 days	49% (10,246)	78% (1,630)	51% (468,557)	68% (15,749)
▸ 5 to 8 days	24% (5,011)	15% (314)	26% (237,936)	11% (2,549)
▸ more than 8 days	27% (5,654)	8% (158)	23% (204,855)	21% (4,771)
For a scheduled appointment with specialists, usually waited:				
▸ 1 to 4 days	40% (5,976)	69% (1,218)	35% (258,235)	12% (3,353)
▸ 5 to 8 days	25% (3,797)	13% (222)	29% (213,086)	42% (12,008)
▸ more than 8 days	36% (5,370)	19% (332)	36% (265,888)	46% (13,061)
Primary HMO doctor failed to provide Medicare covered services that were needed.	20% (4,366)	39% (823)	3% (30,648)	4% (1,285)
Primary HMO doctor failed to refer to a specialist when needed.	21% (4,431)	50% (1,054)	5% (42,743)	6% (1,725)
Sought out-of-plan care while a member of the HMO.	20% (4,160)	49% (1,027)	7% (63,392)	7% (2,237)
Primary HMO doctor didn't take their health complaints seriously.	38% (7,892)	48% (976)	11% (104,185)	20% (4,671)
Holding down the cost of care was most important to:				
▸ primary HMO doctor	26% (5,471)	48% (989)	10% (94,109)	2% (586)
▸ the HMO	34% (7,042)	50% (1,030)	11% (105,041)	11% (3,324)

Source: Office of Inspector General's report entitled, "Beneficiary Perspectives of Medicare Risk HMO's," issued March, 1995.

TABLE B

Gross Mortality for:

ALL INSURANCE			
FACILITY	TOTAL PATIENTS	EXPIRED PATIENTS	GROSS MORTALITY PERCENTAGE
A	211	21	9.05%
B	94	7	6.93%
C	106	11	9.40%
ALL	411	39	9.5%

MEDICARE			
FACILITY	TOTAL PATIENTS	EXPIRED PATIENTS	GROSS MORTALITY PERCENTAGE
A	106	10	8.62%
B	41	4	8.89%
C	71	3	4.05%
ALL	218	17	7.8%

HMO			
FACILITY	TOTAL PATIENTS	EXPIRED PATIENTS	GROSS MORTALITY PERCENTAGE
A	71	8	10.13%
B	37	0	0.00%
C	18	4	18.18%
ALL	126	12	9.5%

COMMERCIAL			
FACILITY	TOTAL PATIENTS	EXPIRED PATIENTS	GROSS MORTALITY
A	11	1	8.33%
B	6	1	14.29%
C	8	2	20.00%
ALL	25	4	16%

TABLE C

8 MONTH INTERIM STANDARD MORTALITY RATIOS FOR THREE MIDWEST DIALYSIS FACILITIES

I. FOR ALL INSURANCE CATAGORIES

FACILITY	PATIENTS	SMR
A	79	.50
B	158	.54
C	70	.30
ALL	307	.47

II. HMO INSURANCE

FACILITY	PATIENTS	SMR
A	15	.93
B	61	.54
C	29	0.00
ALL	105	.43

III. MEDICARE INSURANCE

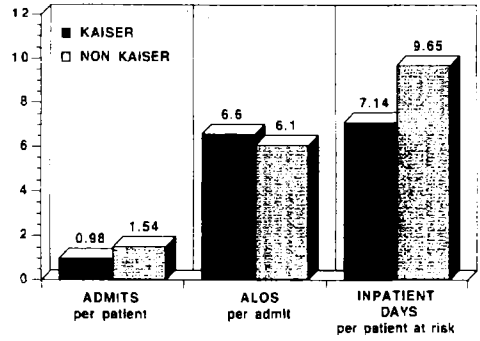
FACILITY	PATIENTS	SMR
A	56	.22
B	90	.51
C	36	.46
ALL	182	.42

IV. COMMERCIAL INSURANCE

FACILITY	PATIENTS	SMR
A	8	2.18
B	7	.98
C	5	.99
ALL	20	1.38

TABLE D

Kaiser Patients Had No Fewer Hospitalizations nor Days in Hospital for 1994



Differences are not significant

TABLE E

No actuarial difference in hospitalizations nor days in hospital for 1994

	KAISER	NON KAISER	SIGNIFICANT DIFFERENCE?
PATIENTS	75	972	n/a
PATIENT DAYS	19477	253653	n/a
HOSPITAL DAYS	536	9382	n/a
% ADMITTED	50.6	62.6	NO
HOSP ADM per 1000 PAT DAYS	3.7	5.9	NO (t-test)
HOSP DAYS per 100 PAT DAYS	2.8	3.7	NO (t-test)

Chairman THOMAS. Thank you very much, Ms. Wish.
Mr. Bowden.

STATEMENT OF A. BRUCE BOWDEN, CHAIRMAN, NATIONAL KIDNEY FOUNDATION

Mr. BOWDEN. Thank you, Mr. Chairman, Members of the Subcommittee. I am chairman of the NKF, National Kidney Foundation, which at age 45, is the oldest and largest of the nonprofit organizations in the United States, representing the interests not only of kidney patients, but of the professional care team that takes care of them.

We appreciate the opportunity to be here this morning to talk about what we view as a tremendously successful 22-year-old program. A number of the benefits of the program have been talked about this morning. One of the most dramatic that hasn't been mentioned is the fact that when this program came in, it ended the existence of committees in hospitals which had to make, on a daily basis, decisions of who would live on dialysis and who would not.

During the life of the ESRD Program, a lot of changes have taken place. The ability to care for a broader range of patients, much more difficult cases, has caused the population to be older, to be sicker, to be poorer, and to be more heavily made up of minorities.

We have submitted written recommendations and I believe they generally fall into four categories. The first one that has been discussed earlier this morning is quality. There is a clear need for quality standards. The most recent USRDS data on mortality, on the high rate of complications and hospitalization, point clearly to the need for quality tools. We believe that government and the renal community should work together on the development of quality tools, not only to measure quality, but also to assure it, that these tools should deal not just with dosage, with Kt/V, but with nutrition, with staffing patterns, and with quality of life issues.

Second, access has been discussed, an equally important area. We believe access means something a little broader than what has been discussed. We believe access means informed access by all patients to all modalities of treatment to include transplantation, home hemodialysis, and peritoneal dialysis. It is not just an issue of geographic access.

Obviously, there are problems with organ donation. Some of those have been discussed. There is a problem with the organ supply. We would again remind the Congress that there is the opportunity to allow a pilot program on the use of financial incentives for cadaveric organ donation, and to allow for the removal of financial disincentives for living related donation. We also believe that Congress has an opportunity not only to allow transplants but to keep healthy transplants by extending Medicare coverage for immunosuppressant drugs for the life of the graft.

The third area that we believe is important is the area of prevention or delay in the progression of kidney disease. Obviously, diabetes and high blood pressure—hypertension—are tremendous causes of end-stage renal disease. We commend Mr. Stark on H.R. 1068 which suggests a demonstration project on the benefits of attempting to delay the onset of ESRD. The NKF is working in a similar

direction. It has had a task force now for almost 3 years on investigating early intervention and prevention. Really, this is a tremendously important area.

The final area that is covered by our recommendations is the area of rehabilitation. We think, as I said earlier, that informed patient choice among all modalities of treatment is tremendously important, which form of treatment best suits their style of life and can support their quality of life. We believe that there should be incentives for units, to emphasize home hemodialysis, which is probably the most effective treatment technique that has yet been shown, also to create night shifts at hemodialysis centers to accommodate working patients.

We also believe that there should be guidelines on staffing patterns, recognizing that these have to be flexible depending on patient makeup, but these staffing guidelines should talk about all the disciplines, nutrition, social work, nurses and technicians, as well as physicians, and should deal not only with the numbers of staff, but also with their qualifications.

In summary, we think this has been a tremendously successful program, but certainly one which, hopefully if some of these modifications would be considered, could be made even more successful.

Thank you.

[The prepared statement follows:]

TESTIMONY OF A. BRUCE BOWDEN, ESQ.
NATIONAL KIDNEY FOUNDATION

Mr. Chairman, Members of the subcommittee, I am A. Bruce Bowden, a practicing attorney from Pittsburgh, Pennsylvania and current Chairman of the National Kidney Foundation (NKF). The NKF is the oldest and largest voluntary health organization representing the concerns of kidney patients and the health care professionals who serve their needs. The Foundation is pleased to have the opportunity to appear before the Committee this morning to discuss the Medicare End Stage Renal Disease (ESRD) Program.

We welcome Congressional oversight on the status of this program. However, we would like to emphasize that the Foundation in its own right has played the role of watch dog continuously since the program's inception in 1973. Our efforts have been focused most recently around a project which we call "Controversies in the Quality of Dialysis Care." That initiative underscored the concern that some aspects of the ESRD program, including its payment system, can be improved. We would like to state at the outset, however, that we do not claim to be experts in reimbursement methodology or on managed care. We would suggest specifically with regard to the role managed care could play in the delivery of ESRD services, that the issue needs careful study and perhaps it would be prudent for the Congress to commission the Institute of Medicine (IOM) or other group to evaluate the implications of such an alternative payment system for this unique patient population.

As patient advocates we would like to make several observations that deserve particular attention as the Committee continues its oversight. We do so in the interest of improving access to and quality of care for Americans who have End Stage Renal Disease.

(1) The Medicare ESRD entitlement has been an overwhelmingly successful program, making life sustaining renal replacement therapy available to hundreds of thousands of people, irrespective of their economic status, their age, gender, race, religion or country of origin.

(2) At the same time we must take into account the changing nature of the patient population being served, which reflects an aging America, improved success in treating ESRD patients with serious comorbidities and an increasing incidence and prevalence of kidney failure among minority groups, which far exceeds their representation in the overall population.

(3) In order to make sure that the program continues to meet its objectives in a cost-effective manner, Congress, the Health Care Financing Administration (HCFA) and the renal community must address the following issues: providing adequate reimbursement for dialysis treatment; establishing a quality assessment methodology and quality assurance system that serves patient and clinical goals; authorizing sensible policies to support transplantation, the most cost-effective ESRD treatment modality; and helping patients, their families, clinicians, and the public come to grips with appropriate criteria for providing long term chronic care to patients of advanced age with multiple comorbid conditions.

HISTORY OF THE ESRD PROGRAM[1]

I want to provide the subcommittee with a brief analysis of the history and results of the Medicare End Stage Renal Disease Program and its relationship and importance to the current discussions about health care and Medicare reform. The program is truly impressive: as Chairman Thomas stated in announcing this hearing, it has saved thousands of lives since it was founded twenty-two years ago. Moreover, it has accomplished this remarkable success while its per-patient costs remained under tight control. Those facts are a source of great pride for the program and provide valuable lessons that may have future usefulness.

The experience with the ESRD Program, however, also teaches that any health delivery system must be more than simply a payment mechanism. We've learned that when the federal government is virtually the only payer for a medical service, cost control can become a dominant consideration in delivering the service. Cost control in isolation can lead to many problems. For instance, it could be argued that reduced dialysis reimbursement may have contributed to the high dialysis mortality rate in the United States, which is the highest of any industrialized nation.

We have learned that quality assurance measures and systems must be included in any payment program from its inception. Any truly successful health care system must be

[1]See Appendix.

concerned with quality, access, translation of scientific advancements and outcomes of patient care, as well as the relationship of these factors to cost.

A landmark in the evolution of the ESRD program was the creation of the United States Renal Data System (USRDS) in 1986. The USRDS is arguably the finest registry of its kind in the world and the epidemiologic data which it collects in conjunction with the 18 ESRD Networks provide direction for the kind of quality improvement initiatives which we advocate.

Epidemiology

There were 11,000 ESRD patients eligible for Medicare at the inception of the program on July 1, 1973.[2] By December 31, 1990, the prevalence of reported ESRD therapy at that point counted 165,353 patients.[3] Today there are over 220,000 Americans currently receiving dialysis treatment. The growth in expenditures under the Medicare ESRD Program can be largely explained by the remarkable expansion in the number of patients served, together with changes in the composition of the ESRD population. Three areas should be highlighted: the shift in age distribution of patients on dialysis or transplantation, alterations in the profile of patients accepted for ESRD treatment (relating to the underlying cause of kidney failure) and increases in the prevalence of patients with serious comorbid conditions. This can be attributed to enhanced ability to provide renal replacement therapy for older and sicker patients.

With respect to the aging of the ESRD population, there were 3,552 Medicare ESRD patients between 70 and 74 years old on December 31, 1980. A decade later there were 14,093 patients in that age group. The growth in the number of ESRD patients over 75 is even more striking -- from 2,578 at the end of 1980 to 16,124 on December 31, 1990. Stated in another way, patients between 70 and 74 comprised 8.5% of the ESRD population in 1990 as opposed to 6.75% in 1980. Comparable percentages for the over-75 age group are 9.75% (1990) and 4.9% (1980).[4]

Per capita Medicare program expenditures for dialysis patients increase with each adult age category. For instance, for 1990, the following annual costs were reported by HCFA:[5]

Age Group	Expenditures Per Dialysis Patient
15-24	$33,220
25-34	$34,495
35-44	$34,795
45-54	$35,960
55-64	$38,256
65-74	$45,405
75 +	$47,926

Another major demographic change has been the growth in the number of ESRD patients with a primary diagnosis of diabetes. On December 31, 1980 there were 4,358 Medicare enrollees in that category, accounting for 8.27% of the ESRD population. This should be compared with the 40,514 Medicare ESRD patients with diabetic nephropathy at the end of 1990, constituting 24.5% of the ESRD population. Indeed, diabetic kidney disease has become the leading cause of irreversible kidney failure in the United States. Moreover, kidney failure is only one consequence of diabetes. Diabetics may become blind and may suffer from neuropathy and peripheral vascular disease which may lead to loss of limbs. Not surprisingly, annualized mean expenditures for dialysis patients with a primary diagnosis of

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[2]Richard A. Rettig, Ph.D., Policy Analysis, Policy Formulation and End-Stage Renal Disease, Rand Corporation: 1980, p. 8.

[3]United States Renal Data System (USRDS), 1993 Annual Data Report, Table B.1.

[4]Ibid.

[5]Health Care Financing Research Report: End Stage Renal Disease, 1991, p. 60.

diabetes are higher than for any other group ($49,040 versus an average of $41,315).

Finally, we should not overlook the ethnic distribution of the Medicare ESRD population. While African Americans make up 12% of the population of the United States, they accounted for 28% of the Medicare ESRD population on December 31, 1980 and 30% of beneficiaries as of December 31, 1990. There were 15,044 African Americans on dialysis or with a kidney transplant on the former date, compared to 49,827 at the latter date.[6] Many African Americans have limited or inconsistent access to health care throughout their life time and many with end stage renal disease have numerous unmet health care needs with which ESRD providers must grapple.

RECOMMENDATIONS FOR STATUTORY AND ADMINISTRATIVE IMPROVEMENTS IN THE ESRD PROGRAM

The NKF believes that the recommendations set forth below are essential for the continued success and improvement of the ESRD Program. This unique federally supported health care experiment is twenty-two years old and is in need of advancements in the areas of quality improvement and assurance, access, prevention, rehabilitation, reimbursement and scientific research. The substance of these proposals was drawn from the Institute of Medicine study, Kidney Failure and the Federal Government, the findings of the Prospective Payment Assessment Commission, the National Kidney and Urologic Diseases Advisory Board's 1990 long range plan Window on the 21st Century, the National Institutes of Health (NIH) 1993 Consensus Conference "Morbidity and Mortality of Dialysis" and a special study group of the National Kidney Foundation, "Controversies in the Quality of Dialysis Care," previously mentioned. In total, they reflect the Foundation's concern for the ESRD patient and its basic philosophy of "moving from treatment to cure." Some of the recommendations can be implemented by administrative actions and others will require legislative remedy by the Congress.

Prevention

Recent research findings indicate that it may be possible to prevent or delay the progression of kidney failure. On the other hand, health insurers in general, and Medicare in particular, have not promoted preventive health care until recently. The NKF has established an Early Intervention and Prevention Task Force which is developing strategies for implementation among patients who are at high risk for ESRD. We also congratulate Mr. Stark for the interest in new approaches to preventive care which are evidenced in H.R. 1068.

Access to ESRD Therapies

The panel for the IOM study estimated that 93% of the U.S. ESRD population is covered by Medicare for renal replacement therapy. The remaining 7% include those receiving benefits from the Veterans Administration, the Indian Health Service and special State Kidney Programs. Furthermore, the United States has the highest referral rate for ESRD therapy of any industrialized nation. These data would suggest that access to ESRD treatment is not a problem. Such a conclusion, however, may be an oversimplification. Recent studies indicate that there is variability in referral by region of the country and by age. Patients in rural areas often have to travel hundreds of miles for dialysis (three times a week) if they cannot be treated at home.

Access to modality options may also be impaired. In particular access to transplantation is limited because the supply of organs has not kept pace with the growth in the number of patients on the transplant waiting list. Moreover Medicare policies may discourage patients from opting for transplantation. Finally, there has been a marked decline in the percentage of patients on home hemodialysis and the proportion of patients receiving peritoneal dialysis does not approach that in many other countries.

To improve access the Foundation proposes:

1. That information and education programs about choices among various

[6]USRDS, supra, note 3.

treatment modalities be available to all patients without regard to Social Security status.

2. That the 3 year limit on Medicare eligibility be eliminated for ESRD patients who are successful transplant recipients.

3. That benefits for anti-rejection drugs be extended to cover the life of the graft.

4. That new programs be instituted which would increase the availability of organs for transplantation by providing financial incentives for cadaveric organ donation or through removal of financial disincentives for living related donation.

Quality of Care

The NKF believes that the data regarding morbidity and mortality among U.S. dialysis patients are disturbing indicators of a decline in the quality of care in the ESRD Program. Our unadjusted annual mortality rate has risen in the past few years to more than 22%, considerably worse than in other industrialized nations (e.g., Spain, France, Germany, Japan). Despite a recent turn for the better, mortality is still higher than in many other industrialized countries. If we accept hospitalization rates or days per year as apt surrogates for morbidity, then patients over 75 years old and diabetics (the two fastest growing groups in the ESRD Program) consume, respectively, 20% and 22% more resources than the average dialysis patient. The number of Medicare covered hospitalizations increased from 183,500 in 1985 to 283,700 in 1990, an average increase of 9.1% per year. During this period, the total number of inpatient days increased at an average annual rate of 11.1%. This hospitalization experience is an indicator of personal suffering. It also constitutes a growing component of ESRD expenditures.

While there is no single cause for this alarming trend, the experts point to certain factors that contribute to the problem. Some believe that the way dialysis services are delivered, and the relationship between payment levels and patterns of care may have contributed greatly to the decline in quality. Over the past several years there has been a movement toward shorter dialysis sessions, in part based on misinterpretation of early studies. Reduction of hemodialysis treatment time may, however, have had an adverse effect on morbidity and mortality. In reference to the negative impact of reimbursement changes on quality, there is wide spread agreement with the opinion that reduced payments have had a negative effect on outcomes.

As the availability of funds became tighter, dialysis units changed staffing patterns. In the early 1970's, before the Medicare ESRD Program began, most ESRD patients were dialyzed in hospitals by registered nurses and were cared for by a nephrologist during each treatment. There was also intense involvement by experienced renal nutritionists and nephrology social workers with masters degrees. Since that time, but especially since the mid-1980's, there has been an evolution toward treatment in outpatient units, non-hospital based, with less care provided by registered nurses, more involvement by licensed practical nurses and technicians and less interaction with renal nutritionists and masters-level social workers. At the same time the government continued to add to the list of services which dialysis units must provide their patients without making corresponding increases in payment levels. These developments occurred while demographic changes resulted in an ESRD population which requires more, rather than less, care.

With these developments in mind, and from the perspective of the ESRD patient, the NKF makes the following recommendations:

1. That the federal government foster the development and validation of tools to measure the quality of care provided to ESRD patients, based on structure, process, and outcome.

2. That the renal community continue to develop specific quality assurance tools including ones for hemodialysis, peritoneal dialysis and transplantation and that total quality management and assurance be instituted for the program.

3. That all relevant government agencies work with the renal community to put in

place the mechanisms needed to implement quality assessment/quality improvement initiatives for ESRD care.

4. That responsibility for implementation of quality assessment/quality improvement be delineated at the unit level, for state surveyors, for ESRD Networks and at HCFA.

5. That HCFA conduct studies of the feasibility of an incentive reimbursement system for dialysis treatments in which payment is tied to the quality of care delivered.

6. That the reimbursement methodology of HCFA reflect changes in the demographics of the ESRD population that have occurred since the composite rate was instituted.

7. That the methodology for reimbursement be modified to take into account both case mix and acuity levels at individual facilities.

8. In order to handle the diverse needs of an older and sicker ESRD population, reimbursement levels should be sufficient to support adequate staffing levels at dialysis units, both as to staff/patient ratio as well as with respect to staff qualifications.

Rehabilitation

Rehabilitation signifies restoration of physical and mental function to the point that a person can once again engage in family and community activities and enjoy a satisfactory quality of life. Rehabilitation of the ESRD patient may include achieving a level of physical health, strength, and endurance to perform activities of daily living, enjoying hobbies and recreational activities, re-engaging in family responsibilities and returning to school or the work force. For those unable to maintain employment or return to work, rehabilitation may mean redirecting their skills into home or community activities that will enhance their self-esteem.

To enhance rehabilitation, the NKF proposes:

1. That the reimbursement program include incentives for facilities to offer home dialysis and evening shifts for the working patient.

2. That the reimbursement program provide appropriate numbers of qualified professional staff who have the expertise to facilitate rehabilitation.

3. That patients be offered a choice of renal replacement modalities, including transplantation.

CONCLUSION

Ready access to dialysis care and renal transplantation has successfully and effectively prolonged the lives of hundreds of thousands of people. However, the evolution of the Medicare ESRD Program has raised concerns which were not foreseen at its inception. Even though the program has many significant accomplishments, we can do a better job in reducing morbidity and mortality and improving the quality of life of ESRD patients. We therefore urge the Congress to consider implementing the above recommendations. This will help assure that the program continues to serve the needs of those Americans who have End Stage Renal Disease and who will experience kidney failure in the future.

Mr. Chairman, thank you again for the opportunity to appear before the subcommittee. I will be pleased to answer any questions that the subcommittee Members may have.

APPENDIX

Overview and Background of ESRD Program

On October 30, 1972 President Richard Nixon signed PL 92-603 into law, and with it a section which provided that every individual who is medically determined to have chronic renal disease and who requires hemodialysis or renal transplantation for such disease shall be considered as disabled and, therefore, eligible for Medicare. The dramatically concise amendment to the inches thick bill finally addressed the "who shall live and who shall die" argument which had been debated in every possible forum for a decade.

Before the enactment of the 1972 amendment and in the absence of any other formal predictable form of financial assistance, families of patients literally took to the streets selling raffle tickets, clipping coupons from food packages, and seeking outright donations to support dialysis treatment for a loved one. They formed voluntary agencies to help collect funds to buy machines, and to approach the government for assistance. These efforts were reported in hundreds of stories in the press, radio, and television. The public effort was given national attention by a troubling "Life" magazine story which focused on a patient selection process being practiced in Washington State. The article brought the "who shall live and who shall die" issue into millions of homes throughout the country. The situation elicited varying but limited responses from the public, professional societies, volunteer agencies, and state and federal governments.

The so-called 1967 "Gottschalk Report," issued by the White House Bureau of the Budget, which was little noticed at the time, called for a national solution to this perplexing problem. While it did not receive wide circulation it became the Bible for those who were convinced that the ultimate solution was a federally supported program for all patients.

The debate, which culminated in final passage of the Medicare ESRD entitlement, focused on cost, utilization, fairness, the transfer of technology, and the appropriate role of the federal government in health care. In the end, however, the imperative of the life-saving procedures and technology dictated the outcome.

The action of the Congress and of President Nixon had its roots in a combination of ethical imperatives, citizen pressures, evolving technology for life-saving procedures, and pressures for expanded national health coverage.

The second phase in the history of the ESRD Program was the process of implementation. This phase had its beginning in the House/Senate conference committee where cost and utilization were the focus of discussion. To arrive at a projected first year cost and outward estimates the Congress relied upon two sources: transplant and dialysis professionals and the Health, Education, and Welfare Department (HEW) actuaries. The physicians gave sincere but optimistic cost reports ($55 million first year) and conservative estimates of patient populations (level out at below 100,000). The HEW Office of Health Insurance Studies, operating on estimates from the community and statistical models, gave the conference committee its best estimates. Their first year projections had the exceedingly wide range of between $100 million and $500 million. Because of the poor data and the large number of variables, the estimates were no better than "educated guesses."

The process of developing a program had to be placed on a very fast schedule because the implementation date by statute was July 1973 (a short eight months). There was little legislative language as to intent for implementation except:

> The Secretary is authorized to limit reimbursement under Medicare for kidney transplant and dialysis to kidney disease treatment centers which meet such requirements as he may by regulation prescribe. Provided, That such requirements must include at least requirements for a minimal utilization rate for covered procedures and for a medical review board to screen the appropriateness of patients for the proposed treatment procedures.

The Department of HEW set about the task with very little data about severity, age, ethnic factors, associated diseases, numbers of patients and total costs. For example, no one suspected that the number of ESRD patients over 65 (which was about 5% of the total in 1973) would reach 40% of the ESRD population in 1993, or that there would be 160,000

dialysis patients on Medicare at the end of two decades. The result of which as been a twenty-two year process of refinement of policies, regulations and rates by the Congress, the Health Care Financing Administration and the providers.

Unlike almost all government supported health care delivery programs, the ESRD Program experienced rate reductions for facilities and providers. In fact, the reimbursement rate for outpatient dialysis in 1974 dollars has declined more than 60%.

The introduction of new drug coverage added an unforeseen cost element to the program. In 1986 the Congress allowed payment for anti-rejection drugs for transplant patients for up to one year post-transplant. The benefit was extended to three years by the Omnibus Budget Reconciliation Act of 1993. In 1989 recombinant erythropoietin, a synthetic hormone used in treating anemia, was added as a covered item.

Another unforseen development has been the lack of growth in the number of kidney donors, thus affecting the number of patients being transplanted. For example, as of March 15, 1995 there were 28,037 patients waiting for kidney transplants, a number that is expected to increase at an annual rate of 20%. This trend was not anticipated in 1973 or indeed in 1983. A kidney transplant is the treatment of choice for all suitable ESRD patients and, when successful, is cost-effective Over a ten year period transplantation offers an 18% savings from the cost of chronic hemodialysis. Thus, the flat donation rate has had a negative impact on both the patients and program costs.

The final part of this overview concerns trends in research. When the ESRD amendment was enacted into law the Institute at the National Institutes of Health (NIH), which was responsible for basic and clinical investigation concerning kidney disease, was spending $18,127,000 for this purpose, of which $4.6 million was supporting a dialysis research contract program. Ten years later the dialysis contract program received $600,000 in allocated funds out of the $47.4 million appropriated for kidney disease research. By 1992 the support for basic and clinical research in kidney disease had reached $118.4 million with virtually no dialysis research being supported. While this amounts to a seven-fold increase in support of kidney research, Medicare expenditures for ESRD patients in the comparable period grew fourteen times. Fortunately, that trend has been reversed with respect to dialysis research and approximately $1.7 million was directed toward dialysis related clinical research in FY93.

It may be argued that spending for kidney research by NIH is not proportional to the costs allocated for patient care. Although it is clear that the financing of these two separate functions (research and patient care) come about in different ways, and are influenced by varied and dissimilar factors, an effort to maintain research to combat renal disease as a fair fraction of expenditures for care, might help narrow the tremendous gap between the costs of patient care and the commitment to find cures.

Chairman THOMAS. Thank you, Mr. Bowden.

Dr. Lundin, I understand you would be the winner in the show-and-tell contest. I look forward to your testimony.

STATEMENT OF A. PETER LUNDIN, M.D., IMMEDIATE PAST PRESIDENT, AMERICAN ASSOCIATION OF KIDNEY PATIENTS, TAMPA, FLORIDA

Dr. LUNDIN. Thank you, Mr. Chairman.

Mr. Chairman and Members of the Subcommittee on Health, my oral testimony will differ from the written in words, but not in content. As immediate past president of the AAKP, American Association of Kidney Patients, I am gratified to be here today to relate to you the concerns of kidney patients for the future of Medicare's ESRD Program.

For most of us, dialysis has been simply the difference between life and death. Without dialysis, I would have died in 1966. Only because my father could afford to pay for dialysis treatments at over $30,000 per year, I was able to finish college, go to medical school, practice my profession as a kidney specialist, and be here today almost 30 years later.

As you are aware, the ESRD Program was enacted in 1972 to make this uniquely predictable, artificial, and lifesaving therapy available to the many thousands who could otherwise not afford it. I urge you to overlook the media-fostered image of the miserably unhappy dialysis patient as a measure of dialysis. The great majority of us, rather, are content to be alive, and by receiving quality treatments, have been able to do something we value with the time we have left. Given the life-sustaining nature of dialysis and transplantation, it is understandable that any changes in accessibility to the ESRD Program should create concern among its beneficiaries.

There are several points I would like to make to the Subcommittee today. As patients, we are concerned that the transfer of all or even part of the ESRD Program to the private insurance sector could again result in limiting access to care for many deserving patients as was the situation prior to 1972.

In the desire for cost savings, providing dialysis and transplantation services of quality may not always be the primary focus of managed care organizations. AAKP continues to hear from managed care patients with kidney disease as to inconveniences and restrictions of choice and travel. Good business practices do not always coincide with appropriate medical care.

In the future, is it implausible to think that dialysis for an HMO patient could only be received at a dialysis center 100 miles away or a transplant exclusively obtained at one 1,000 miles away where the patient must pay all travel and living expenses? This scenario would mean that only the economically fittest patients with renal disease would survive.

Should we assume that the private insurance sector will willingly assume a larger proportion of these costs, of the costs for these expensive treatments, without looking for such limitations to accessibility? Until we know how managed care organizations are going to deal with these life savings treatments, we urge a more cautious approach as was outlined by some of the speakers earlier.

For the patient with terminal kidney disease, delay of more than a few weeks in getting dialysis or a transplant means death. In addition, we are concerned that oversight for quality will not be a priority in a managed care environment. Most experts acknowledge that insufficient oversight of dialysis care in the past has led to higher mortality rates for dialysis patients in this country compared with Japan and Europe.

Let me point out parenthetically that Dr. Belding Scribbner, who developed hemodialysis with patients for chronic renal disease, learned very quickly what quality was back in the early sixties. Unfortunately in the 10 or 20 years immediately following that, that knowledge was lost. We could all speculate on why that knowledge was lost, but today we have the opportunity to regain it.

As you are aware, HCFA, through the ESRD networks and State facilities, surveys our agencies and with the full cooperation of members of the renal professional community, is moving more effectively to reverse this problem. We feel that this interactive approach to quality supervision should be maintained. More than simply an entitlement program, the ESRD Program is a model for efficient health care delivery and control of medical cost with quality oversight. Even at the $21,000 a year which the reimbursement rate covers for the dialysis patients or at $38,000, if you divide the total costs by dialysis patients, dialysis is cost effective in terms of a real life saved. We fear that this fact will not be appreciated by the private insurance industry today as it was by the Federal Government in 1972.

For patients, I appreciate this opportunity to testify and will be happy to answer questions.

[The prepared statement follows:]

TESTIMONY OF A. PETER LUNDIN, M.D.
AMERICAN ASSOCIATION OF KIDNEY PATIENTS

Mr. Chairman and Members of the Subcommittee on Health, I am pleased to be here today on behalf of the American Association of Kidney Patients (AAKP). My name is Peter Lundin. I am the immediate past president of AAKP and a practicing nephrologist. Moreover, I have been a dialysis patient for 25 years and have had a kidney transplant for the past three years.

The membership of AAKP is concerned about the future of the Medicare ESRD Program and how changes may effect the 200,000 beneficiaries. As a national organization of kidney patients, it is our hope that Congress will ensure the continuation of the very successful ESRD Program, which has covered the expenses of dialysis, transplantation, physician services and immunosuppressive drugs for over 20 years. As you are well aware, dialysis is unique among high-tech medical therapies. Without dialysis or transplantation death will certainly occur, however with treatment, patients can expect long term survival allowing them to lead normal healthy lives.

Given the life-sustaining nature of dialysis treatments and transplantation any change in Medicare payments or policy creates concern among ESRD beneficiaries.

The ESRD program has been and continues to be, a model for future health programs and medical spending. The government, in its efforts to provide a cost-effective method of treatment, has developed quality assurance measurements, maintained a national data system and structured a cost-conscious reimbursement system. Throughout the structuring and continuation of this program, patients' interests have always been balanced with costs in such a way that coverage for these life saving treatments continues to be provided to the growing patient population.

There are several points we wish to make to the Subcommittee today:

1. AAKP hopes that the Medicare ESRD Program will continue in the same capacity as is currently legislated. We are concerned that any move to have patients leave the program and enter managed care plans may lead to difficulties in achieving the current level of care. It is our belief that eliminating or changing the program, before a complete analysis of how new plans would incorporate dialysis and transplant care, could be detrimental to the 200,000 patients.

2. We are concerned that quality assurance levels will be lower in a managed care environment. As you know, the Health Care Finance Administration (HCFA) currently sets certain quality assurance guidelines that are reviewed in the dialysis facilities by the ESRD Networks, thus assuring adequate patient care. As patients, we would not want to see any changes in the tracking of kidney patients and the review of quality guidelines.

3. Discrimination is also a worry to patients. If the Medicare beneficiaries are moved to the private sector, we worry that costs and access could prevent patients from securing services.

4. AAKP wishes to bring to your attention the numerous complaints we continue to receive from kidney patients enrolled in HMO's. Complaints include difficulties in securing transplant services outside the HMO and the ability to choose dialysis facilities and physicians. In an effort to cut costs in a managed care environment, hospital admittance times have been shortened for transplantation. This can lead to only the healthiest patients receiving transplants because the hospital can guarantee a short patient stay. Also, in a managed care situation, dialysis patients may no longer be able to travel for business or pleasure because their destination facility most likely would not be covered in their managed care contract. Because of the numerous patient concerns, we ask that you please consider the impact managed care would have on patients before any type of managed care program is implemented.

Mr. Chairman, we appreciate the opportunity to address your distinguished Subcommittee. I will be happy to respond to any questions or comments any member may have.

Thank you.

Chairman THOMAS. Thank you, Dr. Lundin.

The gentlewoman from Connecticut will inquire.

Mrs. JOHNSON. I thank the panel for your very good comments. Dr. Latos, many would argue that kidney transplantation is the best treatment for many ESRD patients. How do nephrologists interact with other physicians in determining which patients are the best candidates for transplants, and do you have any information about how this interaction changes in a managed care setting or doesn't change in a managed care setting?

Dr. LATOS. The relationship between nephrologists and transplant physicians or transplant surgeons is a very close one, as you would imagine. The recommendations generally, and I think these have already been testified to, are that people really need to be apprised of their relative risks of transplantation.

There are actually only a few categories of people who should never be transplanted: People with active malignancies, certain infections that are ongoing, and virtually all other groups have relative risks, either mild risk or severe risk. And while some practitioners, I believe, tend to dissuade some patients away from transplant, the more appropriate, and I think increasing opinion among nephrologists is that people need to have access to transplant surgeons fairly early in the course of their time on dialysis, even prior to transplantation.

My own experience with managed care has been somewhat biased because we have had some difficulty in getting some managed care programs to have patients referred for transplant consideration until they are already on dialysis.

We have had a very active program in preemptive transplantation and I have personally been involved in the care of about 20 people over the last few years that have been able to receive successful transplantation and have never required dialysis.

So the relationships between nephrologists and those other physicians in the managed care programs need to be examined more clearly, and certainly the role of the transplant surgeon early on needs to be defined.

Mrs. JOHNSON. In your experience, are there any managed care plans that are showing an interest in preemptive transplantation?

Dr. LATOS. I am sorry, I didn't hear the last part.

Mrs. JOHNSON. Are there any managed care plans that are showing an interest in preemptive transplantation?

Dr. LATOS. Not specifically. I don't know that any are totally excluding them by policy. This is not a common practice in the country, although it is regional. Again, it depends on how early the patient gets to the renal care team. If the patient shows up on our door already having advanced uremic symptoms, that is not the time to consider transplantation. Those of us who see patients early in the course of their disease when symptoms are minimal can often get them referred to transplant months and months before they actually become ill enough to require dialysis.

Mrs. JOHNSON. A general question to the panel. This panel, as well as the preceding panel, has talked about the need to improve quality measurement tools. Over what period of time do you think this is possible? I mean, are we talking 6 months, 1 year? Are we

talking 5 years before we will be able to do a better job of measuring quality of care in this area?

Dr. LUNDIN. I think we are just about there. I think the end-stage renal disease networks have a whole plan that the other members can comment on, as well as the State surveyors. I think the cooperation between the U.S. Renal Data System, the ESRD networks, and the State surveyors working cooperatively and hand in hand is just about at the point that they can start to do some of this work that needs to be done.

In fact, they began in July, I believe, of this year with their new programs.

Ms. SIMS. I wonder if I could respond to that. As a member from the renal community of the HSQB and the HCFA Core Indicator Project, I can tell you that I agree with Dr. Lundin that we have made great progress in the last 1½ years. In the contract that was signed between the HCFA and the networks, the work that is being done looking at four quality indicators, the first phase of the report was done in January of this year looking at the four areas that Dr. Rettig referred to earlier. That report has just been made available to the community.

There is a 1995 phase of that process which will include those same indicators looking at another year of data collection, also looking at expansion of that program in 1995 to include peritoneal dialysis patient populations, and we will continue to look at other phases of that program throughout the life of that scope of work contract with those networks.

So I would agree with the previous panel and with Dr. Lundin's comments that we have started to make some real progress in these areas in a collaborative manner between the community and the Federal programs.

Mrs. JOHNSON. Thank you.

Mr. BOWDEN. NKF is about 14 months into a project on quality of dialysis care at this point, and we believe that the time necessary to develop guidelines is being looked at by the actuaries. I think there is pretty wide agreement in the community at this point that Kt/V standards such as those discussed earlier by Mr. Stark are pretty broadly accepted.

At the other extreme, nutrition standards are a long way off, and there is a tremendous amount of research that needs to be done before those standards can be put out. I think the answer to your question is it varies tremendously depending on the area.

Chairman THOMAS. The gentleman from California will inquire.

Mr. STARK. Thank you, Mr. Chairman.

Well, I want to not sound so much like a Johnny-One-Note, but Ms. Sims, you kind of stayed away from the standards. We had a Dr. Owen from Brigham and Women's testify last year that while the precise factors—I am quoting from his testimony—"are uncertain, a major contributing feature is the widespread use of abbreviated dialysis times that do not provide adequate treatment."

The common practice of dialysizing for less than 3 hours in the United States can result in cost savings of up to 25 percent per treatment. However, these cost-effective, short treatment times are associated with a major increase in the relative mortality risk from 1.0 to 2.18.

Recently, we observed that despite a standard established 10 years ago for adequate dialysis, 55 percent of a large cohort of hemodialysis patients received a quantity of dialysis that was associated with greatly excessive death risk.

Now, it seems to me that I am not hearing enough urgency from these witnesses about enforcing some standards that professionals seem to know exist. I mean, you are nodding, Mr. Bowden. I don't know why we can't beat on these people a little bit. It may require government regulation, God forbid, but somebody ought to say, this is a minimum, and anybody who doesn't do it that well ought to be kicked out of the program or not paid.

I would just like to urge you all, I know it is going to be tough on some of the people you work with or for, but it is a standard we know, or you all know, and I just would hope that we could be—however this comes out, whether you do it managed care or whether you do it fee-for-service, that we take the standards and start to, if you will pardon me, punish the people who don't live up to them. Maybe they are not perfect, but they are good.

The other thing that I am hearing is a 3.7-percent increase. Now, that is only one-half of the loaf. ProPAC recommended that the base rate is too high, so you can't—in a sense, can't have it both ways here, that you want a 3.7-percent increase but you don't want to raise the base rate. Those things, to me, go together. I guess the third comment is this issue of extending the time for private payers.

Nobody is suggesting that we do private payers permanently until people get to be 65, right? Because you are scared that the insurance companies will end the benefit, right? OK.

Now, I think you are flirting with disaster here. You want to keep pushing the private insurers, say let's go from wherever it is now, 18 months or 24 months to 30 months, because you get almost twice as much reimbursement, right? The private guys pay 80 percent more than Medicare. That is the reason they want to extend the private pay.

Now, I would be for extending it forever except if we required that every insurance plan in the country have the benefit. You got me signed up right now. Let's require every health insurance plan in the United States to make it a benefit and pay it up through age 65, at which point Medicare would take over. I will sign onto that in a New York minute, but then Dr. Lundin is going to worry that people who even have a hint of kidney problem will never get hired, that the employers—because it will kick their insurance up.

So somehow we have got to find—it isn't quite right, and what I am sensing, not from any one of you in particular, is that the providers want to keep inching a few more months of private care because that is a few more months of double rate, and at some point you are going to break that camel's back and then the private insurers are going to stop carrying it as a benefit. I don't know where that is, but I hope we could find a better solution than just extending private pay until we find out. Because when we find out that suddenly people are canceling the benefit, we are going to wish we hadn't gone that far.

So I am going to urge you to find another way to get a little more reimbursement than to keep pushing the private pay, because I think we are flirting with a disaster that we don't want.

I am going to urge you to set a minimum standard, because I think you can. Maybe it is not 1.2, but you can set one that—below which no one dare go. I think you help the patients a lot by doing that. And then we can see maybe whether we can provide more—because my time is expired, but you may want to respond.

Ms. SIMS. I wonder if I could address your first comment. We have, to this point, not supported minimum standards because we feel like they will be interpreted as minimum standards.

Mr. STARK. Above which no one would go?

Ms. SIMS. Exactly. Exactly. But we have supported the work that has been done on the core indicator project which has looked at quality core indicators, in other words, red flag areas that you would want to look at, the patient's outcomes, in four areas, and that is adequacy being one of them and using that number, anemia, hypertension, and albumin or nutrition, and I think another problem with the standard as proposed currently is that there are other factors that need to go with it.

That is, looking at nutrition, there are many studies right now that say it is not an independent factor. Also, I think that we have already seen lately that the standards continue to be elevated by the community itself, so to legislate a number would be a problem; and in fact, again, it would become a minimum, not something that people would strive for.

So that has been our big concern with standards. I think the work that has been done on those quality core indicators has taken a much more appropriate tact so far. It has looked at quality from the research. It is literature-based indicators and it has also provided data back in a very quick turnaround to the community that is, although it is nationally specific and network specific, it allows—the scope of work contract calls for work being done in those facilities specifically where their patients are, against those national core indicators, and then looking at ways under quality improvement for those facilities to start to work with the patient specific data.

Mr. STARK. At some point we ought to be able to set a minimum. No dialysis could be the standard if you say that is a minimum. I hear what you are saying, but it would seem to me there ought to be a floor below which—I am sorry, Mr. Chairman.

Chairman THOMAS. No. I just share the concern that establishing a floor then becomes a ceiling. The core concept is one we should look at. Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Yes. Thank you, Mr. Chairman.

Ms. Wish, earlier you mentioned a study that you have done on EPO, and I wondered if any of your studies reflected the financing arrangement. I am told that in paying providers, a lump sum is how some providers are being paid, and I wanted to know if, in determining the optimal financial solution to the dialysis centers, maybe a monthly composite rate has been looked at.

I am told that by using bundling versus a pay-as-you-go, that we may be causing higher rates of illness, possibly causing hospitaliza-

tion in the long term. I just wanted to hear your comments on that and if any of your studies have reflected that.

Ms. WISH. When EPO was first reimbursed, it was set up as a flat fee, that all providers got the same amount of money regardless of the dosage. Medicare felt that was one way to control the cost of EPO. HCFA's studies have shown that patients were significantly underdosed and we believe there was a profit motivation there. There was a very good opportunity to make money on the flat fee reimbursement at the time.

I believe that some of those studies were skewed a little bit based on the fact that it was a new drug and providers and practitioners had very little experience with it, and there were a lot of serious reservations about starting the drug at high levels.

So there were a lot of facilities that legitimately gave the patients low doses initially until they could get a handle on what kind of symptoms the patients had, whether they had seizures, whether they had massive problems with hypertension, and so forth.

When the drug was first available at the $40 per dose level, a lot of facilities did start off with lower doses and then increased the dosage as they became more comfortable with the drug and found out more about the side effects or lack thereof of the side effects. At the same time that the dosages were starting to increase, Medicare changed the payment to $10 per 1,000 units administered.

From the time the payment mechanism was changed, EPO dosages increased significantly because, at that point, people could appropriately prescribe the amount of drug that the patient needed to get them up to the appropriate hematocrit level.

So a couple things happened at the same time. The payment methodology changed about the same time that providers felt more comfortable with giving the drug and found out about what kind of side effects the patients did or did not have.

I think right now, the average hematocrit has increased. It isn't quite at the national level to the targeted range between 30 and 36 where we would like it, but it is going in the right direction. I think that if the payment methodology was changed back to a flat sum by bundling it into the dialysis payment, there would be a real danger that patients would be underdosed, especially coupled with the fact that we haven't had basically an increase in our dialysis treatment rate in about 20 years. Because Medicare's dialysis payments just keep going down in real dollars, facilities have got to cut somewhere and they have got to find some way, and I think that bundling EPO payments into the dailysis payment would provide people a very easy target to try to underdose EPO. Bundling EPO payments into the dialysis payment would not be good for patients.

Mr. CHRISTENSEN. Do you have any kind of estimate on how much of the total cost is being reimbursed to the manufacturers in this area.

Ms. WISH. How much is being reimbursed to manufacturers?

Mr. CHRISTENSEN. Of the total cost on EPO, how much is actually going back, is being reimbursed. Is there any specific figure, do you know? I mean, I think it is very important that we keep in mind the total cost of the drug, and I am wondering if the actual total cost is being reimbursed.

Ms. WISH. The bundling method doesn't exist right now. But the cost—the reimbursement rate we get is 80 percent of $10 per thousand units, and the cost that most providers pay is just a very small fraction below that. One statement that was made in prior testimony alluded to the fact that the monopoly status that Epogen has right now on EPO will expire within the next couple years, and that is not true. It is my understanding that Amgen will remain the only supplier of EPO for at least another 10 years.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Man I have one more question?

Chairman THOMAS. Sure.

Mr. CHRISTENSEN. We are running out of time but it is for Dr. Latos. Would you explain to me the ESRD networks and who runs these networks?

Dr. LATOS. That is very appropriate. The end-stage renal disease network organization was actually established in approximately 1978. At that time there were 32 networks, I believe, whose job it was to provide oversight and feedback to dialysis practitioners, facilities, as well as nephrologists, nurses, and other staff.

It was funded solely through Medicare and HCFA at that time. Several years ago, the network system was revamped and now there are, I think, 17 networks—19 networks, and these are all funded, by the way, based on a 50-cent-per-treatment basis, so that the dialysis facilities pay into the funding for the network organizations.

The role of the network organizations has actually increased over the years. It has become very important to the practitioners and the facilities. Feedback is provided on a regular basis, and it was already commented that the core indicators project will be a very, very valuable and powerful tool in changing practice patterns where they need to be changed.

Mr. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. As a followup to one of the questions, I believe, Mrs. Sims, in your testimony you said we possibly could extend the secondary payer to 24 months but not longer. Ms. Wish, I believe yours was 24 to 30 months. The gentleman from California indicated that there is a drop-dead point. Is the difference between 24 and 30 months that factor, or is it that you take it in stages to see where we go?

Ms. Sims, what if it was extended to 30 months rather than 24 months?

Ms. SIMS. I couldn't hear the last part of your question.

Chairman THOMAS. If it was extended to 30 months rather than 24 months. You indicated that you thought 30 months was too far.

Ms. SIMS. I didn't—we basically stuck with the number 24 to this point. We do not support it being extended indefinitely, which as Mr. Stark pointed out is not necessarily being suggested right now. I think we would be negotiable on a fixed time. We are concerned about employer group health plans and benefits to those patients.

Ms. WISH. I agree as well. We are concerned, as Mr. Stark mentioned, that we don't know what could happen if the Medicare ESRD secondary payer provision became indefinite. We feel that a small incremental increase is the most appropriate way to go,

which is why we feel that anywhere between 24 and 30 months would be OK. Anything beyond that, we are just too concerned about the ramifications.

Ms. SIMS. I would also like to go back and comment on something Mr. Stark said, I didn't get a chance, and although Ms. Wish could probably more helpfully address this, I am aware of private payers who have negotiated Medicare rates so that it is not our understanding at this point that if you have patients with extended private pay, that the facility is getting any more money because they are private pay. We have heard of specific examples where the private insurer has negotiated a same rate.

Ms. WISH. I agree that that is true, that the private payers are getting much more sophisticated. In the past they really didn't know. They probably had a very small percentage of their patients that were on dialysis and the bills just went through, and they really were not aware of what they were paying.

The managed care providers, in particular, are getting much more sophisticated about this and some of them are either negotiating Medicare rates or below Medicare rates. This is very scary to us because it is very difficult right now, dealing with a low Medicare reimbursement rate, and with the great move toward managed care, we are really concerned that we will be in a situation where we would be forced to take dialysis payment rates that are even significantly lower than the Medicare rates.

Chairman THOMAS. Which puts more weight on our rate setting because we clearly have a direct impact on the private sector.

Dr. Lundin, do you mind if I ask you some personal questions?

Dr. LUNDIN. Not at all.

Chairman THOMAS. You indicated that you began dialysis in the midsixties.

Dr. LUNDIN. That is correct.

Chairman THOMAS. My understanding is that you had a kidney transplant?

Dr. LUNDIN. No. I began on hemodialysis. I spent 25½ years on hemodialysis.

Chairman THOMAS. So you have not had a kidney——

Dr. LUNDIN. I had a kidney transplant 3 years ago.

Chairman THOMAS. Three years ago, and obviously, it was successful?

Dr. LUNDIN. Yes.

Chairman THOMAS. Are you on dialysis now?

Dr. LUNDIN. No. The kidney is working, after 6 weeks of not working, so——

Chairman THOMAS. What led to the decision and the timing?

Dr. LUNDIN [continuing]. You might ask the question why I didn't have a transplant before.

Chairman THOMAS. That was what I was asking.

Dr. LUNDIN. My experience in seeing friends who went off to get a transplant with the promise that if it didn't work, they would be back on dialysis, most of them never made it back on dialysis when it didn't work. So there was—for many years, transplant was sort of a Russian roulette in effect. With the advent of cyclosporine, it has improved substantially. After 25½ years of dialysis, one gets

a little tired of doing the same thing all the time, so it was time to try another therapy.

Chairman THOMAS. Your decision is kind of like my 4/5 lumbar area. They are getting better at it and if I can still wait around, I am going to wait as long as I can.

We are talking about, obviously, quality of life before your transplant and after the transplant is significantly changed. So you waited, but now you are glad you had the transplant?

Dr. LUNDIN. First of all, I don't know that the quality of life was—in some ways it is different in that you are not restricted to a machine, but I was able to go to college, medical school, play basketball, many things on dialysis that I can't do today, although I am almost 30 years older. That may be the explanation.

Chairman THOMAS. When we say that some patients are probably not good candidates for transplants, is that a timing factor, that had we had the capability for a transplant and the organ available at the same time? Or, that at an earlier age, they would have been candidates?

Setting aside the availability of sufficient organs, is it reasonable to say that if we had the timing and the ability to increase the potential for transplants, that virtually everyone at one time on a time progression would be a candidate for transplants?

Dr. LUNDIN. Well, because of the major surgery involved with transplant compared to dialysis and the immunosuppressive drugs which have their own level of toxicity, it becomes increasingly risky for older patients, patients with other medical complications to undergo that and survive.

As I said, it took 6 weeks for my transplant to finally work, and at the state I was in, I doubt very seriously if the kidney had not worked that I would have made it back to dialysis. And that 6 weeks was a very debilitating time of course.

Chairman THOMAS. Well, clearly if you have various infections, because of the immunology, you wouldn't be able to do it, but I am just trying to get a feel for the significant increase in transplants, and then the subsequent reduction in dialysis over the next several years, but I am getting some resistance.

Dr. LUNDIN. No. The availability of donors is quite clearly a problem.

Chairman THOMAS. That is the key.

Dr. LUNDIN. Yes. If there were more donors, then certainly most of the younger people today would opt for a transplant.

Dr. LATOS. If I might comment, Mr. Chairman, I think Dr. Lundin's hesitancy to undergo transplant for many years is no surprise to many of us who have also taken care of people, and the real risks in the days gone by that immunosuppressive agents and the programs, we had to counter the rejection episodes, which occurred virtually 100 percent of the time, were not very good, and patients who got treated for rejection with very high doses of prednisone did not do well.

Even 20- and 25-year-olds did very poorly with repeated episodes of rejection. It was only with the advent of cyclosporine that the early severe rejections have been decreased, that many patients are able to undergo transplant much safer.

There is another point that I think needs to be used for word of caution here is that the experience is not uniform, but it is very clear that some managed care programs are hesitant to have patients undergo transplantation. The policies are not written in many situations. There are intrinsic policy issues that have to do with referrals. Patients get transplanted in one program and then in the midst of a rejection episode are told that they now must transfer their care to another managed care program because the employer has changed.

That doesn't happen—that doesn't have to take place too many times within a dialysis center and patients are going to say, wait a minute, I don't think I want to do that. It is a real problem. I am not sure how widespread it is but it is a factor that needs to be looked at as well.

Chairman THOMAS. We are dealing with a whole set of psychological concerns as well as physiological, and if you add any trauma to that, it makes it very difficult. Is that what you are saying?

Dr. LATOS. Absolutely. The stress, as Peter mentioned, of going through a rejection or a nonfunctioning transplant is substantial. People who are on dialysis know what they have. Good, bad, or indifferent, they know. They have done it for months, they have done it for years, and for many individuals, especially if they have undertaken some type of physical rehabilitation program along with it, can do pretty well and many can do what they need to do with their lives. And that risk of transplant is uncertain enough that they may not be willing to take it.

Dr. LUNDIN. Mr. Chairman, if I might, the reason I stayed on dialysis for so many years is because it is a very predictable therapy. If you have good access, it works. It is a matter of sticking to one successful treatment after another.

I might point out again to Dr. Scribbner, who is Dr. Blagg's mentor, that the very first patient with chronic liver failure put on hemodialysis lived for 11 years, even though those first number of years they didn't know how long to dialyze the patient and what to do in terms of other medical therapy, and one of the original patients is still alive today, exclusively on hemodialysis over 34 years later.

Chairman THOMAS. What about mobility in terms of the ability to travel in dialysis, especially with managed care and restrictions with——

Dr. LUNDIN. Yes. That is going to be a problem. Today, there are many dialysis centers around the country and around the world that, if you plan early enough, you have the opportunity to go. I have spent 6 months in Germany on a sabbatical. I have spent a month in Taiwan getting dialysis and traveled extensively around the world as a dialysis patient.

Ms. SIMS. I wondered if I could just go back to the transplant issue. I thought Mrs. Johnson asked a good question earlier. I am a transplant clinician at the University of Virginia and I will tell you that we have seen patients who we would like to evaluate in our program who cannot be referred in for after 1 year of dialysis, although we would like to preemptively transplant them in our program and that is something we have done very well.

Certainly, there are managed care programs, HMOs right now, that just simply are not referring those patients in. It may be a small number right now, but I think those are patients who are not on that continuum that you asked about. There are some patients who, because of their comorbid diseases, just will never be candidates.

There are patients who need a trial on dialysis to see how they are going to do before they are candidates again. The waiting time is 2 years or longer for kidneys right now. But there are patients who must be on dialysis for over 1 year in some programs before they can even be evaluated. It really lengthens their waiting time to almost 3 years.

Mrs. JOHNSON. As you watch the development of managed care in the next year or two, I hope you will get back to us on this subject. I consider managed care an evolving form of delivering medical services, and in other areas, I have seen enormous change of focus toward more preventative or permanent solutions, so I am not surprised that you aren't seeing it yet in this area, but I would hope that you would begin to see it. If you stumble across any other evidence, I would be interested in that, and I am very interested in your most recent comments.

Thank you.

Dr. LATOS. Mr. Chairman, I feel an urgent need to clarify an issue for this Subcommittee, if I may, now or at your convenience, that has to do with this standard that has been talked about and this dose of dialysis, this thing called Kt/V. I think it is very important that the Subcommittee understand what that represents.

The Kt/V is a mathematical number that is an attempt to define a dose of dialysis, and there are many factors that contribute to that dose, none the least of which is the length of time that an individual stays on dialysis for a given treatment.

And although factors such as the type of dialyzer, the length of minutes one dialyzes, the adequacy of blood flow, many things are beyond the control of the provider group, the physician, and the nurse, that actually are going to encompass a dose of dialysis. If patients, for whatever reason, choose to come off dialysis sooner or they have vascular access that does not work properly, then it is sometimes difficult to actually deliver that dose.

Reflecting a little bit further on the comments about standards, the practice guideline that has been developed, and I was part of the committee that actually wrote that practice guideline, is a guideline, sir. It is not a standard, and it is very important that we focus on that. The data that we have published that suggests that 40 percent or somewhere in that range of dialysis patients may not be getting the proper amount, I suggest will be changing because the community is now much more aware of the need to provide good dialysis for a proper length of time. I think the practices already are changing, and the data that we see this year I suspect will be much different than it was 1 year ago or 2 years ago.

Chairman THOMAS. I thank the panel very much. One last question.

Mrs. JOHNSON. Could I just clarify? Are you saying to us, Dr. Latos, that the guideline is working well and that precise standards could actually not work in the patient's interest?

Dr. LATOS. Yes to both those. There are many studies that have been published over the last couple of years that talk about the number of Kt/V, and the RDA guideline was designed to define not the absolute minimum but sort of a range that would assure a good outcome. We are not able to equate that number, which is still an evolving number, to a standard.

If we were to set a Kt/V, for example, of 1.2, there well could be some practitioners that would decrease the amount of dialysis to achieve only 1.2. Mr. Stark asked whether or not we want to develop a floor below which no one should fall, and we are supportive of trying to do that. I am not sure the science allows us to define that number at the present time. It is certainly in the range of 1.2 or thereabouts.

Chairman THOMAS. Dialysis is a medical procedure. It is not changing oil.

Dr. LATOS. That is correct. There is no magic dose of penicillin that treats pneumococcal pneumonia either.

Chairman THOMAS. All right. I thank the panel very much.

We would call our last panel, Mr. Berger and Mr. Thiry, is it, I believe?

Mr. THIRY. Yes.

Chairman THOMAS. Thank you.

As I have indicated to the other panels, your written testimony will be made a part of the record and you can, for your 5 minutes, inform us any way you see fit. Doctor Berger.

STATEMENT OF EDWARD E. BERGER, PH.D., VICE PRESIDENT, GOVERNMENT RELATIONS, NATIONAL MEDICAL CARE, INC., WALTHAM, MASSACHUSETTS

Mr. BERGER. Thank you, Mr. Chairman, Members of the Subcommittee. I appreciate the opportunity to come here and speak to you today on behalf of National Medical Care.

The positive achievements of the ESRD Program have been well documented in prior testimony today. The Federal guarantee of coverage to those with ESRD has certainly fostered the rapid development of a dialysis and transplantation service system more than adequate to meet the needs of all Americans with ESRD.

With respect to dialysis service, it has done so with a record of cost control unequaled in the recent history of the U.S. health care system.

Over the years, however, and this is the focus of my testimony, the program's guarantee of coverage has evolved into a set of policies which segregate ESRD providers and patients from the mainstream of developments in the private health care sector and which artificially insulate private insurers from responsibility for ESRD.

The resulting disproportionate reliance on the public sector for funding and for management has, over the long term, had a variety of deleterious effects on the ESRD Program, and we have some proposals as to how those might be addressed going forward.

Most immediately, dialysis providers and patients have been rendered excessively vulnerable to public budgetary concerns in a time

of great and legitimate concern over the rising cost of health care. Because dialysis uniquely lacks some form of automatic adjustment for inflation and because we have seen over the last decade a series of budgetary reviews, all done in the context of efforts to control Medicare spending, reduce Medicare spending, reduce overall government spending under Gramm-Rudman-Hollings, we are paid just about the same amount of money today as we were in 1983 when the composite rate was first put into place.

Most authorities who have studied the subject believe that Federal reimbursement policy has been an important factor in limiting or reducing the quality of care available to ESRD patients and that all reasonable sources for efficiency gains have already been fully exploited by providers.

We think it is terribly important, therefore, that Congress turn its attention to this problem, and we urge on the Subcommittee the view that an automatic annual adjustment inflation for dialysis services comparable to that which is already in place for virtually every other class of Medicare provider be instituted.

At the same time, we believe that the Medicare Program has both the right and the obligation to demand that dialysis facilities develop and implement effective outcome-focused quality assurance programs to monitor the quality of care along the critical dimensions that dialysis patients need to live and to prosper. The model for such programs has been fully developed in the literature on continuous quality improvement and is described in detail in the Institute of Medicine's 1990 study, Medicare: A Strategy for Quality Assurance.

I would like to suggest that the special restrictions in the length of the Medicare ESRD secondary payer period, and other existing rules insulating the private sector from involvement with ESRD, should be removed. These rules have been critical in insulating us from the creative adaptations which dominate the private health care sector and keep us segregated from improvements in the nature of medical case management and cost-efficient delivery of care.

Finally, we believe that the conflicting incentives that are created by the diversity of Medicare reimbursement methodologies which apply to dialysis facilities should be rationalized.

Without going into detail, the most obvious case in point is the conflict in incentives created by the difference between the dialysis composite rate, which is for some package of services comprehensive and prospective, and the erythropoietin payment methodology, which is dose related, retrospective, if you will.

There are many other examples in addition to EPO which might be given, but we believe that the combination of these two in the facility creates conflicting incentives which detract from the efficient overall utilization of scarce health care resources for ESRD patients, and we think that that is an issue that should be addressed.

Thank you very much.

[The prepared statement follows:]

The Special Restriction on the Length of the Medicare ESRD Secondary Payer Period, and Other Rules Insulating the Private Sector From Involvement With ESRD, Should Be Removed.

Disproportionate reliance on the public sector for ESRD coverage has relieved private insurers from having to deal with the clinical and cost management of the ESRD patient. As a result, the development of models for the cost-efficient clinical management of the ESRD patient, a population at least theoretically well-suited for managed care, is far behind similar development in clinical areas of more immediate concern to the private payer community. While Medicare appears ready to implement an ESRD capitation demonstration project, that effort is limited and will not bear policy fruit for some time; the natural evolution of the private insurance marketplace would be a far more dynamic engine for development and testing of alternative models for management of ESRD care. The isolation of the ESRD program from the forces shaping the development of the larger health care system have deprived dialysis patients and providers of exposure to the variety of innovative and potentially valuable models for service delivery, care management, quality assurance, and risk-sharing which have been evolving in recent years in the private health care sector.

Congress should remove restriction on length of time for private insurance to be primary to Medicare for ESRD patients. This will give ESRD providers a better payer mix, save the Medicare program a meaningful amount of money each year, (CBO est $800 million in the budget period) and help integrate ESRD clinical management into the mainstream of development of the emerging and more cost-effective health care system. It could be accomplished without any harm to beneficiaries, particularly in conjunction with basic insurance market reforms addressing portability, pre-existing condition exclusions, etc.

Congress should also actively pursue other changes to encourage rather than discourage integration of the clinical management of ESRD patients into the mainstream of the private health care sector. Broader opportunities for ESRD patients to participate in HMO risk contracts would support this goal, as would demonstration projects for a variety of capitation models and/or voucher systems.

The Conflicting Incentives Created by Diverse Medicare Reimbursement Methodologies Which Apply To Dialysis Facilities Should be Rationalized.

Finally, while the dialysis composite rate was an early example of how a prospective payment system could create incentives for providers to behave more efficiently, and dialysis providers have been extraordinarily creative in finding efficiencies to absorb the inflation they have experienced in the last 12 years, the totality of Medicare payment rules applicable to dialysis providers today institutionalizes a welter of perverse incentives which undercut overall cost control efforts and which discourage optimal deployment of clinical resources. Reimbursement policy for human recombinant erythropoietin (EPO) is a case in point.

EPO, an artificial form of a hormone produced by healthy kidneys and essential to red blood cell production, is administered with close to 90% of all dialysis treatments, yet it is reimbursed separately on a dose-related basis. There is, then, an economic incentive for providers to use more as opposed to less EPO. Consistent with that incentives, HCFA data from facility billings shows that the average dose of EPO administered in the last 3-4 years has skyrocketed, from approximately 2,700 units when the present payment system was implemented to about

4,500 units by the end of 1994. Patient hematocrits, the measure of red blood cell count typically used to monitor the effectiveness of EPO therapy, have improved only marginally in this same time frame - certainly in no way proportionate to the increase in dose (and cost) of EPO.

At a reimbursement rate of $40 per 1,000 units, Medicare today spends more than $40 per dialysis treatment for EPO. This is almost one-third of the Program's average cost for a dialysis treatment, and the amount continues to grow inexorably without significant incremental benefit to patients. Anemia control is an important clinical dimension in care of the dialysis patient, and EPO is a valuable and effective tool in an anemia control program. But this investment is arguably highly inefficient, whether viewed narrowly in terms of maximizing the clinical effect of EPO or, more broadly, in terms of the overall clinical quality of ESRD patient care. A more rational and unified set of incentives for providers would likely produce a more efficient pattern of allocation of limited provider resources.

very thoughtful job of this nor did we in working with them 3 years ago. The world is very different today.

The final chart is just to get to the concerns in this area where as HMOs grew over the last 5 or 6 years in every other chronic disease state except dialysis, there were huge concerns about how pregnant women, particularly high-risk pregnant women, would be taken care of. The data couldn't be more clear that in a managed care plan, after managed care plan you have a lower rate of premature births and this includes the Medicaid population.

In the area of AIDS, again, you had huge and very legitimate concerns about how managed care would take care of these very expensive, often employed, high-dollar patients. If you go to southern California where there are more of these patients employed than anywhere else, you will see that many of the AIDS advocates point to the best care systems being those that are managed by managed care.

Managed care is no panacea. There will be mistakes; there will be abuses. But with the right volume of patients, there is a level of up front investment and a level of vigorous monitoring of quality that simply doesn't exist in a fragmented fee-for-service system.

Thank you.

[The prepared statement and attachments follow:]

Testimony of
Kent Thiry
President and CEO, VIVRA

before the
House Ways and Means Committee
Subcommittee on Health

Hearing on
Medicare End Stage Renal Disease Program

April 3, 1995

I would like to start my testimony today by thanking Chairman Bill Thomas for inviting me to testify on managed care for Medicare patients with End Stage Renal Disease (ESRD). I am Kent Thiry, President and CEO of Vivra, a New York Stock exchange listed company, headquartered in Burlingame, California. We operate over 150 kidney dialysis centers in 24 states, including California, Texas, Pennsylvania, Georgia, Louisiana, Virginia, Florida, Michigan and Illinois through a subsidiary company, Community Dialysis Centers. Vivra provides dialysis care to over 9,000 patients (one out of 20 in the country), making us the second largest provider of dialysis care in the country.

Summary

For patients with chronic disease states, the Medicare fee-for-service system is a clinical and economic tragedy. The system provides huge incentives for providing too many services at too late a point in patient care while simultaneously putting immense structural obstacles in front of anyone who would like to invest in preventative care.

The ESRD program in Medicare is no exception. In fact, it is probably the most extreme example of the immense human and economic waste caused by Medicare fee-for-service because it is likely no other patient population has as much of its reimbursement coming from Medicare fee-for-service.

I am here today to make one simple plea -- put more of these patients into the private sector so that:

1. More of them will enjoy the dramatically improved quality of care they would receive in a managed care setting.

2. The government will save $1 - 2 billion over 5 years

3. The country's overall health care costs will be lower within 3-4 years.

4. The government will be spared another blow to its operating credibility with the public, because otherwise it will be embarrassed by study after study showing the patients it "manages" die faster, are less likely to be employed, and cost more.

I will address the following issues in turn:

* Magnitude of the Issue
* The Basic Prevention Concept
* Real-life Examples
* Magnitude of the Opportunity
* Our Policy Recommendations

Magnitude of the Issue

The Medicare fee-for-service approach for serious chronic diseases is bad health care. The graph on the next page is a crude indicator of the power of managed care on the mortality side of the quality question. It is crude because it uses gross mortality, which does not adjust for differences in age, sex, race, etc. that may exist between the HMO population and others.

There is a new "Adjusted Mortality" methodology, however, which does adjust for several of the key patient-specific variables. Most of the government sponsored networks around the country prefer this measure, as do most thoughtful clinicians and analysts.

The economic issues are also large. In the advisory announcing this hearing, it was stated that this year there are approximately 200,000 Medicare beneficiaries with ESRD and that Medicare is spending $8 billion on this program, or $38,900 per beneficiary. These figures used by the Committee are considerably lower than our estimates, perhaps because some expenditures are not included and/or because we estimate there were only 190,000 dialysis patients in 1994. We believe the total national average cost of Medicare non-HMO coverage in 1994 was $56,070 per patient. The national cost of non-HMO care for ESRD patients has been growing at a considerable pace and saw almost a 20% increase from 1991 when the annual ESRD patient costs were $44,413. To make even a more significant comparison, the Medicare non-HMO care cost in California in 1994 was $62,636 versus a Medicare HMO in California where cost was only $35,000. This information is reflected on the next graph in my testimony.

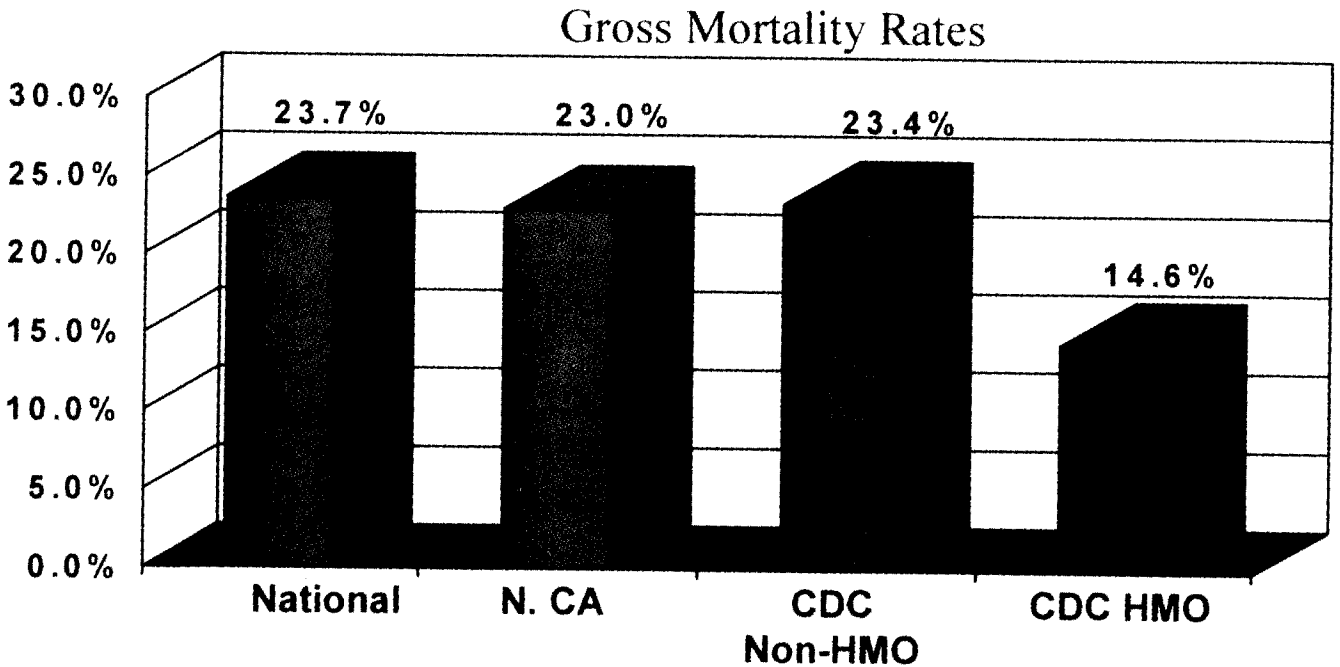
Which costs are increasing most rapidly? And independent of which national average cost per patient is correct, what is the biggest area of cost difference across different patient populations?

The largest drivers of ESRD cost increases over the last five years (and, if unchecked, the most likely drivers of increases for the next five years) are hospital costs and EPO (a drug). Depending upon whose numbers you use, hospital costs represent 20 to 45% of total costs. No matter whose numbers you use, dialysis is one of the few chronic disease states where annual hospital days per patient are increasing. And again, no matter whose numbers you use, managed care leads to significantly fewer hospital days per patient year as is shown in the graph on the following page.

With severe chronic disease states you cannot achieve lower hospitalization rates by "cutting corners" or by withholding care. Any good clinician will tell

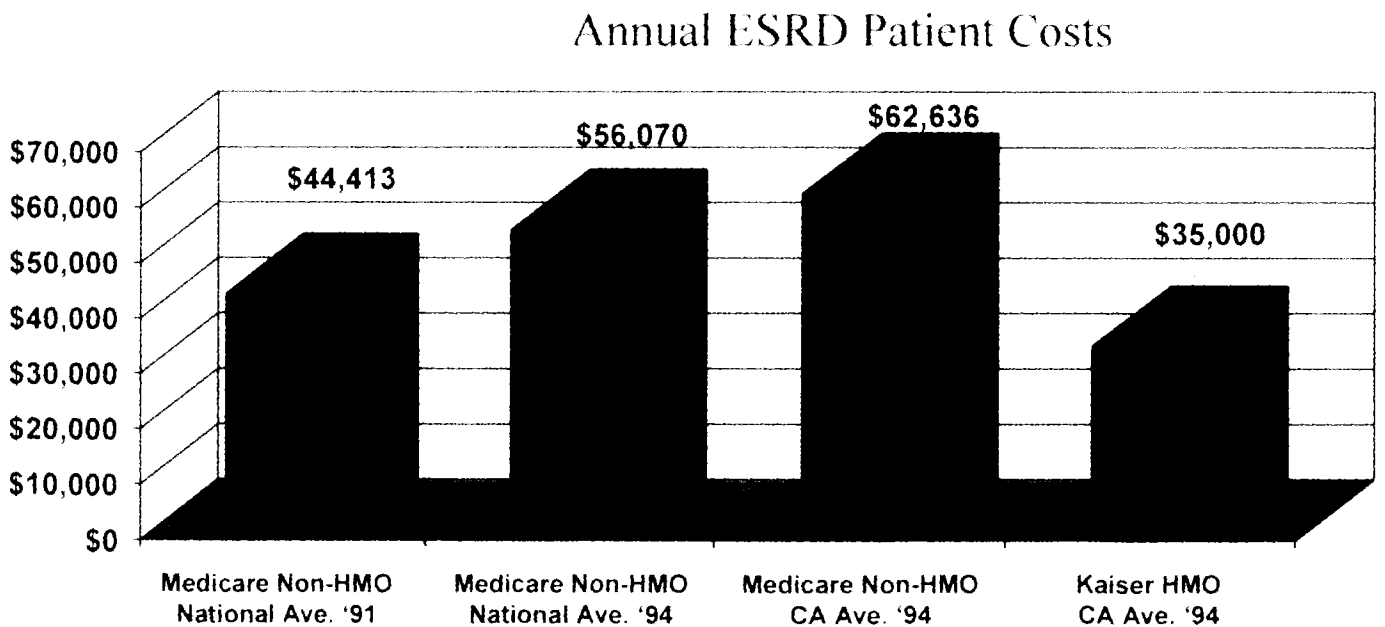
Quality of Life...

The mortality rate for HMO dialysis patients is 30% lower than the national rate, Northern California rate, or CDC Non-HMO rate.



Costs...

In 1994, Kaiser's annual dialysis costs per patient were 44% lower than Medicare's average California cost, and 21% lower even than Medicare's '91 national average cost.



you that if you do, then that patient will be back in the hospital bed sooner and sicker. Any good Medicare HMO executive will tell you that most of their enrollees (and an even higher percentage of their enrollees with chronic conditions, since the economic benefits of an HMO are more powerful for them), do not switch plans often, and so they are very sensitive to the multiple-year cost implications of any care approach.

Equally significant are the indirect expenses. Most dialysis patients who were working stop, because of the trauma and inconvenience associated with the beginning of dialysis and the ongoing disruption caused by the care pattern and regular hospitalizations.

The Basic Prevention Premise

Our premise not complicated, it is common sense. It is not theoretical, it is being proven every day in the actual real world of patient care. It will keep people healthier.

Our premise is that the private sector/managed care system will invest more and more effectively in prevention than Medicare fee-for-service.

This is true whether you assume most care givers are noble humanitarians or medical mercenaries, because for a chronic disease state they both want to do the same thing, namely delay the onset of the disease itself and prevent complications and extreme deterioration once the disease is in place.

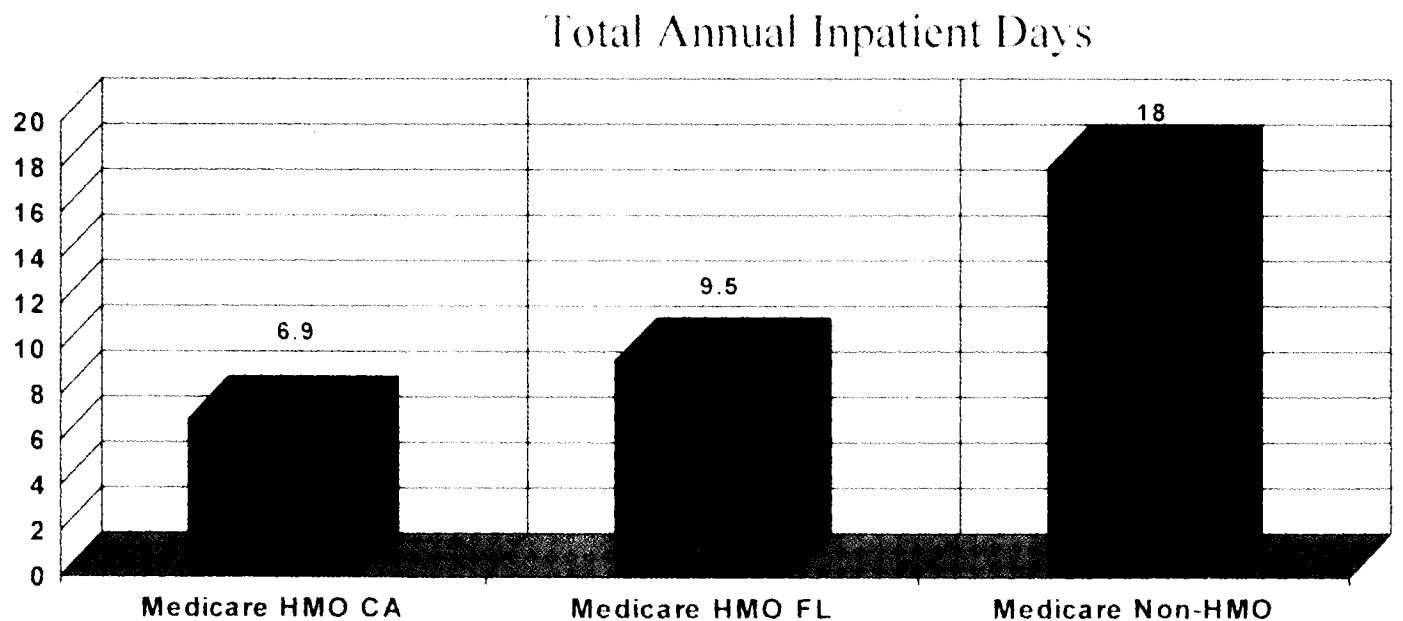
The economic incentives motivate the mercenary. But please understand your fee-for-service system makes things basically impossible for the humanitarian. Some of our patients would be better off if you reimbursed for more social work, dietetic work, homecare, and patient education. As a citizen I do not advocate your loosening the reimbursement restrictions in any of these areas because some providers would abuse the situation and work to the maximum allowed for all eligible patients. But the current system makes it impossible for the caregivers to make the larger investment for the particular patients who would benefit.

The soul of managed care lies in discretion around established baseline standards. Health Care Financing Administration (HCFA) fee-for-service is genetically wired for rigidity, not discretion.

When there is unified multi-year accountability of the total quality and total cost of a patient population, medical magic can and does happen. For patients costing an average of $150,000 to $250,000 each, who have thrice-weekly contact with their caregiver, the private sector/managed care system will put in place the unified, long-term accountability with discretion.

Quality of Life...

California and Florida HMO dialysis patients spend 50-60% less time in the hospital than the average Medicare Non-HMO dialysis patient.



Real-Life Examples

First I will provide three non-dialysis anecdotes, since non-dialysis areas ar dramatically more advanced in applying these basic truths of preventative c and working out the operating bugs.

We at Vivra are also in the diabetic care business. We know that rates of diabetes re-admission (meaning the same person being re-admitted) are low higher managed care areas than in low ones. This is because a greater investment is made on the "soft" side of patient education, care manageme and early identification of emerging problems, often by purchasing our ser

The next two examples are portrayed in the graph on the next page of my statement. The graph reinforces the powerful congruence of cost and quali objectives in "high prevention potential" situations. Private sector AIDS patients enjoy lower mortality and lower health care costs, primarily due to lower hospitalizations. Pregnant women avoid the cost, trauma, and long-t issues associated with premature births, with the obvious societal benefits.

Let's turn to some equally powerful dialysis examples:

1. Delaying Onset of Dialysis. Earlier specialist intervention could slo down kidney deterioration for many patients. Even a six month dela yields immense individual and societal benefits. Payers and provide experienced with capitation have "early warning systems" based on pharmaceutical prescriptions and other indicators which allow them t focus on these patients. They also have management processes whic eliminate the specialist's fear of antagonizing referral sources. This several hundred million dollar issue in itself.

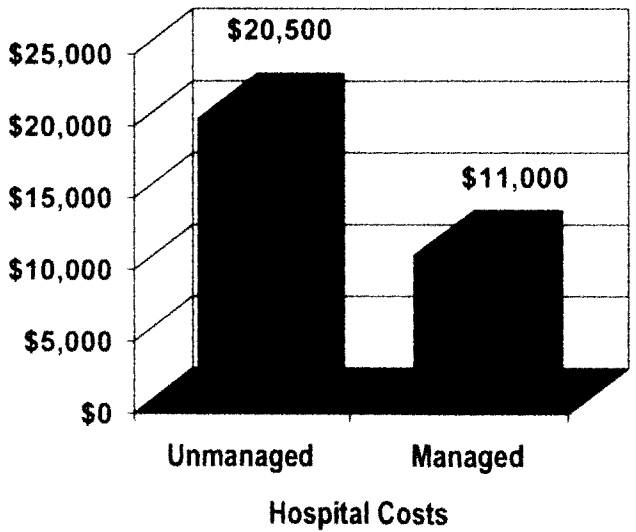
2. Quality Dialysis Initiation. A well managed pre-dialysis patient has simple "access device" placed in their arm though a simple out-patie procedure. This is done well before they need dialysis so their body time to accept it. When their kidneys ultimately fail, they simply be outpatient dialysis.

   Poorly managed patients are not similarly prepared. They will appe the emergency room and require a multi-day inpatient admission to surgically implant a larger and less clinically desirable access device.

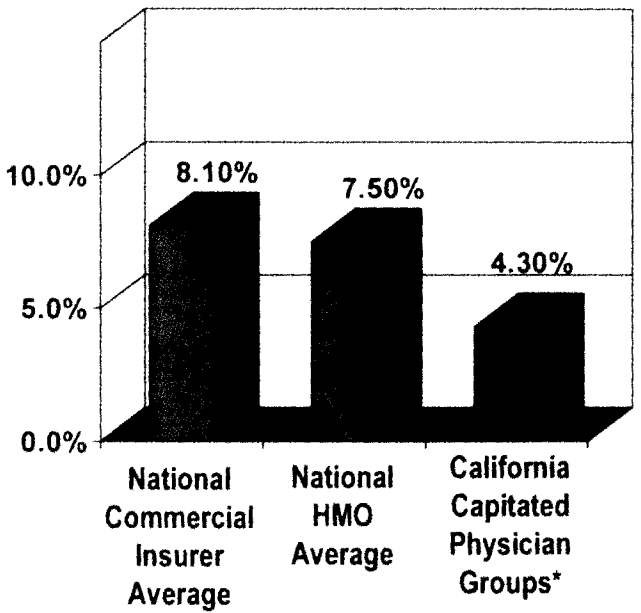
   The latter situation costs anywhere from three to six times more. T patient is less likely to continue working. The patient suffered far m clinical trauma.

   The incident of this latter situation varies by a factor of 10 in differe markets, and in general is already less frequent in high managed car areas due to the spillover benefits of managed care affecting general behavior.

Treatment Costs per AIDs Patient



Premature Birth Rate



* $400 million in revenues

3. Surgeon Selection Surgical and surgically related costs are 5 to 20% of patient costs. They are important to patient care because they are important to the patient retaining good "access" between the dialysis machine and the blood system. Surgical quality differs dramatically by surgeon. Low quality surgeons are high cost surgeons because their patient's accesses perform less well during dialysis and fail more quickly, requiring additional procedures.

   The private sector and managed care give nephrologists the data required to compare surgeons, and the surgeons get an unambiguous message as to the consequences of low quality.

4. Patient Education and Proactive Support. This can have an immense impact, as has been dramatically demonstrated with pregnant women in some Medicaid programs. Some patient populations require far more education and support than others. These are often the same populations who end up with the most complications and the highest annual expenses.

   The private sector will negotiate customized rates for these patients, supporting the larger investment requirement up front in exchange for the rigorously monitored downstream returns. Again, this is not theoretical -- we already see capitated Ob/Gyn rates for Medicaid patients that are a multiple of those for commercial patients. The provider demands the higher rates because there will be more work. The for-profit payer agrees to the higher rates because it knows the downstream savings will exceed the up-front investment. The patient and society benefit.

The list of examples could go on and on. What I would like to highlight is the:

* Alignment of economic and clinical incentives (including multiple-year agreements)

* Common sense

* Magnitude of the quality and cost improvements -- they are dramatic, not incremental

* Fact that a bureaucracy which is well-intentioned but structurally incapable of the requisite creativity, nimbleness and discretion will fail to achieve these improvements. They inevitably fall back on compliance to either administrative procedures which do not powerfully correlate with quality outcomes, or they boldly venture out with actual clinical parameters which are so crude that thoughtful providers are appalled. Finally, the bureaucracy never does what it takes to provoke exciting improvements, namely take patients away from bad physicians by providing referring physicians with compelling data or by eliminating them from a provider panel.

Magnitude of the Opportunity

We can delay onset. We can increase the percentage of patients who work. We can reduce complications and hospitalizations. We can do a lot, not a little, in all these areas.

The current centralized fee-for-service system has had a 22 year experiment. It would be difficult to imagine a more disappointing cost and quality performance. Please give us a chance, buy giving us a customer who can enter into meaningful and decisive discussions on real-world quality and cost per performance.

Our Policy Recommendations

To provoke private sector/managed care leadership in improving the ESRD program, we recommend:

1. **Test Us.** Extending the period patients remain on their private sector insurance from 18 months to 30 months.
2. **Free Choice.** Allowing Medicare beneficiaries with ESRD to enroll in HMOs.
3. **Fair Choice.** Grant ESRD patients the same COBRA continuation of health care rights as other employees.

I'll elaborate on each of these:

The benefits of managed care flow to the patient in the form of better quality of life and to the patient's insurer in reduced cost only if that insurer practices managed care. A problem arises with ESRD managed care in the fact that three months after diagnosis of ESRD a patient becomes eligible for Medicare. If an ESRD patient has private insurance, that private insurance remains the primary payor for 18 months. Because managed care relies on a significant initial investment of resources in the patient which would be recouped later in patient care, private insurers have little financial incentive to make that initial investment in managed care for their ESRD patients when Medicare will take over after 18 months. This then all but eliminates the financial incentive for insurers to manage the ESRD patient's care. To remedy this situation, we propose extending from 18 months to 30 months the period that private insurance remains the primary payer.

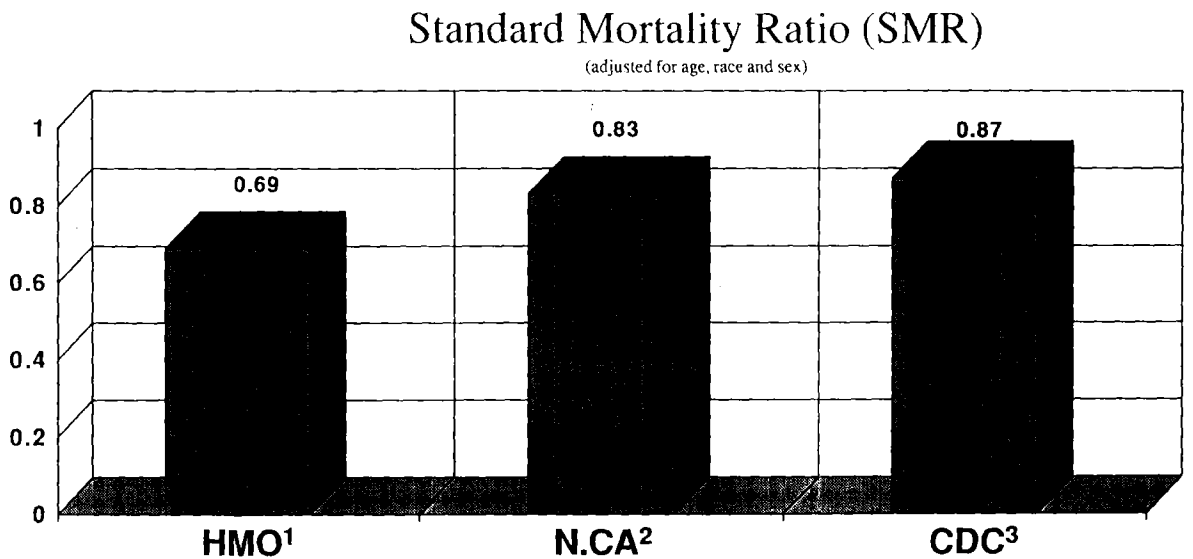
This is not a unique proposal. Last year, all of the comprehensive health care reform proposals (except for the Gephardt proposal) would have increased the period to 24 months in which private insurance would be primary. We believe that 30 months is more likely to encourage managed care and result in more significant savings to Medicare. The overall cost to insurers will be: a) minuscule as it will be taken from one payer (Medicare) and spread across thousands, and b) not proportional to the increase in months, because costs per patient will decrease over time. In going to a 30 month period for insurance as primary payer, it would be important to also write into law that insurance policy limits could not be reduced for ESRD. Limits are not generally applied to other chronic diseases, and ESRD should be no exception.

The benefits of managed care for ESRD patients are obvious. However, the country's largest insurer -- the Medicare program -- prevents ESRD patients from enrolling in an HMO after the advent of ESRD. While an ESRD patient who is already enrolled in a Medicare HMO may remain in it after the onset of ESRD, Medicare rules actually prevent individuals from choosing HMO care after the advent of ESRD. This rule no longer makes sense and ESRD patients should be permitted to enroll in managed care. This policy is especially perverse as Medicare HMOs grow. Many seniors will not join if they must change physicians. As HMOs grow, more physicians will become involved. Once a patient's physician is affiliated with a plan the patient can directly benefit from the superior pharmaceutical benefits and co-pay arrangements, which are economically significant for chronically ill patients.

Finally, as a result of being eligible for Medicare after three months, the Federal courts have held, despite HCFA's arguments to the contrary, that ESRD patients are not eligible for COBRA continuation of their private health insurance after leaving employment. If an ESRD patient could maintain COBRA coverage, the private insurance would be the primary payer. Another reason for permitting this COBRA coverage is that current case law is not clear with regard to whether dependents of ESRD patients are eligible for COBRA coverage when the ESRD patient becomes eligible for Medicare. HCFA's advocacy on this issue should not go unnoticed.

Quality of care...

Dialysis patients in HMOs experience lower standard mortality rates than patients in traditional fee-for-service plans.



[1] Kaiser of Northern California, CDC facility survey, 1994.
[2] Trans-Pacific Renal Care Network Annual Report, 1990.
[3] CDC company-wide average, 1994.

Chairman THOMAS. Mrs. Johnson will inquire.

Mrs. JOHNSON. Thank you for your very interesting testimony. Mr. Thiry, how do you account for the fact that some of the preceding panelists really had no sense that managed care was contributing to quality or managed care was doing a good job of both quality and cost reduction in dialysis, and particularly they focused on the insecurity that managed care would create for dialysis patients. In other words, all the negative arguments and none of the positive arguments. Why is the community that is most involved in delivering this care so unaware of the kinds of advances that you note?

Mr. THIRY. Dialysis patients that are in managed care probably only represent about 3 to 4 percent of the total. If you are running one center or a few centers, you have an exceptionally small number of patients. That also means the payers with whom you are dealing have a very small number of patients and therefore they probably aren't doing anything thoughtful with respect to dialysis because they only have four or five of them and after 18 months they turn them over to the government for the rest of the person's care life.

We are active in Florida and southern California, working with a small number of HMOs who have a sufficient number of dialysis patients so that it makes sense for them to allocate a lot of management time. We, all by ourselves, have about 600 managed care patients. That is probably a multiple of what anyone else other than national medical care is working with on a day-to-day basis. Not only do we care for 600 HMO patients, but they are concentrated in a couple of geographic areas.

Mrs. JOHNSON. So the news just hasn't spread yet.

Mr. THIRY. They literally are not dealing with managed care or thoughtful managed care. They may be dealing with thoughtless management care, exactly as they describe.

Mrs. JOHNSON. Your experience is in HMOs, which isn't an organization of managed care that maximizes the ability to manage. Are you aware of more flexible PPOs and organizations like that that also deliver managed care getting into dialysis?

Mr. THIRY. We have received our first phone calls from them and made our first phone calls to them only in the last 6 months, again, because of the same volume issue. There is tremendous opportunity to work within the PPO, POS industry.

Mrs. JOHNSON. Could you clarify for me again the volume issue, why is it other plans don't have to deal with the volume issue?

Mr. THIRY. If I have 150,000 enrollees in Cincinnati and x number of them are dialysis patients and x is a very small number, I will first deal with AIDS, asthma, allergy, oncology, Alzheimer's, and so forth, before I get to dialysis because it is such a small number of patients and I only have them for a short time.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. The gentleman from Nevada.

Mr. ENSIGN. Thank you. Dr. Berger, you mentioned an inflation adjuster. Do you know what we would currently be spending if we had an inflation adjuster all along in relation to the dollars per year that we are spending on ESRD today?

Mr. BERGER. There are two components that have not been traditionally adjusted for inflation. One is the physician monthly capita-

tion, and in the last year that has been folded into the physician payment system and will be adjusted. The remaining one is the dialysis system. I don't know, given the number of Gramm-Rudman-Hollings freezes and other specially legislated freezes and suspensions, what the actual difference would have been between 1983 and 1985 had there been the same sort of mechanism in place, no.

Mr. ENSIGN. If we built in an inflation adjuster, it would seem to me that advances in technology that would save costs would preclude the government from saving these costs.

Mr. BERGER. Congress has asked the Prospective Payment Assessment Commission to look at dialysis facility reimbursement and to make an annual recommendation and it has done so for 3 years. In doing that, it looks at the actual trend to the best it can calculate in the inflation, the costs of labor and other goods that dialysis providers have to buy.

It also looks at provider efficiency gains and at the net effect of new technology. It comes up with a single composite from those three factors which is its recommendation in terms of those quantitative numbers that are available for an annual change.

I think that is almost precisely comparable to the way in which the ProPac recommendation for hospital reimbursement is made, and we would certainly be very happy to see those elements factored in.

Mr. ENSIGN. So that would be acceptable to you on the inflation adjuster?

Mr. BERGER. Absolutely. Not just a pure blank check for some financial indicator; no.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Nebraska.

Mr. CHRISTENSEN. Mr. Thiry, in your written testimony you talk about the extension of COBRA benefits. Did you want to expand on that or not?

Mr. THIRY. The reasons for advocating are the same reasons that we advocate in general putting more of these patients in the private sector. In that particular scenario it seems especially unfair that ESRD patients are not having the same right of choice that other employees have. But our basic motivation is the same.

Mr. CHRISTENSEN. OK. I tend to agree with most of your testimony and appreciate your time here today. Thank you, Mr. Chairman.

Mr. THIRY. Mr. Chairman, you asked a question earlier about breakthrough investments which could radically improve the quality and reduce the cost of dialysis care. I believe some of those are out there.

I just recently received the highest quality investment opportunity in a wearable kidney, truly the best one I've seen. It is not going to get funded because even if it ends up working, it would cost several million dollars and a few years of development. Yet no one is confident under the current reimbursement system that the government will be able to do an effective, long-term cost analysis and weigh in the up front investment versus the downstream costs of managing those patients. I would submit that there is a definite chilling effect. This particular venture would radically alter the economics of my business in a way that will be very bad for my

shareholders, but it is a development I would welcome. That won't happen with the way the system works today.

Chairman THOMAS. I would expand the question and ask, if you have a wearable kidney and you have those kinds of expenses up front under a managed care structure or you have a transplant where you wouldn't continue—say, the success rate is very high and we have sufficient organs—why would any managed care operation on a capitated basis make the investment in fixing that problem given the high mobility that people have today in terms of their chances of moving on, having been fixed by you at great expense to provide a very handsome profit margin on a capitated basis to some other plan? Where is the incentive for you to make that decision?

Mr. THIRY. I would submit that if and when there are a lot of dialysis patients in the private sector, even an unethical company would be absolutely unable to underperform their competitors in terms of doing early transplants. Every thoughtful clinician knows that doing early transplants is a key to effective care in this area. Just as there are emerging key indicators in asthma allergy, and AIDS, and so forth, in dialysis you would be slitting your own neck as a proprietor of your own business to cut corners in that area.

Chairman THOMAS. In the long run?

Mr. THIRY. Correct.

Chairman THOMAS. You are in it for the long run.

Mr. THIRY. I am sure there are companies that are not, but the short run is getting shorter as employers are getting much more rigorous every month in the data they are demanding from providers.

Chairman THOMAS. Dr. Berger, that is why in your testimony you say that you would remove any month's period. We discussed with the earlier panel going from 18 to 24 or to 30. If I recall, your testimony indicated that you would leave it open ended.

Mr. BERGER. Leaving it open ended is where the logic of the analysis takes it. Mr. Chairman, we are knowledgable and sympathetic to some of the concerns that were voiced earlier, and we would be very pleased to have the Subcommittee look at those concerns to see whether there are some reasonably simple ways of alleviating them. But the logic of the problem, of the isolation of this program from the developing mainstream of the American health care system, is as Kent has said, to see to it that the private sector bears its fair share of the burden.

This is not a matter of trying to dump responsibility that is rightfully the public sector's on to the private sector, but rather to bring the distribution more into line with what is in fact conventionally found elsewhere in the health care system.

Chairman THOMAS. Perhaps the solution lies not narrowly within the public months relationship, but in the larger area of reforming health insurance which is offered and denied?

Mr. BERGER. Certainly, the package of what we are always told are almost universally agreed upon health insurance reforms having to do with portability and preexisting conditions would go a long way to alleviating the concerns expressed earlier.

Chairman THOMAS. One of the concerns I have in dealing with payment structures is that oftentimes you find to a certain extent

choices dictated by the payment method, especially in skilled nursing facilities—home health care areas that are growing rapidly, they are the last fee-for-service bastion. I am concerned that if we begin to make changes in structures, we do not create any opportunity for choices based upon a payment schedule rather than the efficacy of the choice toward the patients.

Any additional questions? I thank the panel very much for your participation and the Subcommittee hearing is adjourned.

[Whereupon, at 1:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Amgen Inc. to House Ways and Means Subcommittee on Health on Medicare End-Stage Renal Disease Program

Amgen Inc. is pleased to submit this statement for consideration by the subcommittee and inclusion in the record of the April 3, 1995 hearing on the Medicare end-stage renal disease (ESRD) program. As the manufacturer of EPOGEN® (Epoietin alfa), an important part of the treatment of many dialysis patients, Amgen closely follows trends in the cost and quality of the ESRD program. The company's observations are informed by its experience during almost a decade of participation in efforts to improve the clinical status and quality of life of Americans who depend on kidney dialysis to survive. Amgen strongly believes that focusing on quality of outcomes in dialysis patients and aligning incentives and payments around these outcomes is the best way to control costs and benefit patients.

BACKGROUND

Amgen is the U.S. (and the world's) largest independent biotech company.

Amgen, headquartered in Thousand Oaks, California, is the largest independent biotechnology company in the world. Since its founding in 1980, the company has spent $1.2 billion dollars on research and development, with emphasis on finding new treatments for diseases for which current therapeutic interventions are inadequate. Last year, the company was awarded the National Medal of Technology, an award established by Congress in 1981 to recognize technological achievement. Amgen is the only biotechnology company ever to receive this tribute.

Epogen is a breakthrough application of genetic engineering for dialysis patients.

In 1989, the Food and Drug Administration approved for marketing Amgen's first product, EPOGEN. First cloned and developed by Amgen scientists, EPOGEN is a biopharmaceutical product with the same amino acid sequence as natural erythropoietin, which is produced by healthy kidneys and acts to stimulate the maturation of red blood cells.

Kidney failure almost always results in anemia because the kidneys no longer produce adequate amounts of erythropoietin. Before the availability of EPOGEN, most dialysis patients were severely anemic, reflected in low hematocrit readings. Hematocrit is the ratio of red blood cells to total blood volume; low hematocrit readings are associated with increased morbidity and poor quality of life. Indeed, prior to 1989 many dialysis patients were dependent on blood transfusions to survive. Since the introduction of EPOGEN, blood transfusions to combat the

anemia of renal failure have become unnecessary, and the quality of life of dialysis patients has improved significantly.

The Medicare payment experience for EPOGEN illustrates the importance of establishing and maintaining incentives for proper patient outcomes.

Shortly after EPOGEN was approved for marketing, the Health Care Financing Administration (HCFA) established a policy to pay for it as an add-on to the prospective payment rate for dialysis services. (While the product is also covered by Medicare when administered in physicians' offices or dispensed for self-administration to qualified dialysis patients, most EPOGEN is administered to dialysis patients at the end of the dialysis session by injecting it into the venous access route).

The rate set in 1989 was a flat $40 per EPOGEN treatment for most patients, regardless of the amount administered. In setting the rate, HCFA assumed that average doses would reach 5,000 units per administration, the average for patients in Amgen's phase III clinical trial. While it was always understood that the vast majority of dialysis patients would eventually receive EPOGEN therapy, HCFA also assumed that, as with most new products, the use would grow gradually.

In retrospect, it is clear that those assumptions (which Amgen shared at the time) failed adequately to reflect the financial incentives created by the payment mechanism. By mid-1990, the Office of Technology Assessment (OTA) and the HHS Office of Inspector General (OIG) had reported to this subcommittee that the doses were significantly lower than anticipated, to the detriment of patients. The OIG report concluded that the effect of the flat rate reimbursement system was windfall profits to dialysis facilities and recommended that Medicare pay for EPOGEN based on actual doses administered.

Congress in the Omnibus Budget Reconciliation Act (OBRA) of 1990 changed the reimbursement methodology from the flat rate to $11 per thousand units administered. In OBRA 1993, the payment amount was reduced to $10 per thousand units. Doses, which had averaged 2700 units in 1990, are currently averaging about 4400 units per administration, enabling more patients to achieve hematocrit levels within the FDA-approved target range of 30-36 percent. Amgen data suggest that nearly all dialysis patients for whom EPOGEN therapy is indicated now receive it, but only approximately 65 percent have hematocrits within target range. This means that doses for some patients are still inadequate and that closer clinical management of iron stores and other factors should be encouraged, as discussed below. (Since HCFA's reimbursement guidelines require a hematocrit reading below 30 to initiate EPOGEN therapy, it is unlikely that patients who are not anemic are being treated.)

COST AND QUALITY OF MEDICARE ESRD PROGRAM

Costs per beneficiary of ESRD program to Medicare have risen at a rate lower than the rest of the Medicare program.

The subcommittee has indicated its intention to examine trends in Medicare spending on the ESRD program. Amgen's first observation on this subject will no doubt be echoed by a number of witnesses at the hearing: It is clear that on a per beneficiary basis, the rate of growth in spending for this program over the past 10 years has been relatively moderate. Indeed, the aggregate increase in program expenditures per ESRD beneficiary since 1985 (34%), is dramatically lower than the increase over the same period in the average Medicare benefit payments per enrollee (108%). (Source: 1994 Green Book)

Amgen has contributed to the effort to restrain the rates of increase in Medicare spending. Influenced by extensive discussions with HCFA officials, Amgen set the price for EPOGEN in 1989 at $10 per thousand units, well below the average European price ($15) set by its licensee. The U.S. list price has never been increased in the intervening years, and it remains on average 34.4 percent lower than the European price and 68 percent lower than the price in Japan. Adjusting for inflation, Amgen's list price for EPOGEN has declined by 21.4 percent since 1989.

The introduction of EPOGEN and -- more recently -- the progress achieved in bringing hematocrit levels into target range also contribute indirectly to cost control in the ESRD program. Dialysis patients receiving EPOGEN have been found to develop fewer comorbid conditions that require inpatient hospital treatment. Since inpatient costs account for almost half of all Medicare payments for dialysis patients, adequately managing anemia could result in reductions in outlays. A recent study conducted by the Johns Hopkins School of Medicine and HCFA found that patients on EPOGEN are less likely to have heart failure, angina, myocardial infarction, depression and strokes than patients not receiving the drug. The study also concluded that use of EPOGEN may be associated with fewer overall hospital admissions and fewer days spent in the hospital. (Powe et al., JASN, 1994: 4:1455-1465).

The current reimbursement rate for EPOGEN provides some incentive to providers to increase doses if the patient's hematocrit is not within the target range. (As discussed in more detail below, it is important that iron stores be monitored carefully to insure that the lowest effective dose is used.) Some have suggested that the Medicare payment rate should be reduced or folded into a composite or capitation rate for dialysis. These suggestions should be rejected. If the incentives to properly dose were reduced, removed, or reversed, hospitalization costs could rise and--at the extreme--transfusions could return as the treatment of choice for anemia due to renal failure. This, of course, would lead to additional costs for

treating blood-borne infections, and patients would risk development of antibodies, increasing the chances that a kidney transplant would be rejected. These additional costs would likely wipe out any anticipated savings associated with changing the payment rate/method for EPOGEN.

Focusing on the quality of care of dialysis patients provides the greatest return on the Medicare investment in its ESRD program.

Any careful observer of the ESRD program would note a growing concern about the quality of care delivered to ESRD patients, particularly those dependent on dialysis. The ESRD mortality rate in the United States is reported to be the highest in the industrialized world. The National Institutes of Health, the Institute of Medicine and the National Kidney Foundation have all expressed concern and made recommendations regarding the adequacy of dialysis and the morbidity and mortality of dialysis patients.

Last year, HCFA launched a Core Indicators Project to measure how key clinical parameters are being managed. HCFA is also developing quality screens for care of dialysis patients. The first of these to be implemented deals with management of the anemia of chronic renal failure. These efforts should be encouraged, although it may never be possible to assure high quality using only the power of the payor to survey and certify providers.

There is a strong correlation between Medicare reimbursement policy and the quality of delivered care to ESRD beneficiaries. To focus on cost minimization without a corresponding investment in quality assurance would result in short-term savings at the cost of long-term costs and absolute reductions in the quality of life of a particularly vulnerable group of beneficiaries.

Since such extraordinary efforts are being taken to extend the length of the lives of ESRD patients, it would be unfortunate indeed if the quality of those lives was allowed to deteriorate through neglect or inadvertence. Amgen has supported, financially and through participation of its staff, the development by the Rand Corporation of a Kidney Disease Quality of Life Instrument which could assist researchers in measuring the impact of various therapies. In addition, the company has sponsored a Life Options Program, which identified barriers faced by dialysis patients attempting to achieve more normal lifestyles, including returning to work. The program is now seeking ways to surmount those barriers.

The Ranking Minority Member of the subcommittee, Mr. Stark, has introduced a bill (H.R. 1067) to require renal dialysis facilities to meet certain standards relating to the adequacy of dialysis as a condition of payment. This is a step in the right direction. It also would be appropriate to monitor more closely how anemia is managed in dialysis patients. In addition to appropriate use of EPOGEN, such monitoring should require that patient iron stores are maintained at a sufficient

level to allow optimal development of red blood cells. In other words, no amount of EPOGEN will cure the anemia of a patient who is allowed to become severely iron-deficient.

CONCLUSION AND RECOMMENDATIONS

The Medicare ESRD program is remarkable in that it keeps 200,000 Americans alive regardless of their social or economic status. Even successful programs can usually be improved, but the Congress should beware of "improvements" in the ESRD program that put patient quality of life at risk. Amgen recommends that the Congress:

- Resist changes in payment policy to effect short-term savings; any reduction in payments could result in additional long-term costs.
- Continue to support HCFA's efforts to monitor the quality of care provided to ESRD patients.
- Require that patients receive adequate dialysis and that their hematocrits be appropriately maintained to control anemia, as a condition of payment for dialysis and EPOGEN.

TESTIMONY OF BAXTER HEALTHCARE CORPORATION

COMMITTEE ON WAYS AND MEANS
SUBCOMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

HEARING ON THE MEDICARE END-STAGE RENAL DISEASE PROGRAM
APRIL 3, 1995

I. INTRODUCTION

Baxter Healthcare Corporation appreciates the opportunity to submit written testimony to the Subcommittee on the Medicare End Stage Renal Disease (ESRD) program in connection with its hearing on April 3. We applaud the Subcommittee for its efforts in evaluating this program and examining other alternative payment and administrative approaches for the management of this chronic condition.

Baxter is a subsidiary of Baxter International, Inc., a publicly traded company headquartered in Deerfield, Illinois. Through its Renal Division, Baxter manufactures and distributes a full range of hemodialysis and peritoneal dialysis equipment and supplies to the renal community. Baxter has pioneered many of the technological breakthroughs in dialysis that have enabled hundreds of thousands of patients to survive and live quality lives despite chronic renal failure. Baxter believes it is critical that this vulnerable patient population continue to receive access to quality care and integrated, comprehensive services. Over the years, we have had the opportunity to listen to and work closely with all interested members of the renal community, including physicians, providers, suppliers, payers, professional associations, and most importantly, patients. It is based on this perspective that we offer these comments.

We believe strongly that the Medicare ESRD program generally has been successful in meeting the needs of patients with chronic renal failure. We feel equally strongly, however, that the program can be significantly improved in terms of quality of care, patient satisfaction and cost-effectiveness. There is much we have learned since the inception of the Medicare ESRD benefit twenty three years ago, and the time to apply these lessons, we believe, is now.

Recently, there has been a great deal of examination and discussion regarding current and alternative payment policies for the ESRD program, both within and outside of the context of broader Medicare reform. While many of the proposed Medicare reform initiatives will require a long-term analysis and evaluation, we believe that several initiatives can be implemented now that can improve beneficiary options and encourage the renal community to further adopt and implement certain managed care mechanisms. These mechanisms, we believe, will promote improved patient quality, provider accountability and cost-effective care.

Our recommendations do not suggest a total overhaul of the ESRD system, nor do we endorse a rapid movement of the entire ESRD program to a capitated payment methodology. Rather, we believe that the endorsement of certain integrated delivery system principles, such as the concept of "disease management," coupled with incremental changes in the current payment and reimbursement system offer the potential for improved quality of care, greater system efficiency and lower total costs.

II. THE ESRD PROGRAM TODAY

As it is currently structured, the Medicare reimbursement system, through its focus on the treatment of and payment for acute, isolated services, discourages integrated care for patients with ESRD. Medicare reimburses facilities for services strictly related to dialysis based on a prospectively determined composite rate; ancillary supplies and services are

covered under a fee-for-service methodology; outpatient physician services are subject to a separate monthly cap; and inpatient care is reimbursed under the applicable DRG classification. An inevitable yet unintended consequence of this fragmented approach is that providers are encouraged to manage only that portion of the patient's care for which they are responsible. Decisions may be made without collaborating with other health care providers and without fully taking into account their impact on the entire disease process. Due to this lack of integration and multidisciplinary management, which are becoming commonplace in the private sector, continuity of care for ESRD across care settings has not occurred. Patients themselves have not received the benefits of an integrated, coordinated care system.

III. THE IMPORTANCE OF INTEGRATED CARE

Through Baxter's involvement in the development and distribution of products to treat other chronic, high cost disease states (including cancer and hemophilia), we have seen the successful application of "disease management" principles and integrated delivery system models in other contexts. We believe that these principles and models represent equally viable approaches for addressing the special needs of the ESRD population. Under some chronic disease management models, for example, providers are given the flexibility and are charged with the accountability of managing the patient's disease from the onset of diagnosis, when well-informed decisions can be made regarding modality of treatment and site of care. These models encourage prevention and treatment that will provide maximum effectiveness and efficiency at the time of onset of illness. As with other chronic illnesses, and as other hearing witnesses have confirmed, intensive disease management of ESRD at an early stage is critical. Unlike a traditional acute managed care model where the focus is typically on avoiding overutilization, an integrated disease management model strives to ensure that patients are not underserved. Under this model, patients receive comprehensive care that helps minimize many of the more costly complications arising from a lack of intervention and provider coordination.

We believe that <u>any</u> initiative that is developed for the ESRD population must include some form of case management that focuses on coordination of care and encourages collaboration among all providers of the health care team. In working with providers and patients to create optimal home care therapy solutions for ESRD patients, we have seen first-hand the challenges of creating and managing a comprehensive care plan encompassing the clinical, psychosocial and economic needs of these individuals. We applaud the American Nephrology Nurses Association endorsement of a comprehensive nurse case management approach to the ESRD population and we encourage the further development and refinement of these types of initiatives. This endorsement is consistent with the position of the Renal Physicians Association. In any chronic disease management approach, we support the role of the nephrologist as the primary care physician who is responsible for the overall management of the ESRD patient's care.

IV. INTEGRATED CARE AND PATIENT INVOLVEMENT

We believe that moving in the direction of a chronic disease management model for ESRD also will give patients the opportunity to actively participate in their care and make meaningful, well-educated choices regarding their treatment. In our experience, the more active the patient is in his or her therapy, the more likely the patient is to adhere to the treatment plan. This has a positive impact on patient outcome. A chronic disease management program promotes active patient involvement through aggressive case management, which includes patient/family education, regular follow-ups and supportive services. These activities help decrease the incidence of complications and, for a significant number of patients, minimize the utilization of expensive services in costly acute or subacute care settings.

V. *QUALITY AND COST-EFFECTIVENESS IN AN INTEGRATED CARE SYSTEM*

We concur with many of the concerns raised by members of the renal community regarding the potential impact of cost-containment objectives in a managed care setting. On the other hand, we believe an integrated disease management approach that is properly supported by an appropriate payment policy can align the quality and cost-containment concerns of all parties involved. Through a capitated payment methodology or other comparable global system, the clinical team responsible for the care of the ESRD patient will work to minimize costly complications, prevent unnecessary hospitalizations and ensure the proper prescription and administration of life-sustaining therapy.

An integrated disease management approach that is properly supported by an appropriate payment policy can be an effective means of controlling costs. The quality concerns of the patient and provider and the cost-containment focus of the payer or employer can be aligned to produce the optimal clinical result. ESRD services are already subject to a modified capitated system under the composite rate methodology. This methodology has been viewed as a relatively effective means of controlling program costs. The monthly capitation for physicians also has proven to be an effective cost-controlling mechanism for physician outpatient care. Significantly, cost increases in the program are primarily related to non-dialysis, non-capitated services. A global capitated method that encompasses all services provided to ESRD patients -- from the time of diagnosis throughout the course of therapy -- will properly align incentives to encourage appropriate utilization from all providers and will thereby minimize total illness costs, rather than just component costs of the disease.

VI. *RECOMMENDATIONS*

We believe that to properly implement integrated disease management initiatives in the ESRD program, certain incremental changes should be made in the current program. First, we recommend that Congress lift the current restrictions or barriers that prevent ESRD patients from electing to enroll in managed care programs. Under the current system, an ESRD beneficiary is prohibited from enrolling in a Medicare prepaid health plan, unless that individual is already a member of such a plan at the time his or her kidneys fail. This restriction deprives ESRD beneficiaries of a meaningful choice of care available to other Medicare beneficiaries and prevents managed care plans from gaining the valuable experience necessary to apply disease management concepts to this population. Significantly, managed care plans have demonstrated that they will make the initial investment of resources in the patient through optimal disease management if this investment can be realized through greater cost savings over the long term.

In addition, given the unique nature of the ESRD program and the complex medical, technological and social demands facing ESRD patients and the providers that care for them, we recommend that Congress encourage the development of specially qualified ESRD delivery systems by allowing greater flexibility in the types of integrated delivery models that are eligible to care for these patients. Under the current regulatory structure, an ESRD patient must disenroll from the health plan of his or her choice at the end of the Medicare secondary payer period if that health plan does not have a contract with HCFA. If more patients are allowed to remain in their networks, we believe managed care plans will be more inclined to make the initial investment in the prevention, early identification and case management of this population -- all necessary and critical elements in the successful treatment of ESRD patients. Greater flexibility will allow patients already enrolled in managed care networks to maintain existing physician relationships and remain in these delivery systems throughout the duration of their illness.

Baxter strongly supports the efforts of HCFA in implementing a demonstration project to assess the impact of a capitated payment system for ESRD patients. We agree with members of the renal community that the demonstration will provide valuable insights in the development of broader changes to the current ESRD payment policy. Nevertheless, we

believe it would be unwise to delay implementing the relatively simple initiatives described above until a final analysis and evaluation of that demonstration is achieved. Our desire to construct a perfect system should not prevent the introduction of logical reforms that can produce benefits immediately. The demonstration which was originally targeted to be completed by 1998, has already been significantly delayed and will not be completed until the 21st century.

We also believe it is unwise to rely on one demonstration project to evaluate the impact of a capitated payment system on ESRD services. As currently structured, the demonstration itself fails to capture patients prior to the eighteen month Medicare secondary payer period and therefore does not allow a plan to manage the patient from the onset of diagnosis when critical decisions must be made regarding treatment and modality. We also believe that equally valuable information can be obtained from monitoring the experience of a number of creative integrated financing and delivery models that are already in place and successfully providing care to ESRD patients. Foregoing the exploration of innovative and comprehensive approaches for managing this chronically ill population until after the demonstration is unwise and unnecessary. Therefore, we encourage the Subcommittee to apply the experience and lessons we have learned from the private sector to spur further debate and to help formulate policy changes for the future. In implementing any of these changes, we recommend that appropriate attention be devoted to educating both the patient and provider communities about the underlying principles and objectives of a chronic disease management approach.

Finally, Baxter recognizes that concerns have been expressed by patient and provider representatives that quality assurance measures must be included in any approach or initiative that is adopted to protect the interests of this highly vulnerable patient population. We share these concerns. We believe there is a legitimate role for the government to define baseline standards applicable to both the public and private sectors. We support HCFA's efforts and encourage the implementation of mechanisms to provide for careful oversight to measure performance. We look forward to the opportunity to work with HCFA to help achieve these goals.

STATEMENT OF DIALYSIS CLINIC, INC. TO THE SUBCOMMITTEE ON HEALTH OF THE HOUSE WAYS AND MEANS COMMITTEE

Dialysis Clinic, Inc. (DCI) is a not-for-profit organization based in Nashville, Tennessee. DCI was established in 1971 in an effort to ensure that medical decisions for individuals with End-Stage Renal Disease (ESRD) would be made on the basis of patient need instead of on the basis of investment returns. DCI currently provides dialysis services to more than 6,000 ESRD patients at over 90 outpatient dialysis units throughout the continental United States. DCI is active in kidney transplantation and operates three independent organ procurement agencies. DCI also has affiliations with numerous major universities and teaching hospitals throughout the United States in an effort to continually improve the care provided to individuals with ESRD. We applaud the interest of the Subcommittee on Health of the House Ways and Means Committee for individuals with ESRD and the Medicare ESRD program and appreciate the opportunity to submit comments for the Subcommittee's consideration.

Although the viability of a shift towards managed care for ESRD is currently a topic receiving great attention, DCI feels that the ESRD program's experience with managed care is insufficient to make major programmatic changes at this time based upon perceived benefits of managed care in this area. However, DCI feels that several areas of the Medicare ESRD program deserve attention and would like to take this opportunity to address several of these areas. Briefly, these areas are: (i) providing funding for quality of care programs; (ii) maintaining Epogen® as separately reimbursable; (iii) extending Medicare's secondary payer status to 24 months; and (iv) providing inflation updates for dialysis providers;.

Funding for Quality of Care Programs

DCI feels that maintaining and improving the quality of care provided to individuals with ESRD is of paramount importance. By continuously striving for increased quality of care, DCI feels that complications associated with ESRD and dialysis can be reduced while simultaneously making dialysis treatments less burdensome and more effective for individuals with ESRD. DCI has data that relates the quality of care to the incidence of hospitalization. This data demonstrates that improving the quality of care in dialysis units reduces the incidence of hospitalization, thus reducing the cost to the Medicare program.

DCI encourages the development and use of quality assurance programs such as the ESRD Health Quality Improvement Program and urges Medicare to support this program and similar programs through funding. DCI feels that outcome focused quality assurance programs will result in elevating the standard of care provided to individuals with ESRD and provide a benchmark with which to evaluate the care provided by dialysis providers. The benefit of such programs will aid not only individuals with ESRD through higher quality care, but also aid the Medicare ESRD program through cost savings associated with greater efficiencies.

Epogen® (EPO) Reimbursement

In the course of receiving dialysis treatments, individuals with ESRD often times require the administration of certain drugs. The cost of some of these drugs are included in the dialysis composite rate while others are separately reimbursable by Medicare. One such drug that Medicare currently reimburses separately from the composite rate is EPO. DCI strongly believes that Medicare should continue to separately reimburse providers for EPO supplied to individuals with ESRD. While including EPO in the composite rate may save Medicare money in the short run, the adverse effects which would result from such a shift will far outweigh the monetary savings realized.

One of the side effects of ESRD is that the kidneys often times cannot produce erythropoietin, a glycoprotein necessary for the production of red blood cells. As a result, individuals with ESRD often contract anemia which leads to other medical complications. However, the use of EPO, a synthetic version of erythropoietin, allows the body to produce red blood cells, thus avoiding anemia and the resulting complications. Medicare currently reimburses EPO on the basis of actual doses administered. At present, this rate is $10 per 1,000 units of EPO. DCI feels that the current reimbursement mechanism ensures that individuals who require EPO will receive the drug.

To the extent EPO is included in the dialysis composite rate, some providers may have a disincentive to provide EPO to individuals with ESRD who would benefit from its use. Since providers will receive the same rate regardless of whether EPO is used, many providers may elect to not administer EPO and save the cost otherwise associated with procuring the drug. To the extent the patient contracts anemia which leads to other complications, the cost of such complications will be borne by another provider (such as a hospital); ultimately Medicare will incur the cost of such complications.

As a result, not only will it be more cost effective for Medicare to reimburse EPO in the first instance, but by removing any element of cost justification on the part of providers, individuals with ESRD will be guaranteed to receive medically necessary treatments integral to their care.

Extension of Coordination Period

Under the current Medicare ESRD program, once an individual is diagnosed with ESRD and becomes Medicare eligible (after a 3 month waiting period), Medicare assumes secondary payer responsibility for the individual's dialysis expenses for an 18 month coordination period. During this period, the individual's employer group health plan or other private insurance assumes the primary responsibility for the individual's dialysis related expenses. DCI feels that extending the duration of this coordination period from 18 months to 24 months will result not only in a benefit to the Medicare ESRD program, but also a benefit to individual's with ESRD.

Requiring private insurers to remain primary payer for an additional 6 month period will result in several distinct benefits. First, the extension of this period will allow Medicare to save approximately $25,000 per patient. With approximately 60,000 new patients undergoing dialysis each year, the savings associated with such a change would be substantial. These savings can be used to fund programs such as quality assurance programs and inflation updates for dialysis providers, all of which will benefit the Medicare ESRD program, dialysis providers and individuals with ESRD.

Secondly, requiring private insurers to remain primary payer for an additional 6 month period will require these insurers to assume a greater responsibility for the care and treatment of their enrollees with ESRD. Under the current system, the short period of responsibility (18 months) for enrollees with ESRD provides private insurers little incentive to maximize efficiencies. This situation occurs because unlike the health care costs of other enrollees which can be recouped over time, enrollees with ESRD require costly treatments continually during this period which will not be recouped over time. However, extending this period will provide insurers with more of an opportunity to increase their efficiency through beneficial relationships with dialysis providers in an effort to better manage their enrollees with ESRD.

As a corollary, requiring private insurers to assume an increased responsibility for the care of their enrollees with ESRD will likely result in the expansion of managed care relationships between insurers and dialysis providers. The proliferation of individuals with ESRD who are covered by managed care programs from the current low percentages will generate greater amounts of data with which to evaluate the feasibility and benefits, if any, of shifting the Medicare ESRD program from a fee-for-service model to a managed care model.

In favoring a longer coordination period for individuals with ESRD, DCI recognizes that too long a coordination period would be counterproductive and work to the detriment of individuals with ESRD. Faced with the possibility of unduly long periods of responsibility, many employers or private insurers might be reluctant to become associated with individuals with ESRD because of the high costs associated with caring for such individuals. This reluctance might hinder the ability of individuals with ESRD to shift employment or obtain replacement health coverage. Consequently, DCI feels that a 24 month coordination period would achieve the desired shift in responsibility without endangering the ability of individuals with ESRD to obtain employment or health coverage.

Inflation Updates

DCI feels that updating the dialysis composite rate to reflect the impact of inflation will enable dialysis providers to continue providing the highest quality of care possible to individuals with ESRD. The composite rate dialysis providers receive for dialysis treatments is at approximately the same rate as existed when Medicare first established the composite rate in 1983. Although dialysis providers have suffered inflationary effects since that time, the dialysis composite rate has remained constant.

Medicare is the primary payer for the vast majority of ESRD patients. Consequently, the composite rate for dialysis treatments establishes the parameters of providers' revenues. The failure of Medicare to grant dialysis providers inflation updates has resulted in a situation where providers' per treatment revenue has remained constant, yet per treatment costs have increased consistent with the rate of inflation.

While the composite rate for dialysis has remained insulated from the effects of inflation, the operational costs of providers have not fared so well. Costs such as salaries, benefits, dialysis supplies and equipment have increased because of inflation and technological advances, and providers have been forced to absorb such increases. Aggravating this situation is the fact that items which Medicare historically reimbursed separately, such as albumin, mannitol and oxygen use, have been bundled into the dialysis composite rate, further increasing the costs of dialysis providers. It has been estimated that providers' costs will increase 3.7% in the next year. However, since providers have not received corresponding increases in revenues to offset the inflationary effects on their costs, providers must attempt to provide the same level of care for ESRD patients on reduced margins. In time, this tightening of the gap between revenues and costs will force many providers to make adjustments in an effort to maintain their facilities. Such adjustments will likely change the dynamic of access to services and the nature of the services provided. DCI believes that most dialysis providers already have cut costs as much as possible and that further cuts in response to inflationary pressures will compromise the quality of care these providers provide.

Providing annual inflation updates to the dialysis composite rate not only will allow providers to continue to provide the quality of care ESRD patients require and deserve, but it will also grant dialysis providers the same consideration Medicare grants to other Medicare providers. Since the services provided to ESRD patients are equally important as the services provided to other Medicare beneficiaries, inflation adjustments to the dialysis composite rate should be equally available to dialysis providers.

DCI would like to thank the Subcommittee of Health for its kind consideration of the issues we have addressed in this statement and express our willingness to assist the Subcommittee in increasing the benefits the Medicare ESRD program generates for individuals with ESRD.

STATEMENT OF DONALD K. GALLION, SR. SUBMITTED TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS HEARING ON MEDICARE END-STAGE RENAL DISEASE PROGRAM APRIL 3, 1995

My daughter, Elizabeth A. Greeson, was a healthy, insured working mother of one son. However, near the end of her second pregnancy, Elizabeth began to experience complications, including taking on excess fluid. Her son, Matthew was born by "C" Section on July 15, 1988. Elizabeth remained in intensive care for many weeks, full of fluid. The doctor in charge at that time, treated Elizabeth with pills, in an attempt to dry up the fluid. This medication did not work and in the end, the fluid build-up damaged her heart. To make things worse, Elizabeth was later diagnosed with LUPUS.

After Elizabeth's employer-provided insurance paid out thousands of dollars under the COBRA Act, Elizabeth was placed on Medicare because of her end-stage renal disease-related disability.

Elizabeth was required to travel approximately thirty miles round trip to Atlanta, Georgia, every Monday, Wednesday and Friday to receive dialysis treatment. She was informed by her doctor that she would have to continue traveling to the Peachtree Dialysis Center in order to continue to be provided care by her physician, Dr. Donna Craig. I did not know until after Elizabeth's death that Dr. Donna Craig owned 20% of Peachtree Dialysis Center. Also, this dialysis center was controlled by one man in Florida who owned centers within the states of Florida, Georgia and California.

After Elizabeth's death, I requested that the Inspector General of Atlanta, Georgia, investigate the Peachtree Dialysis Center. This request was made after I had been informed by the center's staff that Elizabeth was not being properly dialyzed. Congressman Mac Collins (GA-3) and I did not know until June 1994 that an unannounced inspection was conducted by Georgia Regulatory Services, during November 1993. During this inspection, the Peachtree Dialysis Center was cited for sixteen violations. Furthermore, I later learned that during 1991, 1992 and 1993, this center was cited by Georgia Regulatory Services while HCFA took no action and apparently ignored these violations.

My CONCERN is the lack of regulatory oversight of these dialysis centers; and the failure to protect the patients.

My MOTIVATION is the death of my daughter, Elizabeth A. Greeson, who was a patient of the Peachtree Dialysis Center.

After her death, I looked very closely into that center and discovered that it had been in repeated violation of regulatory standards, while NO action was taken by HCFA or Georgia Regulatory Services.

As was the case for Elizabeth, most dialysis center patients have expended their private insurance and are receiving government coverage through the End-Stage Renal Disease program. These centers make an enormous amount of money from this federal government program. If the regulatory agencies in charge fail to protect the American people, who are paying for these programs? Who will protect them? WHO IS ENSURING THAT THE REGULATORS DO THEIR JOB?

Why has it been so difficult for me to get information? I can only assume there may be something to hide.

How can we correct this situation, before other unsuspecting dialysis patients are subjected to this substandard life-threatening mistreatment?

In my daughter's name, I want to improve the regulation of these centers. I am asking that the following changes be made to make these centers operate safely and professionally.

1. Require all dialysis centers under Medicare, to provide services on a 24 hour basis; seven days per week; and 365 days per year.

2. Require all centers to have a trained, registered nurse on duty at all hours. A kidney doctor should be on call on a twenty-four hour basis.

3. Require all dialysis centers to have a coronary program in effect twenty-four hours per day. Properly trained personnel should be on duty to handle emergency coronary problems.

4. Require all dialysis centers to provide beds that can be used when a patient is forced to be removed from the dialysis machine before being fully dialyzed. Once this patient regains the ability to be placed back on the machine, then this patient would be fully dialyzed before leaving the center. If the patient is too sick to be fully dialyzed, then it would be the responsibility of the center to have this patient transported to a nearby hospital.

5. Require State Regulatory Services to inspect these centers on a six month schedule. HCFA should be required to enforce any corrections needed to correct violations. Centers that continue to violate the regulatory requirements, should be closed.

Congressman Mac Collins has spent a great deal of time meeting with me, because he understands just how serious this dialysis center problem has become. I urge each Member to support Congressman Collins and pass dialysis patient protection legislation.

Thank you for your support.

Options for Improving Cost Effectiveness of Medicare End Stage Renal Disease (ESRD) Program by Increasing Organ Donation

Submitted to the Hearing Record of the
House Ways and Means Subcommittee on Health of
April 3, 1995

By

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Introduction and Overview

Work done by HCFA confirms that if more end-stage renal disease (ESRD) patients could receive kidney transplants, rather than relying on hemodialysis, their quality of life would improve and the Medicare ESRD program would save money, an estimated $42,000 per patient transplanted.[1] Therefore it would be worth investing resources to increase kidney donation.

Work done by The Partnership for Organ Donation in collaboration with eight organ procurement organizations (OPOs) and hundreds of hospitals in the United States confirms that only about one third of the medically suitable potential organ donors actually donate organs.[2] By identifying all potential donors and asking families to donate in a systematic and sensitive manner, donation could substantially increase. Furthermore, most potential donors are found in a relatively few large hospitals, which allows interventions to be focused and efficient. Our work confirms that there is substantial opportunity to increase donation by focusing on a few hospitals and implementing a systematic donation process. Some thoughts on how Medicare could facilitate effective donation practices follow:

General Guidelines:

To have the desired impact on organ donation, any programs or policies initiated by Medicare should be guided by the following principles:

- Use performance measures and quality assurance approaches. Organ donation lends itself well to a quality assurance approach. Large hospitals could be required to analyze their donor potential and to track donation outcomes for all suitable cases. This should be done with an established medical record review methodology. OPOs can be helpful in carrying out and analyzing medical record review.

  As a rule of thumb, any acute care hospital with more than 350 beds should have a medical record review at least annually; and hospitals with between 150-350 beds should review their donor potential and performance at least every two years.

  One option is to require a specified performance level – maybe 50% realization of potential organ donors – and those major institutions that

fall below the benchmark, should be required to develop donation protocols as a high priority.

- Focus on modifiable elements in the organ donation process that have been shown to correlate with higher rates of donation,[3] specifically:
  - Protocols to ensure early identification and referral of all potential organ donors to organ procurement organizations (currently about a third of eligible families are not asked -- despite required request policies).
  - Requiring OPO procurement coordinator participation in family request, along with trained hospital staff
  - Clear explanation of brain death to families, and raising donation only after the family has been informed of death (decoupling).

- Strategically target those hospitals most likely to care for potential donors typically large hospitals (greater than 150 beds) that are trauma centers and are affiliated with medical schools.[4]

Perspectives on Using Economic Incentives to Encourage Organ Donation:

The Partnership urges caution in applying direct financial incentives. So far, the reaction of the public and health professionals[5] to financial incentives for organ donation has been at best lukewarm. It is essential to preserve public trust in the donation and transplantation system, and financial incentives have the potential to erode this.

Financial incentives at the hospital level could exacerbate public fears that potential organ donors receive less attentive medical care, or that a black market in organs could be operating in the U.S. Members of ethnic minority groups are especially likely to harbor these concerns, potentially depressing even further the low rate of organ donation among ethnic minorities.[6]

Options for Structuring Economic Support for Organ Donation

While caution is called for, there may be a strategy for targeting financial support to remove *institutional disincentives* for organ donation, particularly in those large hospitals with significant donor potential that are not transplant centers. Large hospitals, especially public hospitals caring for significant numbers of indigent or underinsured patients, seldom have the resources to devote to improving organ donation practices. The public would benefit from supporting the adoption of good organ donation practices in these hospitals.

Grants could be offered to support the creation of in-house teams to diagnose donation performance and institute effective donation protocols. Continuing funding could be contingent on documenting significant gains in donation effectiveness. Because donor potential is concentrated, grants could be targeted to the largest 500-600 hospitals in the United States, enabling access to 70 percent or more of all the potential donor cases in the country.

To facilitate the administration of these grants, the following provisions could be made:

- Focus initially on hospitals with 350 beds or more. If limiting the program further is a consideration, support could be restricted to those hospitals that are <u>not</u> also solid organ transplant centers, since transplant centers presumably have some inherent incentive to improve organ donation performance.
- Create a very simple application process by requiring minimum criteria to be met, for example: documented medical record review showing a minimum of 10 potential organ donor cases in the prior year.

- Provide a standard grant of $5,000-$10,000 with a set of guidelines about how the funds are to be used, rather than asking each hospital to design a program individually.

The other area in which to consider financial incentives is living kidney donation. Living kidney donation has a number of advantages over cadaveric donation, including more control over the scheduling of surgery, and close tissue matching when blood relatives donate. A preliminary pilot study[7] suggests that there is wide variation in practice around living donation. Many believe that lack of financial coverage for family members' time away from work operates as a powerful disincentive to donate. HCFA might consider a pilot program to identify more accurately the current financial disincentives in the system, and test the impact of providing some financial support to living donors.

The Partnership for Organ Donation has extensive experience in working with hospitals to improve organ donation. We would welcome the opportunity to provide input to the design of any program intended to increase the effectiveness of our organ donation system in the United States.

References:

[1] Eggers, Paul, "Comparison of Treatment Costs Between Dialysis and Transplantation," Seminars in Nephrology, 12:3, May 1992, pp 284-289

[2] Gortmaker, et al, "Organ Donor Potential and Performance: The Size and Nature of the Organ Donor Shortfall." Unpublished draft

[3] Helander et al, "Standards of Practice Needed to Ensure Effective Donation Process," Abstract presented February 1994, Society of Critical Care Medicine

[4] This finding comes from a study funded by the Division of Organ Transplantation. Results have not yet been published, but preliminary data are available on request to The Partnership for Organ Donation

[5] Altshuler and Evanisko, "Financial Incentives for Organ Donation: The Perspectives of Health Care Professionals," Letter published in JAMA, April 15, 1992

[6] "The American Public's Attitudes Toward Organ Donation and Transplantation," conducted for The Partnership for Organ Donation, Boston, MA, February, 1993.

[7] Survey on living kidney donation conducted at the American Society of Nephrology meeting, October 1994 by The Partnership for Organ Donation

TESTIMONY OF LISA R. KORY, BSN, RN, CPTC
TRANSPLANT RECIPIENTS INTERNATIONAL ORGANIZATION, INC.

Transplant Recipients International Organization, Inc. (TRIO) welcomes the opportunity to comment on the Medicare End Stage Renal Disease Program.

TRIO is a member supported organization with 3,000 Members world-wide (32 national and 2 international Chapters). TRIO was founded in 1983 to support patients waiting for organ transplants, individuals who have been transplanted, their family members, and the families of organ donors. Our mission is to provide accurate and timely information on all aspects of the transplant process, including:

- to be there on a one-to-one basis for these individuals throughout the time of hospitalization before and after transplant;
- to provide a community of interested individuals who understand what the candidates and recipients and their family members, and donor family members have gone through;
- to serve as a national voice on transplant issues; and
- to increase donor awareness.

Who better to comment on the ESRD Program than those who have experienced renal failure, life while on dialysis and the life-saving benefits of kidney transplantation.

The following comments outline TRIO's position regarding the privatization of the ESRD Program, proposed increases in the primary payer status, the need for increased organ donation and the life-enhancing benefits of organ transplantation.

Privatization of the ESRD Program

TRIO understands the importance of deficit reduction and fiscal responsibility but primarily, we are concerned for the welfare of ESRD patients. Despite recent testimony regarding the cost-effectiveness of managed care, it is unclear whether or not the ESRD Program could be replicated by managed care facilities and still provide quality care with unlimited access and without regard to economic status or race.

While dialysis is a costly therapy, it is important to point out that dialysis costs have remained stable over time. In his 1992 study, "Comparison of Treatment Costs Between Dialysis and Transplantation," Paul Eggars, of HCFA, indicates that payment per dialysis in 1989 was around $125, representing a 61% reduction in inflation adjusted dollars from the payment level in 1974 ($138)[i]. In their study "Cost-effective care and endstage renal diseases: A billion dollar question," Roberts et.al., discovered that home dialysis, as an alternative to in-center dialysis treatment, produced a savings of $7,000 to $8,000 per life-year[ii].

Privatization of the ESRD Program is not necessarily the answer to reducing costs. Alternatives to in-center dialysis; the most cost-effective being home dialysis and transplantation, need to be fully explored. Given the profit of in-center treatment and the financial incentive for doctors to recommend in-center hemodialysis however, it may be difficult to alter prevailing medical opinion.

Since its inception in 1972, the ESRD Program as administered by HCFA, has treated **all** eligible ESRD candidates without regard to age, sex, race or religion. Prior to 1972, ESRD care was characterized by inequities, with hospital boards deciding who would, and wouldn't, receive the life-saving benefits of dialysis. It is all too possible that an analogous situation would exist under an ESRD system controlled by managed care providers. In short, managed care providers would be the "gate-keepers," providing coverage to a limited number of ESRD patients while excluding older ESRD populations and those with limited financial resources. Faced with rising costs of treating ESRD patients, managed care providers will have greater incentive to reduce expenditures, perhaps by limiting ESRD for those populations at greater risk of hospitalization or those populations unable to afford rising premiums.

Given the steady ESRD patient population growth (9% annually), the aging of the ESRD population and the level of comprehensive specialized care required, the multi-billion dollar costs of ESRD are comprehensible. Continued protection from rising inflation, forthcoming analysis of ESRD capitation studies, and the exploration of alternatives to in-center dialysis, will serve to slow rising costs and reduce Medicare expenditures.

Primary Payer Provision

TRIO supports the current system, with Medicare as secondary payer for 18 months. Undoubtedly, extending the secondary payer provision from 18 to 30 months would reduce Medicare costs in the short-term; however, these gains would most likely be offset by the negative impact on ESRD patient life-style and care.

If coverage were not dropped altogether, some combination of measures would be implemented to reduce expenditures. In all likelihood, employers would be unwilling to hire ESRD patients or those predisposed to ESRD, such as diabetics and minorities. Lower reimbursement rates would be implemented, with some insurers eliminating ESRD coverage outright. And, in some instances, we fear that an extension could serve to drive private insurance costs even higher, leaving individuals with no choice but to drop their coverage. In each one of these cases, ESRD patients would revert back to Medicare with potentially greater health problems, requiring even greater government expenditures.

Government involvement with the ESRD program ensures the extension of benefits to all in need of care. Extending the primary payer provision makes economic sense, but the decision to reduce costs should be tempered by the resultant negative effects on patient care. These may include:

- loss of coverage for those who want to work and utilize private insurance;

- the possibility of reductions in Epogen dosing as insurers reduce reimbursement levels; and
- premature death for those patients who loose or can't afford coverage.

Organ Donation

Organ transplantation is in part a victim of its own success. With improvements in technology more and more patients become candidates for life-saving kidneys, livers, hearts, lungs and other vital organs. Tragically however, 8 people die each day while on the waiting list. Simply put, a rising demand in transplants and a flat supply of adequate donors means a severe shortage in organs for transplantation.

There are nearly 40,000 people waiting for an organ transplant, with greater than 28,000 awaiting a healthy kidney. In addition, there are 500 children waiting to benefit from transplantation. Half of these children will die, and every thirty minutes another child will be added to the pediatric waiting list[iii]. **The need for increased organ donation can not be stressed enough!**

Transplantation as a Cost-Effective Alternative

Numerous studies have been conducted that compare the long-term costs of dialysis and transplantation. In many cases, when looked at over a period of between 7 to 10 years, transplantation has been the least costly option for treating ESRD patients.

With the advent of cyclosporine, and other immunosuppressive drugs, the survival rates of kidney recipients have shown a marked improvement. According to data provided by the United Network for Organ Sharing (UNOS), in 1993, the first-year survival rates for living donor recipients was 93.8%.

Paul Eggers, in the aforeto mentioned study, concluded his findings with the following comments,

> The results of this study confirm the widely held belief that kidney transplantation is, over time, a less costly alternative to maintenance dialysis. The high initial cost of transplantation is recovered in about 4.5 years (3 years for a living-related donor) with a net discounted savings of about $42,000 over a 10 year time frame. To the extent that transplantation may result in superior patient survival rates and a higher quality of life, the results would more forcefully favor transplantation as the preferred renal replacement therapy. Combined with the better quality of life assumed to result from transplantation, it appears that transplantation is the preferred alternative for ESRD patients both from a medical as well as an economic perspective (288)[iv].

TRIO is not encouraging a doing away of the ESRD program, and we concede that older individuals currently on dialysis are not necessarily adequate candidates for transplantation. With proper incentive however, kidney transplantation for a significant number of dialysis patients is realistic and would reap benefits that exceed current ESRD costs.

We urge the Congress to consider implementing our recommendations which will help assure that the ESRD Program continues to serve the needs of those Americans in saving them from premature deaths and provide them with the opportunity for a second chance to lead productive and more rewarding lives.

Transplant Recipients International Organization, appreciates the opportunity to provide comments on the ESRD Program. We have seen first-hand the benefits of this program and encourage your continued support. We would be happy to speak with the Members of the Subcommittee for any further clarifications or recommendations.

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[i] Eggers, Paul, "Comparison of Treatment Costs Between Dialysis and Transplantation," Seminars in Nephrology, Volume 12, No. 3 (May), 1992: pp 284-289.

[ii] Tousignant, Pierre, et.al., "Transplantation and Home Hemodialysis: Their Cost-Effectiveness," Journal of Chronic Disease, Volume 38, No. 7, pp 589-601.

[iii] UNOS, March 31, 1995

[iv] Eggers, Paul, "Comparison of Treatment Costs Between Dialysis and Transplantation," Seminars in Nephrology, Volume 12, No. 3 (May), 1992: pp 284-289.