105TH CONGRESS 1st Session } HOUSE OF REPRESENTATIVES { REPORT 105–186, Part I

VETERANS MEDICARE REIMBURSEMENT DEMONSTRATION ACT OF 1997

JULY 16, 1997.—Ordered to be printed

Mr. STUMP, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany H.R. 1362, as amended]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 1362) to establish a demonstration project to provide for Medicare reimbursement for health care services provided to certain Medicare-eligible veterans in selected facilities of the Department of Veterans Affairs, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill as amended do pass.

The amendment in the nature of a substitute reads as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Medicare Reimbursement Demonstration Act of 1997".

SEC. 2. ESTABLISHMENT OF MEDICARE REIMBURSEMENT DEMONSTRATION PROJECT.

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary of Veterans Affairs and the Secretary of Health and Human Services shall jointly carry out a demonstration project under which the Secretary of Health and Human Services provides the Department of Veterans Affairs with reimbursement, determined in accordance with section 4, from the medicare program for health care services provided to targeted medicare-eligible veterans in or through medical centers of the Department of Veterans Affairs selected under subsection (b).

(2) DURATION.—The Secretaries shall conduct the demonstration project during the three-year period beginning on January 1, 1998. The Secretaries may extend such project for an additional period of up to two years.

(3) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary of Health and Human Services may, to the extent necessary to carry out the dem-

onstration project, waive any requirement of part B of title XI of the Social Security Act, title XVIII of that Act, or a related provision of law.

(b) SELECTION OF PARTICIPATING MEDICAL CENTERS.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, shall establish a plan for the selection of up to 12 medical centers under the jurisdiction of the Secretary and located in geographically dispersed locations to participate in the project.

(2) GENERAL CRITERIA.—The selection plan shall favor selection of those medical centers that are suited to serve targeted medicare-eligible individuals because—

(A) there is a high potential demand by targeted medicare-eligible veterans for their services;

(B) they have sufficient capability in billing and accounting to participate;

(C) they have favorable indicators of quality of care, including patient satisfaction;

(D) they deliver a range of services required by targeted medicare-eligible veterans; and

(E) they meet other relevant factors identified in the plan.

(3) MEDICAL CENTER NEAR CLOSED BASE.—There shall be at least one medical center selected that is in the same catchment area as a military medical facility which was closed pursuant to either of the following laws:

(A) The Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101–510; 10 U.S.C. 2687 note).

(B) Title II of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526; 10 U.S.C. 2687 note).

(c) VOLUNTARY PARTICIPATION.—Participation of targeted medicare-eligible veterans in the demonstration project shall be voluntary, subject to the capacity of participating medical centers and the funding limitations specified in section 4, and shall be subject to such terms and conditions as the Secretary may establish. In the case of a demonstration project at a medical center described in subsection (b)(3), targeted medicare-eligible veterans who are military retirees shall be given preference in participating in the project.

(d) COST SHARING.—The Secretary shall establish cost-sharing requirements for veterans participating in the demonstration project. Those requirements shall be the same as the requirements that apply to targeted medicare-eligible patients at nongovernmental facilities.

(e) CREDITING OF PAYMENTS.—A payment received by the Secretary under the demonstration project shall be credited to the applicable Department of Veterans Affairs medical appropriation and (within that appropriation) to funds that have been allotted to the medical center that furnished the services for which the payment is made. Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary during the fiscal year during which the payment is received.

SEC. 3. USE OF MANAGED HEALTH CARE PLAN.

(a) MANAGED HEALTH CARE PLANS.—(1) In carrying out the demonstration project, the Secretary may establish and operate managed health care plans.

(2) Any such plan shall be operated by or through a Department of Veterans Affairs medical center or group of medical centers and may include the provision of health care services through other facilities under the jurisdiction of the Secretary as well as public and private entities under arrangements made between the Department and the other public or private entity concerned. Any such managed health care plan shall be established and operated in conformance with standards prescribed by the Secretaries.

(3) The Secretary shall prescribe the minimum health care benefits to be provided under such a plan to veterans enrolled in the plan. Those benefits shall include at least all health care services covered under the medicare program.

(4) The establishment of a managed health care plan under this section shall be counted as the selection of a medical center for purposes of applying the numerical limitation under section 2(b)(1).

(b) MEDICAL CENTER REQUIREMENTS.—The Secretary may establish a managed health care plan using one or more medical centers and other facilities only after the Secretary submits to Congress a report setting forth a plan for the use of such centers and facilities. The plan may not be implemented until the Secretary has received from the Inspector General of the Department of Veterans Affairs, and has forwarded to Congress, certification of each of the following:

(1) The cost accounting system of the Veterans Health Administration (known as the Decision Support System) is operational and is providing reliable cost in-

formation on care delivered on an inpatient and outpatient basis at such centers and facilities.

(2) The centers and facilities have operated in conformity with the eligibility reform amendments made by title I of the Veterans Health Care Act of 1996 (Public Law 104–262) for not less than three months.

(3) The centers and facilities have developed a credible plan (on the basis of market surveys, data from the Decision Support System, actuarial analysis, and other appropriate methods and taking into account the level of payment under section 4 and the costs of providing covered services at the centers and facilities) to minimize, to the extent feasible, the risk that appropriated funds allocated to the centers and facilities will be required to meet the centers' and facilities' obligation to targeted medicare-eligible veterans under the demonstration project.

(4) The centers and facilities collectively have available capacity to provide the contracted benefits package to a sufficient number of targeted medicare-eligible veterans.

(5) The entity administering the health plan has sufficient systems and safeguards in place to minimize any risk that instituting the managed care model will result in reducing the quality of care delivered to enrollees in the demonstration project or to other veterans receiving care under subsection (a)(1) or (a)(2) of section 1710 of title 38, United States Code.

(c) RESERVES.—The Secretary shall maintain such reserves as may be necessary to ensure against the risk that appropriated funds, allocated to medical centers and facilities participating in the demonstration project through a managed health care plan under this section, will be required to meet the obligations of those medical centers and facilities to targeted medicare-eligible veterans.

SEC. 4. DETERMINATION OF REIMBURSEMENT AMOUNTS.

(a) PAYMENTS BASED ON 95 PERCENT OF REGULAR MEDICARE PAYMENT RATES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs for services provided under the demonstration project at the following rates:

(A) NON-CAPITATION.—Except as provided in subparagraph (B) and subject to paragraphs (2)(A) and (4), at a rate equal to 95 percent of the amounts that otherwise would be payable under the medicare program on a non-capitated basis for such services if the medical center were not a Federal medical center, were participating in the program, and imposed charges for such services.

(B) CAPITATION.—Subject to paragraphs (2)(B) and (4), in the case of services provided to an enrollee under a managed health care plan established under section 3, at a rate equal to 95 percent of the payment rate otherwise applicable under a risk-sharing contract under section 1876 of the Social Security Act (42 U.S.C. 1395mm) with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

(2) EXCLUSION OF CERTAIN AMOUNTS.—

(A) NONCAPITATION.—In computing the amount of payment under paragraph (1)(A), the following shall be excluded:

(i) DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT.—Any amount attributable to an adjustment under subsection (d)(5)(F) of section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(ii) DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Any amount attributable to a payment under subsection (h) of such section.

(iii) PERCENTAGE OF INDIRECT MEDICAL EDUCATION ADJUSTMENT.—40 percent of any amount attributable to the adjustment under subsection (d)(5)(B) of such section.

(iv) PERCENTAGE OF CAPITAL PAYMENTS.—67 percent of any amounts attributable to payments for capital-related costs under subsection (g) of such section.

(B) CAPITATION.—In computing the amount of payment under paragraph (1)(B), the payment rate shall be computed as though the amounts excluded under subparagraph (A) had been excluded in the determination of the adjusted average per capita cost under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) .

(3) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this section shall be made—

(A) on a periodic basis consistent with the periodicity of payments under the medicare program; and

(B) in appropriate part, as determined by the Secretary of Health and Human Services, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

(4) ANNUAL LIMIT ON MEDICARE PAYMENTS.—The amount paid to the Department of Veterans Affairs under this section for any year for the demonstration project may not exceed $50,000,000, of which not more than $10,000,000 may be for the conduct of the project through managed health care plans under section 3..

(b) REDUCTION IN PAYMENT FOR VA FAILURE TO MAINTAIN EFFORT.—

(1) IN GENERAL.—In order to avoid shifting onto the medicare program costs previously assumed by the Department of Veterans Affairs for the provision of medicare-covered services to targeted medicare-eligible veterans, the payment amount under this section for the project for a fiscal year shall be reduced by the amount (if any) by which—

(A) the amount of the VA effort level for targeted veterans (as defined in paragraph (2)) for the fiscal year ending in such year, is less than

(B) the amount of the VA effort level for targeted veterans for fiscal year 1997.

(2) VA EFFORT LEVEL FOR TARGETED VETERANS DEFINED.—For purposes of paragraph (1), the term "VA effort level for targeted veterans" means, for a fiscal year, the amount, as estimated by the Secretaries, that would have been expended under the medicare program for VA-provided medicare-covered services for targeted veterans (as defined in paragraph (3)) for that fiscal year if benefits were available under the medicare program for those services. Such amount does not include expenditures attributable to services for which reimbursement is made under the demonstration project.

(3) VA-PROVIDED MEDICARE-COVERED SERVICES FOR TARGETED VETERANS.—For purposes of paragraph (2), the term "VA-provided medicare-covered services for targeted veterans" means, for a fiscal year, items and services—

(A) that are provided during the fiscal year by the Department of Veterans Affairs to targeted medicare-eligible veterans;

(B) that constitute hospital care and medical services under chapter 17 of title 38, United States Code; and

(C) for which benefits would be available under the medicare program if they were provided other than by a Federal provider of services that does not charge for those services.

(c) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

(1) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

(A) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for targeted medicare-eligible veterans during the period of the demonstration project compared to the expenditures that would have been made for such veterans during that period if the demonstration project had not been conducted.

(B) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary of Health and Human Services under the medicare program increased during the preceding fiscal year as a result of the demonstration project.

(2) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

(A) IN GENERAL.—If the Secretaries find, based on paragraph (1), that the expenditures under the medicare program increased (or are expected to increase) during a fiscal year because of the demonstration project, the Secretaries shall take such steps as may be needed—

(i) to recoup for the medicare program the amount of such increase in expenditures; and

(ii) to prevent any such increase in the future.

(B) STEPS.—Such steps—

(i) under subparagraph (A)(i) shall include payment of the amount of such increased expenditures by the Secretary from the current medical care appropriation of the Department of Veterans Affairs to the trust funds under the medicare trust program; and

(ii) under subparagraph (A)(ii) shall include suspending or terminating the demonstration project (in whole or in part) or substitution of a lower percentage for 95 percent under subsection (a)(1).

SEC. 5. PRIOR NOTICE TO CONGRESS.

The Secretary may not carry out the demonstration project at a medical center (either on a fee basis under section 2 or under a managed health care plan under section 3) until 30 days after the date on which the Secretary submits to Congress a report on the Secretary's plans for the selection of medical centers and on the rationale for the medical centers selected.

SEC. 6. EVALUATION AND REPORTS.

(a) ONGOING EVALUATION AND ANNUAL REPORTS BY INDEPENDENT ENTITY.—

(1) ONGOING EVALUATION.—The Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an ongoing evaluation of the demonstration project.

(2) ANNUAL REPORTS.—The entity shall submit a report on the project jointly to the Secretaries and to the appropriate committees of the Congress not later than March 1 following each year during which the project is conducted.

(3) ASSESSMENT.—Each such report shall include the results of the ongoing evaluation under paragraph (1), including an assessment of each of the following:

(A) The cost to the Department of Veterans Affairs of providing care to veterans under the project.

(B) Compliance of participating medical centers with applicable measures of quality of care, compared to such compliance for other medicare-participating medical centers.

(C) A comparison of the costs of medical centers' participation in the program with the reimbursements provided for services of such medical centers.

(D) Any savings or costs to the medicare program from the project.

(E) Any change in access to care or quality of care for targeted medicare-eligible veterans participating in the project.

(F) Any effect of the project on the access to care and quality of care for targeted medicare-eligible veterans not participating in the project and other veterans not participating in the project.

(G) The provision of services under managed health care plans under section 3, including the circumstances (if any) under which the Secretary uses reserves described in section 3(d) and the Secretary's response to such circumstances (including the termination of managed health care plans requiring the use of such reserves).

(b) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission of the penultimate report under subsection (a), the Secretaries shall submit to the Congress a report containing their recommendation as to—

(1) whether to extend the demonstration project (in addition to the extension authorized under section 2(a)(2)) or make the project permanent;

(2) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under section 3) under the project in any year; and

(3) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.

SEC. 7. DEFINITIONS.

For the purpose of this Act:

(1) DEMONSTRATION PROJECT; PROJECT.—The terms "demonstration project" and "project" mean the demonstration project carried out under section 2(a).

(2) MEDICARE PROGRAM.—The term "medicare program" means the programs of health benefits provided under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) MILITARY RETIREE.—The term "military retiree" means a member or former member of the Armed Forces who is entitled to retired pay.

(4) SECRETARY; SECRETARIES.—Unless otherwise provided, the term "Secretary" means the Secretary of Veterans Affairs and the term "Secretaries" means the Secretary of Veterans Affairs and the Secretary of Health and Human Services acting jointly.

(5) TARGETED MEDICARE-ELIGIBLE VETERAN.—The term "targeted medicare-eligible veteran" means an individual who—

(A) is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in section 1710(a)(3) of title 38, United States Code; and

(B) is entitled to hospital insurance benefits under part A of the medicare program and is enrolled in the supplementary medical insurance program under part B of the medicare program.

INTRODUCTION

On September 12, 1996, the Honorable Bob Stump, Chairman of the House Veterans' Affairs Committee, was joined by the Honorable G.V. (Sonny) Montgomery, the Honorable Floyd Spence, the Honorable Lane Evans, the Honorable Terry Everett, the Honorable Chet Edwards, the Honorable Steve Buyer, the Honorable Frank Tejeda, and the Honorable Joel Hefley in the introduction of H.R. 4068, legislation to establish a demonstration project to provide that the Department of Veterans Affairs may receive Medicare reimbursement for health care services provided to certain Medicare-eligible veterans.

On September 18, 1996, the Committee on Veterans' Affairs ordered H.R 4068 reported amended to the full House by a vote of 17–0. The Ways and Means Committee, which had primary jurisdiction, heard testimony on the bill. No further action was taken on the bill in the 104th Congress.

On April 17, 1997, the Honorable Bob Stump, Chairman of the House Veterans' Affairs Committee, was joined by the Honorable Lane Evans, the Honorable Cliff Stearns, the Honorable Luis Gutierrez, the Honorable Chris Smith, the Honorable Joe Kennedy, the Honorable Terry Everett, the Honorable Bob Filner, the Honorable Jack Quinn, the Honorable Jim Clyburn, the Honorable Dan Schaefer, the Honorable Corrine Brown, the Honorable Jerry Moran, the Honorable Peter Doyle, the Honorable John Cooksey, the Honorable Frank Mascara, the Honorable Asa Hutchinson, the Honorable Collin Peterson, the Honorable Helen Chenoweth, the Honorable Julia Carson, the Honorable Ray LaHood, the Honorable Silvestre Reyes, the Honorable J.D. Hayworth, the Honorable Vic Snyder and the Honorable Bill Barrett in the introduction of H.R. 1362, legislation to establish a demonstration project to provide for Medicare reimbursement for health care services provided to certain Medicare-eligible veterans in selected facilities of the Department of Veterans Affairs.

The Subcommittee on Health met on May 8, 1997 to hear expert testimony on three pieces of legislation, including H.R. 1362, the Veterans' Medicare Reimbursement Demonstration Act of 1997. Testifying on H.R. 1362 at the hearing were Mr. Paul Van de Water, Assistant Director for Budget Analysis at the Congressional Budget Office; Dr. Kenneth Kizer, Under Secretary for Health at the Department of Veterans Affairs; Ms. Kathleen Buto, Associate Administrator for Policy at the Health Care Financing Administration; Mr. John Vitikacs, Assistant Director of the National Veterans Affairs and Rehabilitation Commission of the American Legion; Mr. Dennis Cullinan, Deputy Director for National Legislative Service of the Veterans of Foreign Wars; Colonel Charles Partridge, Legislative Counsel for the National Military and Veterans Alliance; Mr. Chuck Burns, National Service Director of AMVETS; Ms. Kelly Willard West, Director of Government Relations of the Viet-

nam Veterans of America; Mr. John Bollinger, Deputy Executive Director of the Paralyzed Veterans of America; and Mr. Larry Rhea, Deputy Director of Legislative Affairs of the Non Commissioned Officers Association.

On May 15, 1997, the Subcommittee on Health met and ordered H.R. 1362 reported favorably to the full Committee by unanimous voice vote with an amendment in the nature of a substitute.

On May 21, 1997, the full Committee met and ordered H.R. 1362, as amended, reported favorably to the House by unanimous voice vote.

SUMMARY OF THE REPORTED BILL

H.R. 1362, as amended, would:

1. Create a three-year demonstration project in up to 12 geographically dispersed VA medical centers allowing the VA to be reimbursed by Medicare for the care of certain category C Medicare-eligible veterans.
2. Provide that Medicare payments be capped at $50 million annually; of that amount, a managed care component would be limited to $10 million, and care furnished under the traditional fee-for-service model could not exceed $40 million.
3. Specify that VA may implement a managed care component only after submitting a plan on proposed demonstration sites to include certifications from its Inspector General that the participating facilities have: (1) a reliable cost-accounting system in place; (2) implemented eligibility reform; (3) developed a plan on the basis of market surveying, actuarial analysis, and other business techniques; to minimize the risk that appropriated funds will be needed to subsidize the demonstration; (4) the capacity to provide the contracted benefits package; and (5) sufficient systems and safeguards in place to ensure provision of high-quality care.
4. Specify criteria for selecting demonstration sites, and require that at least one site would be near a military medical facility which had closed under the base realignment and closure process, with military retirees having preference for participation at that site or sites.
5. Require VA to maintain its current level of services to Medicare-eligible veterans and effectively limit payments to the additional episodes above that baseline level.
6. Provide that the Secretaries of the Departments of Health and Human Services and Veterans Affairs monitor expenditure levels during the project in relation to expenditures that would have been made but for the project, and provide for annual audits by the Comptroller General to ensure that Medicare is not incurring additional costs.
7. Provide for adjusting payment rates, or shrinking or terminating the program, at any point if Medicare costs rise under the demonstration.
8. Authorize reimbursement at 95 percent of otherwise applicable rates.

9. Establish a rigorous evaluation of the program by independent entities.

BACKGROUND AND DISCUSSION

THE MEDICARE PROGRAM

Created in 1965, the Medicare program, title XVIII of the Social Security Act, is a statutory entitlement for health insurance coverage for the aged and certain disabled persons. Those 65 years of age or older and eligible for Social Security or railroad retirement cash benefits are automatically entitled to hospital insurance under Medicare Part A, which is financed by payroll taxes. Part A provides coverage for inpatient hospitalization, up to 100 days of post-hospital skilled nursing home care, home health services, and hospice care. Physician and outpatient services are provided under Medicare Part B, which is financed through a combination of payments by beneficiaries who elect to enroll and general revenues.

Some 88 percent of the 38 million Medicare beneficiaries obtain services under a fee-for-service system through providers of their choice, with Medicare making payment for each service rendered. Payments for inpatient hospital services are made in accordance with a prospective payment system with rates based on the patient's diagnosis. Payments for physicians' services are based on a fee schedule.

Under Medicare's risk contract program, Medicare pays participating health maintenance organizations a predetermined monthly "capitation" payment for each Medicare enrollee, regardless of the amount of care provided. The payments equal 95 percent of the estimated adjusted average per capita cost (AAPCC) of providing Medicare services to a given beneficiary under the fee-for-service-system. The HMO must provide any needed services offered under its contract, regardless whether it can do so within the capitation payment. Managed care plans participating in the Medicare program are required to offer beneficiaries either benefits in addition to those available to beneficiaries who opt for fee-for-service care or lower cost-sharing requirements.

VA AND THE MEDICARE PROGRAM

Provisions of Medicare law (codified at section 1395f(c) of title 42, United States Code) specify that no Medicare payments may be made to a Federal provider of services, except a provider which the Secretary determines is providing services to the public generally as a community institution or agency, and no payment may be made to any provider for services which the provider is obligated by law to render at public expense. A narrow exception to that policy, in section 8153(d) of title 38, United States Code, requires that VA be reimbursed by Medicare (notwithstanding any condition, limitation, or other provision in title XVIII) when it provides services to Medicare-covered individuals who are not eligible for care under chapter 17 of title 38 and who are afforded VA care or services under a "sharing" agreement. Under existing law, therefore, although many of its patients are Medicare-eligible, VA may not seek payment from the Medicare program when it provides care to a Medicare-covered veteran.

ELIGIBLE VETERANS WHO CANNOT GAIN ACCESS TO VA CARE

VA's obligation to provide care to eligible veterans is effective "only to the extent and in the amount provided in advance in appropriations Acts for such purposes." 38 USC section 1710(a)(4). Eligibility reforms enacted in 1996 established priorities for categories of eligible veterans to govern their relative standing for registration or enrollment for VA care. VA may enroll only such numbers of veterans as it can reasonably expect to be able to treat within available funds. Service-connected veterans rated 10 percent or more disabled have highest priority for enrollment. This statutory priority system assigns its lowest priority to veterans who have no other special eligibility status and whose incomes exceed a statutory "means test" (that is, income above $21,610 in the case of an individual with no dependents).

While eligible for VA care subject to co-payment requirements, so-called "category C" veterans have generally been denied access to VA care because the system lacks resources to treat them. Authorizing VA to collect and retain Medicare reimbursement for Medicare-covered services provided higher-income dual-eligible veterans would allow VA to provide care to more of these veterans.

The VA medical care appropriation has generally been sufficient only to enable VA to serve veterans in high-priority classifications (notably, the service-connected disabled, those with limited financial means, and such special cohorts as former prisoners of war and Persian Gulf veterans). Nevertheless, some individual VA facilities have had capacity to provide some level of services to higher-income veterans.

CURRENT LEVEL OF EFFORT

VA has estimated that in Fiscal Year 1996 it would treat some 34,200 Medicare-eligible "category C" veterans who were at least 65 years old and another 5,300 whose Medicare eligibility is based on disability. While VA information systems do not provide a basis to ascertain with precision the extent to which it has subsidized Medicare in treating dual eligible veterans, VA does have substantial data. In a 1995 analysis, the Veterans Health Administration identified VA facilities which in 1994 were treating the greatest number of individual dual-eligible category C veterans. Northport, NY; Hines, IL; and Amarillo, TX VA Medical Centers saw the greatest number of individual patients, while Hines, West Los Angeles, and Northport treated more veterans on an inpatient basis than other VA facilities. Of the 25 sites serving the greatest number of these dual-eligible, category C veterans, almost one-third (8) were in the Northeast. A VA draft report on this analysis indicates that most of these inpatients were seen for mental disturbances or illness (the most frequent diagnosis related groups include organic disturbances and mental retardation, degenerative nervous system disorders, and psychoses). The most common surgical procedures these veterans received were cystoscopy, cataract surgery, and transurethral prostatectomy. Outpatient services most frequently provided these veterans included nursing care, general internal medicine, and laboratory services.

The General Accounting Office, in a 1994 report, "Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS)" reviewed FY 1990 data to determine the types of care Medicare-eligible veterans sought at VA. GAO examined inpatient and outpatient services, including prescription drugs (for which Medicare does not provide coverage). While it considered income, the report did not attempt to differentiate between Category A and C veterans. The study found that Medicare-eligible veterans tended to use VA for services or products for which Medicare provided little or no reimbursement such as prescription drugs. Dual users obtained almost as many drugs from VA as veterans who only used VA for care. The report also found that VA users used slightly fewer audiology services (which Medicare does not reimburse) than dual users, but slightly more optometry and dental services (also benefits Medicare does not cover). The report also notes that VA is an important source of inpatient psychiatric care and nursing home care (services for which Medicare provides limited reimbursement under certain circumstances).

HEALTH CARE REFORM WITHIN THE VA

The VA health care system is a vertically integrated delivery system, and this ability to provide veterans with a full continuum of health care services makes VA a unique provider. While VA had long seemed a relatively static hospital based system, VA health care is undergoing major changes in delivery systems, organization, and management philosophy. These changes, which have accelerated in the last two years, have included a shift in much of VA care from inpatient to outpatient settings. With accompanying decentralization of decisionmaking, downsizing of VA's workforce and its middle-management layer, and consolidation of numbers of its medical centers, VA is becoming a more cost-effective provider. At the same time, VA is seeking to improve its service-delivery and the level of its beneficiaries' satisfaction with VA care. VA is also increasing its number of community-based outpatient clinics to make care more accessible and reduce the cost of care-delivery. It is also attempting to improve case management and continuity of care by assigning each veteran to a primary care provider.

In its May 1997 report to Congress, entitled "Journey of Change", on its national strategic plan, VA states that, as of October 1996, 97 percent of its facilities had developed primary care teams, and that 53 percent of its patients had enrolled in primary care as of September 30, 1996. All of its networks had implemented utilization management programs to increase the efficiency and appropriateness with which services are provided and resources used. VA describes its shift to managed care as a major strategy to transform its delivery system, and reports that accordingly, it is developing and implemented clinical guidelines for treating specific health problems. Guidelines for treating stroke, amputation, ischemic heart disease, major depression disorder, and major depression with post traumatic stress disorder were implemented in fiscal year 1996. VA plans to disseminate another 12 clinical practice guidelines this year.

While VA's shift to outpatient care, primary care, and increasingly more convenient access appear to be markedly improving its

"customer service", relatively few higher income veterans are likely to benefit from these changes. Although VA seeks to increase the numbers of veterans it treats, it is unlikely, given current law and a constrained budget, that the VA health care system can expand significantly the numbers of these veterans it serves. To the contrary, one might anticipate that the numbers served would, in fact, decline. The new access criteria established in the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104–262), for example, may alter facilities' abilities to deliver care to some of these prior users. That law assigns higher income veterans the lowest priority for enrollment. VA medical-care budgets which do not keep pace with inflation will, in general, reduce VA's capability to serve veterans whose eligibility for care is based on the availability of resources. Moreover, VA is also changing the way individual facilities have been funded. Funds are now distributed to networks based on the type and number of individuals served; network directors are free to distribute funds to the facilities in their catchment area. Facilities which had provided care to higher-income veterans in the past, may be struggling for resources today under the new resource allocation methodology.

RATIONALE FOR H.R. 1362

Many of these considerations have for some time led this Committee—as well as Medicare-eligible higher-income veterans—to urge that they be offered greater choice under the Medicare program. The VA health care system, which is otherwise largely closed to them as veterans because of funding constraints, should not also be closed to them as Medicare beneficiaries, particularly not if such access would be beneficial both to VA and the Medicare program.

This Committee proposed legislation in the 104th Congress to mount a demonstration project that would permit certain veterans to use Medicare benefits in the VA and also require that VA accept a discounted reimbursement rate. It has been this Committee's view that the Medicare program, VA, and these veterans can all benefit from establishing VA as a choice for category C, Medicare-covered veterans. Given fiscal pressures on the Medicare trust funds, it has been proposed that this concept be implemented on a limited basis through a demonstration program so that its underlying assumptions can be tested. H.R. 1362, as amended, would provide for such a test.

Allowing VA to collect and retain Medicare funds would allow VA to provide care to a greater number of veterans. To the extent that VA can serve Medicare beneficiaries without needing to expand its staffing or other overhead costs, Medicare reimbursement will bring down VA's cost of care per patient. (VA has articulated a strategic goal of cutting costs per individual patient by 30 percent; increasing veterans' access to health care by 20 percent; and relying on non-appropriated funds for 10 percent of funding.)

THE REPORTED BILL

H. R. 1362, as amended, would for the first time allow certain Medicare-eligible veterans to elect VA as their Medicare-provider. This legislation would authorize the Department to establish a three-year test program to demonstrate that VA can help reduce

Medicare costs and at the same time improve access to care for certain veterans. The veteran-beneficiaries of this legislation are unique in being eligible for VA care but, because of VA funding levels and because of personal income exceeding VA's "means test", generally have been denied care by a system designed to serve them. The bill is designed to achieve Medicare savings through provisions which call for reimbursement levels to VA at 95 percent of otherwise applicable reimbursement rates.

The demonstration program would have two components—a traditional fee-for-service model (subject to the limitation that annual Medicare payments may not exceed $40 million) and a managed care plan (subject to a $10 million cap). Under the reported bill, these tests would be mounted in up to 12 geographically dispersed VA medical centers. The VA Secretary is to develop a site selection plan in consultation with the Secretary of Health and Human Services. In selecting medical centers to participate in the demonstration project, the Secretary is to select at least one medical center within the catchment area of a military medical facility which has been closed; VA is to give military retirees preference to participate in the demonstration at that site or sites.

The Committee is concerned that facilities selected to participate in the demonstration be suited to serve the targeted beneficiaries, based on such factors as high potential demand, capability and capacity to provide a range of required services, a sophisticated cost-accounting and billing capability, and favorable indicators of quality of care, including high levels of patient satisfaction. Accordingly, the reported bill requires that, before implementing a demonstration project at a proposed site, the Department report to Congress regarding the medical center or centers which have been selected for participation and the rationale for site or sites selected.

The reported bill would impose specific additional reporting requirements applicable to carrying out managed care demonstration projects. The Committee has established these additional requirements in light of its finding that many elements associated with successful provision of care under a risk contract are not yet in place at any VA medical centers. Yet the harm which may result from VA's lack of experience with managing a risk-contract, as well as its lack of cost-accounting capability and of sufficient actuarial and other data, ultimately fall not on either VA as a provider or on VA administrators, but on other veterans. The Committee is concerned that those now depending on VA could fall through its "safety net" if appropriations were diverted to subsidize the cost of care to new Medicare beneficiaries.

The Committee has made every effort to ensure that the reported bill would impose no additional cost on the Medicare trust funds. Among those provisions, the measure takes specific account of the fact that VA has provided Medicare-covered services to some number of dual eligible veterans who would be among the targeted beneficiaries of the bill. That level of services may be said to represent a VA subsidy to the Medicare trust funds. Insofar as that "level of effort" has been supported by the VA's medical care appropriation, the bill seeks to avoid a situation where medicare-covered services VA would otherwise have provided (but for this legislation) declines because of the legislation. That is, the reported bill seeks

to avoid any shifting of costs from the VA medical care appropriation to Medicare. The reported bill, accordingly, requires VA to maintain an "effort level for targeted veterans" reflecting the level provided in fiscal year 1997.

The level of effort for these targeted veterans represents an amount (which must be estimated) which the Health Care Financing Administration (HCFA) would have paid for VA-provided medicare-covered services to targeted veterans for a fiscal year. To avoid shifting costs onto Medicare, the reported bill provides that VA would be reimbursed in any fiscal year only for covered services exceeding the level of effort for fiscal year 1997.

In addition to accounting for maintenance of prior level of effort, the reported bill includes other elements to help ensure that the medicare trust funds are held harmless under the demonstration. The reported bill would task the Secretaries, in consultation with the Comptroller General, to closely monitor expenditures made under the demonstration project and compare them with expenditures which would have been made if the demonstration had not been conducted. In addition, the measure calls on the Comptroller General to report to the Secretaries and the Congress on the extent to which the demonstration has resulted in increasing Medicare costs. The reported bill affords specific remedies to address such cost-shifting, including recoupment of the increase in expenditures and suspension or termination of the demonstration project.

Under the reported bill, once VA had met its required "level of effort" it would receive discounted reimbursement from HCFA. The rates would be discounted in two ways. First, HCFA would eliminate all or part of the reimbursement it makes to other providers for disproportionate share hospitals, indirect and direct medical education, and capital investments. Second, HCFA's intermediaries would reimburse VA at 95 percent of the rate it would provide to non-federal providers.

The Congressional Budget Office (CBO) analysis of the reported bill, printed herein, projects that "Medicare's cost would probably increase, but CBO cannot estimate the amount." CBO explains that data limitations make it difficult to determine accurately VA's "current level of effort" to targeted veterans. In postulating that it would not be possible to determine if VA was actually maintaining its level of effort even if that level could be estimated accurately, however, CBO's "analysis" veers off a rational course. CBO states that:

> The nature of the demonstration would encourage VA to serve targeted veterans at facilities where Medicare would provide reimbursement. As a result, spending on medical care for targeted veterans would rise at VA facilities participating in the demonstration, and VA's spending on medical care for targeted veterans at nonparticipating facilities would fall. VA could appear to meet or exceed its maintenance-of-effort requirement while actually falling short of the target.

This analysis offers no foundation for the assumptions made in the above-quoted paragraph. In essence, CBO assumes that VA health care administrators, in the face of a law that requires a

maintenance of effort throughout its health care system, will ignore that requirement with resultant shifting of costs to Medicare. CBO, thus, appears to assume not only that VA's most powerful incentive is to shift costs, but that it also has the will to defy a requirement of law and that it has the means to do so and evade detection. The VA's own internal budget documents for Fiscal Year 1998 make it apparent that the Department's objective is quite the opposite. VA's goal for the demonstration is to achieve success so as to demonstrate the benefit of expanding this model into a nationwide program. Accordingly, it is inconceivable that VA would seek to pursue a short-term advantage at a handful of facilities at the expense of its national strategy. Moreover, it is inconceivable that a drop in numbers of "targeted veterans" at "nonparticipating facilities" could escape detection, whether by the General Accounting Office or Inspectors General of the VA or Department of Health and Human Services.

In essence, H.R. 1362, as amended, seeks to establish a modest demonstration to test the view that VA can provide certain dual eligible veterans a choice not now available to them as veterans or Medicare beneficiaries and reduce costs to Medicare. The qualified CBO view that Medicare costs would "probably" increase under the bill is equally untested, and flawed in this Committee's view. In favorably reporting H.R.1362, as amended, the VA Committee advances legislation which should be tested.

SECTION-BY-SECTION ANALYSIS

Section 1 would name the Act the "Veterans Medicare Reimbursement Demonstration Act of 1998".

Section 2(a)(1) would authorize the Secretaries of Veterans Affairs and Health and Human Services to jointly carry out a VA-Medicare subvention demonstration project.

Section 2(a)(2) would specify that the demonstration project would begin on January 1, 1998 and last three years.

Section 2(a)(3) would, to the extent necessary to carry out the demonstration project, authorize the Secretary of Health and Human Services to waive otherwise applicable Medicare requirements.

Section 2(b)(1) would require the Secretary, in consultation with the Secretary of Health and Human Services to establish a plan for selection of up to 12 sites.

Section 2(b)(2) would specify that participating medical centers must be suited to serve targeted veterans and specify criteria to be used by the Secretaries in making these site selections.

Section 2(b)(3) would specify that at least one medical center selected would be in close proximity to a military medical facility which closed during the Base Closure and Realignment (BRAC) process.

Section 2(c) would provide that veterans' participation in the demonstration project is to be voluntary; subject to participating facilities' capacities and available resources; and is to be subject to terms and conditions that the Secretary may set.

Section 2(d) would require the establishment of the same cost-sharing policy applicable to participating veterans as would apply under the Medicare program at nongovernmental facilities.

Section 2(e) would establish a policy for crediting Medicare payments to ensure that such funds would be retained and made available to the facility which provided services.

Section 3(a) would authorize the Secretary to establish and operate managed care plans within the demonstration; any one of the managed care plans would constitute one of the 12 pilots which may be undertaken under the demonstration, and may be carried out through one or more VA medical centers and may involve the provision of services by or through other public or private entities.

Section 3(b) would require that the Inspector General review any proposed managed care site, and certify that specified criteria are met, before the Secretary may implement a managed care plan.

Section 3(c) would require the Secretary to maintain reserves from monies held for contingency purposes in VA's headquarters office to ensure that appropriated funds allocated to participating VA facilities to meet obligations to veterans who are not participating in the demonstration project are not used to meet the obligations of the demonstration project.

Section 4(a) would establish a Medicare reimbursement formula to involve a rate of 95 percent of the amount that would otherwise be payable to a non-Federal provider, and specify those elements to be excluded in whole or in part from the payment. The section would also cap the annual payment made to the VA at $50 million, of which not more than $10 million can be used for projects employing managed care plans.

Section 4(b) would provide that to avoid shifting any costs previously assumed by the VA for category C, Medicare-eligible veterans to the Medicare program, payment to VA would only be made for "VA-provided medicare-covered services for targeted veterans" for services which exceed the "VA effort level for targeted veterans" for fiscal year 1997. The subsection would also define the quoted terms.

Section 4(b)(2) would define the term "VA effort level for targeted veterans."

Section 4(b)(3) would define the term "VA-provided medicare-covered services for targeted veterans."

Section 4(c)(1)(A) would direct VA and HHS, in consultation with the Comptroller General, to closely monitor the program to ensure that no increases in the cost of the Medicare program will be incurred.

Section 4(c)(1)(B) would require that the Comptroller General submit a report on the extent to which the cost of the Medicare program had changed due to enactment of this legislation.

Section 4(c)(2)(A) would direct VA and HHS to take appropriate action if it is determined that Medicare costs have risen due to enactment of this legislation.

Section 4(c)(2)(B) would specify what steps should be taken should such cost increases be found.

Section 5 would require that the Secretary notify Congress of the location of any proposed demonstration sites and rationale for the site-selection, and defer carrying out such demonstration at the proposed site or sites for 30 days.

Section 6(a)(1) would require VA and HHS to arrange for an independent agency to conduct an ongoing evaluation of the demonstration project.

Section 6(a)(2) would require that entity to submit an annual report to Congress on its findings.

Section 6(a)(3) would specify what criteria the entity should use in assessing the demonstration project.

Section 6(b) would direct VA and HHS to submit recommendations to Congress—after studying the independent entity's assessment—on whether to extend or expand the demonstration project.

Section 7 would define various terms used in the legislation.

Oversight Findings

No oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

Statement of Administration's Views

In May 8, 1997 testimony before the Subcommittee on Health, Dr. Kenneth Kizer, VA's Under Secretary for Health, offered the Department's support for the enactment of H.R. 1362 "with some changes." The testimony strongly urged that the legislation be revised to authorize VA to test not only a fee-for-service model but a capitation model as well. The bill, as amended, incorporates changes to reflect that recommendation as well as a number of specific revisions suggested by VA in its testimony.

The Department has since expressed formal support for section 5047 of H.R. 2015, legislation passed by the Senate which is very similar to H.R. 1362, as amended.

Congressional Budget Office Cost Estimate

The following letter was received from the Congressional Budget Office concerning the cost of the reported bill:

U.S. Congress,
Congressional Budget Office,
Washington, DC, May 28, 1997.

Hon. Bob Stump,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1362, the Veterans Medicare Reimbursement Demonstration Act of 1997.

If you wish further details on this estimate, we will be pleased to provide them.

The CBO staff contacts are Shawn Bishop, who can be reached at 226–2840, and Tom Bradley, who can be reached at 226–9010.

Sincerely,

June E. O'Neill,
Director

Enclosure

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

H. R. 1362—Veterans Medicare Reimbursement Demonstration Act of 1997

As ordered reported by the House Committee on Veterans'Affairs on May 21, 1997

Summary. H.R. 1362 would establish a demonstration project for Medicare reimbursement to the Department of Veterans Affairs (VA) for care that VA provides to certain veterans eligible for Medicare, a program sometimes called Medicare subvention. Although the bill would probably raise Medicare's costs, CBO cannot estimate the amount of the increase. Any increase in Medicare's outlays would represent an additional source of funds for VA; thus, the needed authorization of appropriations for veterans' medical care would decline by the same amount. Because it would affect direct spending, H.R. 1362 would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. H.R. 1362 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995 and would not have a significant impact on the budgets of state, local, or tribal governments.

Estimated Cost to the Federal Government. H.R 1362 would establish a demonstration project in which Medicare would reimburse VA for the care that VA provides to certain veterans who are also eligible for Medicare. The demonstration project would have the following characteristics:

- The project would be conducted during the 1998–2000 period at up to 12 VA medical centers in diverse locations where there would be a high demand for the program.
- Medicare would reimburse VA at 95 percent of the rate paid to private providers for Medicare-covered services furnished to certain veterans. Those veterans would have to be eligible for Medicare, participate in Medicare Part B, and have no service-connected disability. Such veterans currently receive care from VA if resources are available and if the veteran pays a share of the costs. Participants in the demonstration would be subject to Medicare's cost-sharing requirements.
- Although Medicare would reimburse VA primarily on a fee-for-service basis, VA could establish and operate managed health care plans as part of the demonstration.
- VA would be responsible for maintaining a basic level of effort to be eligible for reimbursement by Medicare. The required level of effort would be based on an estimate of the amount of Medicare-covered services provided by VA to targeted veterans in 1997 (VA's effort level would not include services reimbursed by Medicare.)
- VA and the Department of Health and Human Services (HHS), in consultaton with the General Accounting Office, would monitor Medicare's expenditures in an at-

tempt to ensure that it spent no more than it would have spent without the demonstration.

- Medicare's payments under the demonstration would be limited to $50 million a year, of which not more than $10 million could be for managed care plans operated by VA.

One of the legislative goals is that the demonstration project not increase either VA's or Medicare's costs. In theory, VA would continue to pay for the care that it would provide under current law to beneficiaries eligible for Medicare, and Medicare would continue to pay for people currently receiving care in the private sector. Medicare's costs would experience no net change because lower payments to private-sector providers would offset payments to VA. VA's net costs would remain the same because the receipts from Medicare would be matched by higher outlays for the care it would provide to extra patients. In practice, however, Medicare's cost would probably increase, but CBO cannot estimate the amount.

Assuring budget neutrality for Medicare would be diffcult to achieve for two reasons. First, available data do not allow an accurate determination of the portion of VA's current workload that is attributable to providing Medicare-covered services to targeted veterans. Second, VA could shift future costs to Medicare while nominally meeting its maintenance-of-effort requirements.

Medicare's costs would rise if VA's basic level of effort is underestimated, and that level cannot be measured very well. Establishing a base level for 1997 requires knowing the number of targeted veterans who seek care from VA, the extent of that care, and the costs of providing it. This information is not available for individual VA facilities or in the aggregate and must be estimated based on accounting and survey data.

Even if VA's current level of effort could be estimated accurately, it would not be possible to determine if VA was actually maintaining that level of effort in future years. The nature of the demonstration would encourage VA to serve targeted veterans at facilities where Medicare would provide reimbursement. As a result, spending on medical care for targeted veterans would rise at VA facilities participating in the demonstration, and VA's spending on medical care for targeted veterans at nonparticipating facilities would fall. VA could appear to meet or exceed its maintenance-of-effort requirement while actually falling short of the target.

Under these circumstances, differences in the access to information and funding make it likely that some of VA's spending would be shifted to Medicare. Because annual discretionary appropriations limit VA's health care funding, the department would have to reduce the size of its program if it overestimated its required level of effort or underestimated its actual effort in the future. Medicare's costs, however, are paid from a permanent, indefinite appropriation that would not readily reveal a loss stemming from a demonstration program such as this one. It would not be easy for the General Accounting Offfice or any other auditing agency to determine the financial outcome of the demonstration. It, too, would have to rely on estimates and assumptions about events and behavior that would have been different under current law.

Pay-as-you-go considerations. Enactment of the bill would probably increase direct spending in fiscal year 1998, but CBO cannot estimate the amount of the increase.

Intergovernmental and private-sector impact. H.R. 1362 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995 and would not have a significant impact on the budgets of state, local, or tribal governments.

Estimate prepared by:

Veterans Costs: Shawn Bishop

Medicare Costs: Tom Bradley

Impact on State, Local, and Tribal Governments: Marc Nicole

Impact on the Private Sector: Neil Singer

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis

Inflationary Impact Statement

The enactment of the reported bill would have no inflationary impact.

Applicability to Legislative Branch

The reported bill would not be applicable to the legislative branch under the Congressional Accountability Act, Public Law 104–1, because it would apply only to certain Department of Veterans Affairs and Health and Human Services programs and facilities.

Statement of Federal Mandates

The reported bill would not establish a federal mandate under the Unfunded Mandates Reform Act, Public Law 104–4.

Statement of Constitutional Authority

Pursuant to Article I, section 8 of the U.S. Constitution, the reported bill would be authorized by Congress' power "{T}o provide for the common Defence and general Welfare of the Untied States."