

HONORING AIR FORCE SECRETARY
SHEILA E. WIDNALL

HON. JANE HARMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 23, 1997

Ms. HARMAN. Mr. Speaker, at the end of the month, a distinguished leader of the Air Force will leave office and begin a new chapter in her life.

Sheila E. Widnall, the first woman to serve as a Service Secretary, will leave her position and I want to join her other friends and colleagues in commending her for a job well done.

During her tenure, Dr. Widnall led the Air Force through a critical period of post-cold-war consolidation and modernization. She directed a time-phased modernization program to shape the future of the Air Force and further integrate space systems into military operations.

Dr. Widnall championed the Department's revolution in business practices with unprecedented acquisition reform initiatives and outsourcing and privatization ventures which have assured that scarce taxpayer dollars are wisely spent. And, she helped lead the Nation's stewardship of space by partnering the Air Force with the National Reconnaissance Office, NASA, and the commercial space sector.

Most notably, Dr. Widnall took care of the individuals who serve in the Air Force. She focused on core values of respect and dignity, assured opportunity for men and women, and pursued tirelessly quality of life issues during a period of personnel reductions and increasing operations temp. She made tough, but courageous decisions during her 4-year tenure, particularly a recent one involving Air Force Lt. Kelly Flynn.

A sailor, jogger, and friend, I regret that I was not able to join Sheila on a trip we often discussed—a transcontinental flight aboard a C-17 cargo plane—an Air Force procurement we both worked to reform and save.

I join my colleagues on behalf of a grateful nation in thanking Dr. Widnall and her husband, Bill. Dr. Widnall set a high standard of leadership and vision, and has prepared the U.S. Air Force for the challenges of the 21st century.

INTRODUCTION OF LEGISLATION
TO SAVE MEDICARE MONEY AND
LIVES

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 23, 1997

Mr. STARK. Mr. Speaker, on behalf of Representative BECERRA and myself, I am today introducing legislation which will save Medicare money—and save the lives of many of its beneficiaries.

The bill we are introducing passed the House in the Budget reconciliation bill (H.R. 2015) and was known as the Centers of Excellence proposal. CBO scored the provision as saving \$300 million over the 5 years and \$800 million over 10 years.

To quote from the Department of Health and Human Service's justification:

The Center of Excellence proposal originated as a result of a demonstration conducted in the early 90's under which certain facilities, referred to as "Centers of Excellence," were paid a single fee to provide all of the facility, diagnostic and physician services associated with coronary artery bypass graft [CABG] surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. Medicare achieved an average of 12 percent savings for CABG procedures performed through the demonstration.

The House provision would have made the Centers of Excellence program a permanent part of Medicare by authorizing the Secretary to pay selected facilities a single rate for all services, potentially including post-acute services, associated with a surgical procedure or hospital admission related to a medical condition. As with the CABG demonstration, selected facilities would have to meet special quality standards and would be required to implement a quality improvement plan.

The amendment was dropped in conference because of resistance from the Senate. Some Senators from States where no hospitals were designated felt that the program tended to cast into doubt the quality or excellence of non-designated hospitals. Mr. Speaker, the name of this program is not important—what is important is that it can save money and by encouraging beneficiaries to use hospitals that have high volume, quality outcomes, it can save lives. Therefore, I am dropping the term "centers of excellence" and just using the phrase "contracting entities."

Like Lake Wobegon, where all the children are above average, it is human nature for all Members of Congress to want their local hospitals to be above average. But not all hospitals are above average—and this is a serious matter. In fact, it is a matter of life and death. Hospitals which do large volumes of a certain type of procedure tend to have better outcomes and quality. Indeed, really good health policy in this Nation would prohibit hospitals from doing sophisticated procedures if they do not do a certain volume per month. This principle is applied to liver transplants, for example, and ought to be applied to some other procedures as well. We may all have pride in our local hospitals, but the fact is: some of them are killing people because they do not do enough of certain types of procedures and therefore are not skilled in those procedures.

Medicare should be able to contract with certain hospitals for quality and volume—both to save money and to deliver better health care.

We are about to begin a commission to make recommendations for the long-term survival of Medicare. Many on that commission will want to cut back benefits and ask beneficiaries to pay more—but before they do, they should explore every possible cost saving in the system. This bill is a two-fer: it saves money while improving quality.

I regret this provision was not included in this summer's budget bill. I hope it will be included in the next Medicare bill that moves through Congress.

As further explanation of why this legislation makes great sense, I am including below "Extracts from the November, 1995 Research Report" on the Centers of Excellence Demonstration.

CENTERS OF EXCELLENCE DEMONSTRATION—
EXTRACTS FROM NOVEMBER 1995 RESEARCH
REPORT

Rational for the Demonstration: Physicians operate under different payment incentives than hospitals, so hospital managers have difficulties implementing more efficient practice patterns. A global fee that includes physician services aligns incentive and encourages physicians to use institutional resources in a more cost effective.

Design of the Demonstration: Under the demonstration, Medicare paid each of the hospitals a single global rate for each discharge in DRGs 106 and 107 bypass with and without catheterization. This rate included in all inpatient and physician services. The standard Medicare hospital passthroughs were also included, i.e., capital and direct medical education, on a prorated basis. Any related readmissions were also included in the rate. Pre- and post-discharge physician services were excluded except for the standard inclusions in the surgeon's global fee. All four hospitals agreed to forego any outlier payments for particularly expensive cases. The hospitals and physicians were free to divide up the payment any way they chose.

Medicare Savings under the Demonstration: From the start of the demonstration in May 1991 through December 1993, the Medicare program saved \$15.3 million on bypass patients treated in the four original demonstration hospital. The average discounted amount to roughly 14 percent on the \$111 million in expended spending on bypass patients, including a 90-day post-discharge period.

90 percent of the savings came from HCFA-negotiated discounts on the Part A and B inpatient expected payments.

8 percent came from lower-than-expected spending on post-discharge care

Beneficiary Savings under the Demonstration: Beneficiaries (and their insurers) saved another \$2.3 million in Part B coinsurance payments.

Total Savings under the Demonstration: Total Medicare savings estimated to have been \$17.6 million in the 2.5 year period.

Also included is an article from the October 23 Washington Post entitled "Turning to a Specialist [Hospital] to Curb Rising Health Care Cost." It is an excellent explanation of how contracting with quality hospitals for a high volume of services can help both the Medicare trust fund and the patient.

TURNING TO A SPECIALIST TO CURB RISING
HEALTH CARE COSTS

(By Steven Pearlstein)

Legal Sea Foods. The Cap. Federal Express. Nucor Steel.

One of the things common to all of these successful companies is focus. Rather than try to be all things to all people, they do one thing and do it very well. And by virtue of their high volume and specialization, they have raised quality and lowered prices for their consumers and made a nice profit beside.

But will the same formula work in health care? In small way, it already has.

At the Shouldice Hospital in Toronto, which performs only hernia operations, the average price of \$2,300 was more than a third less than the cost of the same operation at the typical general hospital in the United States. And yet despite the lower cost, only one-half of 1 percent of Shouldice patients need to have the procedure repeated, compared with 10 percent of patients at general hospitals.

And at surgeon Denton Cooley's famed Texas Heart Institute in Houston, a coronary bypass operation cost \$26,000, compared with