105TH CONGRESS
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HOUSE OF REPRESENTATIVES

REPT. 105–793
Part 1

VETERANS MEDICARE ACCESS IMPROVEMENT ACT OF 1998

OCTOBER 7, 1998.—Ordered to be printed

Mr. ARCHER, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 3828]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3828) to amend title XVIII of the Social Security Act to improve access to health care services for certain Medicare-eligible veterans, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

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

SECTION 1. SHORT TITLE; PURPOSES.

(a) SHORT TITLE.—This Act may be cited as the "Veterans Medicare Access Improvement Act of 1998".

(b) PURPOSES.—The purposes of this Act are—

(1) to establish a program that permits medicare-eligible veterans who have a service-connected disability or are financially needy and for whom access to medical care of the Department of Veterans Affairs has been historically deficient because of geographic remoteness or inaccessibility to receive their medicare benefits through a service network of providers established by the Department of Veterans Affairs; and

(2) to establish a 3-year demonstration project that permits other medicare-eligible veterans to receive such benefits through the Department of Veterans Affairs.

SEC. 2. IMPROVEMENT IN VETERANS' ACCESS TO SERVICES UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act, as amended by sections 4603, 4801, and 4015(a) of the Balanced Budget Act of 1997, is amended by adding at the end the following:

"IMPROVING VETERANS' ACCESS TO SERVICES

"SEC. 1897. (a) DEFINITIONS.—In this section:

"(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary of Health and Human Services and the Secretary of Veterans Affairs acting jointly.

"(2) PROGRAM.—The term 'program' means the program established under this section with respect to category A medicare-eligible veterans.

"(3) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section with respect to category C medicare-eligible veterans.

"(4) MEDICARE-ELIGIBLE VETERANS.—

"(A) CATEGORY A MEDICARE-ELIGIBLE VETERAN.—The term 'category A medicare-eligible veteran' means an individual—

"(i) who is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in paragraph (1) or (2) of section 1710(a) of title 38, United States Code;

"(ii) who 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; and

"(iii) for whom the medical center of the Department of Veterans Affairs that is closest to the individual's place of residence is geographically remote or inaccessible from such place.

"(B) CATEGORY C MEDICARE-ELIGIBLE VETERAN.—The term 'category C medicare-eligible veteran' means an individual who—

"(i) 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

"(ii) 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.

"(5) MEDICARE HEALTH CARE SERVICES.—The term 'medicare health care services' means items or services covered under part A or B of this title.

"(6) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

"(b) PROGRAM AND DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—

"(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish—

"(i) a program (under an agreement entered into by the administering Secretaries) under which the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to category A medicare-eligible veterans; and

"(ii) a demonstration project (under such an agreement) under which the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to category C medicare-eligible veterans.

"(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

"(i) a description of the benefits to be provided to the participants of the program and the demonstration project established under this section;

"(ii) a description of the eligibility rules for participation in the program and demonstration project, including any cost sharing requirements;

"(iii) a description of the process for enrolling veterans for participation in the program, which process may, to the extent practicable, be administered in the same or similar manner to the registration process established to implement section 1705 of title 38, United States Code;

"(iv) a description of how the program and the demonstration project will satisfy the requirements under this title;

"(v) a description of the sites selected under paragraph (2);

"(vi) a description of how reimbursement requirements under subsection (g) and maintenance of effort requirements under subsection (h) will be implemented in the program and in the demonstration project;

"(vii) a statement that all data of the Department of Veterans Affairs and of the Department of Health and Human Services that the administering Secretaries determine is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the program and the demonstration project shall be available to the administering Secretaries;

"(viii) a description of any requirement that the Secretary of Health and Human Services waives pursuant to subsection (d);

"(ix) a requirement that the Secretary of Veterans Affairs undertake and maintain outreach and marketing activities, consistent with capacity limits under the program, for category A medicare-eligible veterans;

"(x) a description of how the administering Secretaries shall conduct the data matching program under subparagraph (F), including the frequency of updates to the comparisons performed under subparagraph (F)(ii); and

"(xi) a statement by the Secretary of Veterans Affairs that the type or amount of health care services furnished under chapter 17 of title 38, United States Code, to veterans who are entitled to benefits under part A or enrolled under part B, or both, shall not be reduced by reason of the program or project.

"(C) COST-SHARING UNDER DEMONSTRATION PROJECT.—Notwithstanding any provision of title 38, United States Code, in order—

"(i) to maintain and broaden access to services,

"(ii) to encourage appropriate use of services, and

"(iii) to control costs,

the Secretary of Veterans Affairs may establish enrollment fees and copayment requirements under the demonstration project under this section consistent with subsection (d)(1). Such fees and requirements may vary based on income.

"(D) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under the program and demonstration project to medicare-eligible veterans enrolled in the program or project. Those benefits shall include at least all medicare health care services covered under this title.

"(E) ESTABLISHMENT OF SERVICE NETWORKS.—

"(i) USE OF VA OUTPATIENT CLINICS.—The Secretary of Veterans Affairs, to the extent practicable, shall use outpatient clinics of the Department of Veterans Affairs in providing services under the program.

"(ii) AUTHORITY TO CONTRACT FOR SERVICES.—The Secretary of Veterans Affairs may enter into contracts and arrangements with entities (such as private practitioners, providers of services, preferred provider organizations, and health care plans) for the provision of services for which the Secretary of Health and Human Services is responsible under the program or project under this section and shall take into account the existence of qualified practitioners and providers in the areas in which the program or project is being conducted. Under such contracts and arrangements, such Secretary of Health and Human Services may require the entities to furnish such information as such Secretary may require to carry out this section.

"(F) DATA MATCH.—

"(i) ESTABLISHMENT OF DATA MATCHING PROGRAM.—The administering Secretaries shall establish a data matching program under which there is an exchange of information of the Department of Veterans Affairs and of the Department of Health and Human Services as is necessary to identify veterans who are entitled to benefits under part A or enrolled under part B, or both, in order to carry out this section. The provisions of section 552a of title 5, United States Code, shall apply with respect to such matching program only to the extent the administering Secretaries find it feasible and appropriate in carrying out this section in a timely and efficient manner.

"(ii) PERFORMANCE OF DATA MATCH.—The administering Secretaries, using the data matching program established under clause (i), shall perform a comparison in order to identify veterans who are entitled to benefits under part A or enrolled under part B, or both. To the extent such Secretaries deem appropriate to carry out this section, the comparison and identification may distinguish among such veterans by category of veterans, by entitlement to benefits under this title, or by other characteristics.

"(iii) DEADLINE FOR FIRST DATA MATCH.—The administering Secretaries shall first perform a comparison under clause (ii) by not later than October 31, 1998.

"(iv) CERTIFICATION BY INSPECTOR GENERAL.—

"(I) IN GENERAL.—The administering Secretaries may not conduct the program unless the Inspector General of the Department of Health and Human Services certifies to Congress that the administering Secretaries have established the data matching program under clause (i) and have performed a comparison under clause (ii).

"(II) DEADLINE FOR CERTIFICATION.—Not later than December 15, 1998, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the certification under subclause (I) or the denial of such certification.

"(2) NUMBER OF SITES.—The program and demonstration project shall be conducted in geographic service areas of the Department of Veterans Affairs, designated jointly by the administering Secretaries after review of all such areas, as follows:

"(A) PROGRAM SITES.—

"(i) IN GENERAL.—Except as provided in clause (ii), the program shall be conducted in not more than 3 such areas with respect to category A medicare-eligible veterans.

"(ii) ADDITIONAL PROGRAM SITES.—Subject to the certification required under subsection (h)(1)(B)(iii), for a year beginning on or after January 1, 2003, the program shall be conducted in such areas as are designated jointly by the administering Secretaries after review of all such areas.

"(B) PROJECT SITES.—

"(i) IN GENERAL.—The demonstration project shall be conducted in not more than 3 such areas with respect to category C medicare-eligible veterans.

"(ii) MANDATORY SITE.—At least one of the areas designated under clause (i) shall encompass the catchment area of a military medical facility which was closed pursuant to either 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) or title II of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526; 10 U.S.C. 2687 note).

"(3) RESTRICTION.—Funds from the program or demonstration project shall not be used for—

"(A) the construction of any treatment facility of the Department of Veterans Affairs; or

"(B) the renovation, expansion, or other construction at such a facility.

"(4) DURATION.—The administering Secretaries shall conduct and implement the program and the demonstration project as follows:

"(A) PROGRAM.—

"(i) IN GENERAL.—The program shall begin on January 1, 2000, in the sites designated under paragraph (2)(A)(i) and, subject to subsection (h)(1)(B)(iii)(II), for a year beginning on or after January 1, 2003, the program may be conducted in such additional sites designated under paragraph (2)(A)(ii).

"(ii) LIMITATION ON NUMBER OF VETERANS COVERED UNDER CERTAIN CIRCUMSTANCES.—If for a year beginning on or after January 1, 2003, the program is conducted only in the sites designated under paragraph (2)(A)(i), medicare health care services may not be provided under the program to a number of category-A medicare-eligible veterans that exceeds the aggregate number of such veterans covered under the program as of December 31, 2002.

"(B) PROJECT.—The demonstration project shall begin on January 1, 1999, and end on December 31, 2001.

"(C) IMPLEMENTATION.—The administering Secretaries may implement the program and demonstration project through the publication of regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

"(5) REPORTS.—

"(A) PROGRAM.—By not later than September 1, 1999, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) with respect to the program to Congress.

"(B) PROJECT.—By not later than September 1, 1998, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) with respect to the project to Congress.

"(6) REPORT ON MAINTENANCE OF LEVEL OF HEALTH CARE SERVICES.—

"(A) IN GENERAL.—The Secretary of Veterans Affairs may not implement the program at a site designated under paragraph (2)(A) unless, by not later than 90 days before the date of the implementation, the Secretary of Veterans Affairs submits to Congress and to the Comptroller General of the United States a report that contains the information described in subparagraph (B). The Secretary of Veterans Affairs shall periodically update the report under this paragraph as appropriate.

"(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is a description of the operation of the program at the site and of the steps to be taken by the Secretary of Veterans Affairs to prevent the reduction of the type or amount of health care services furnished under chapter 17 of title 38, United States Code, to veterans who are entitled to benefits under part A or enrolled under part B, or both, within the geographic service area of the Department of Veterans Affairs in which the site is located by reason of the program or project.

"(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Veterans Affairs under the program or demonstration project shall be credited to the applicable Department of Veterans Affairs medical care appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Veterans Affairs during the fiscal year during which the payment is received.

"(d) APPLICATION OF CERTAIN MEDICARE REQUIREMENTS.—

"(1) AUTHORITY.—

"(A) IN GENERAL.—Except as provided under subparagraph (B), the program and the demonstration project shall meet all requirements of Medicare+Choice plans under part C and regulations pertaining thereto, and other requirements for receiving medicare payments, except that the prohibition of payments to Federal providers of services under sections 1814(c) and 1835(d), and paragraphs (2) and (3) of section 1862(a) shall not apply.

"(B) WAIVER.—Except as provided in paragraph (2), the Secretary of Health and Human Services is authorized to waive any requirement described under subparagraph (A), or approve equivalent or alternative ways of meeting such a requirement, but only if such waiver or approval—

"(i) reflects the unique status of the Department of Veterans Affairs as an agency of the Federal Government; and

"(ii) is necessary to carry out the program or demonstration project.

"(2) BENEFICIARY PROTECTIONS AND OTHER MATTERS.—The program and the demonstration project shall comply with the requirements of part C of this title that relate to beneficiary protections and other matters, including such requirements relating to the following areas, to the extent not inconsistent with subsection (b)(1)(B)(iii):

"(A) Enrollment and disenrollment.

"(B) Nondiscrimination.

"(C) Information provided to beneficiaries.

"(D) Cost-sharing limitations.

"(E) Appeal and grievance procedures.

"(F) Provider participation.

"(G) Access to services.

"(H) Quality assurance and external review.

"(I) Advance directives.

"(J) Other areas of beneficiary protections that the administering Secretaries determine are applicable to such program or project.

"(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the program and demonstration project, including compliance with the provisions of this title and all other relevant laws.

"(f) VOLUNTARY PARTICIPATION.—Participation of a category A medicare-eligible veteran in the program or category C medicare-eligible veteran in the demonstration project shall be voluntary.

"(g) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs for services provided under the program or demonstration project at a rate equal to 95 percent of the amount paid to a Medicare+Choice organization under part C of this title with respect to such an enrollee. In cases in which a payment amount may not otherwise be readily computed, the Secretary of Health and Human Services shall establish rules for computing equivalent or comparable payment amounts.

"(2) EXCLUSION OF CERTAIN AMOUNTS.—In computing the amount of payment under paragraph (1), the following shall be excluded:

"(A) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

"(B) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

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

"(A) on a periodic basis consistent with the periodicity of payments under this title; and

"(B) in appropriate part, as determined by the Secretary of Health and Human Services, from the trust funds.

"(4) CAP ON REIMBURSEMENT AMOUNTS.—The aggregate amount to be reimbursed under this subsection pursuant to the agreement entered into between the administering Secretaries under subsection (b) is as follows:

"(A) PROGRAM.—With respect to category A medicare-eligible veterans, such aggregate amount shall not exceed—

"(i) for 2000, a total of $50,000,000;

"(ii) for 2001, a total of $75,000,000; and

"(iii) subject to subparagraph (B), for 2002 and each succeeding year, a total of $100,000,000.

"(B) EXPANSION OF PROGRAM.—If for a year beginning on or after January 1, 2003, the program is conducted in sites designated under subsection (b)(2)(A)(ii), the limitation under subparagraph (A)(iii) shall not apply to the program for such a year.

"(C) PROJECT.—With respect to category C medicare-eligible veterans, such aggregate amount shall not exceed a total of $50,000,000 for each of calendar years 1999 through 2001.

"(h) MAINTENANCE OF EFFORT.—

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

"(A) IN GENERAL.—The administering Secretaries, in consultation with the Comptroller General of the United States, shall closely monitor the expenditures made under this title for category A and C medicare-eligible veterans compared to the expenditures that would have been made for such veterans if the program and demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require the Department of Veterans Affairs to maintain overall the level of effort for services covered under this title to such categories of veterans by reference to a base year as determined by the administering Secretaries.

"(B) DETERMINATION OF MEASURE OF COSTS OF MEDICARE HEALTH CARE SERVICES.—

"(i) IMPROVEMENT OF INFORMATION MANAGEMENT SYSTEM.—Not later than October 1, 2001, the Secretary of Veterans Affairs shall improve its information management system such that, for a year beginning on or after January 1, 2002, the Secretary of Veterans Affairs is able to identify costs incurred by the Department of Veterans Affairs in providing medicare health care services to medicare-eligible veterans for purposes of meeting the requirements with respect to maintenance of effort under an agreement under subsection (b)(1)(A).

"(ii) IDENTIFICATION OF MEDICARE HEALTH CARE SERVICES.—The Secretary of Health and Human Services shall provide such assistance as is necessary for the Secretary of Veterans Affairs to determine which health care services furnished by the Secretary of Veterans Affairs qualify as medicare health care services.

"(iii) CERTIFICATION BY HHS INSPECTOR GENERAL.—

"(I) REQUEST FOR CERTIFICATION.—The Secretary of Veterans Affairs may request the Inspector General of the Department of Health and Human Services to make a certification to Congress that the Secretary of Veterans Affairs has improved its management system under clause (i) such that the Secretary of Veterans Affairs is able to identify the costs described in such clause in a reasonably reliable and accurate manner.

"(II) REQUIREMENT FOR EXPANSION OF PROGRAM.—The program may be conducted in the additional sites under paragraph (2)(A)(ii) and cover such additional category A medicare eligible veterans in such additional sites only if the Inspector General of the Department of Health and Human Services has made the certification described in subclause (I).

"(III) DEADLINE FOR CERTIFICATION.—Not later than the date that is the earlier of the date that is 60 days after the Secretary of Veterans Affairs requests a certification under subclause (I) or June 1, 2002, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the certification under subclause (I) or the denial of such certification.

"(C) MAINTENANCE OF LEVEL OF EFFORT.—

"(i) REPORT BY SECRETARY OF VETERANS AFFAIRS ON BASIS FOR CALCULATION.—Not later than the date that is 60 days after the date on which the administering Secretaries enter into an agreement under subsection (b)(1)(A), the Secretary of Veterans Affairs shall submit a report to Congress and the Comptroller General of the United States explaining the methodology used and basis for calculating the level of effort of the Department of Veterans Affairs under the program and project.

"(ii) REPORT BY COMPTROLLER GENERAL.—Not later than the date that is 180 days after the date described in clause (i), the Comptroller General of the United States shall submit to Congress and the administering Secretaries a report setting forth the Comptroller General's findings, conclusion, and recommendations with respect to the report submitted by the Secretary of Veterans Affairs under clause (i).

"(iii) RESPONSE BY SECRETARY OF VETERANS AFFAIRS.—The Secretary of Veterans Affairs shall submit to Congress not later than 60 days after the date described in clause (ii) a report setting forth such Secretary's response to the report submitted by the Comptroller General under clause (ii).

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

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

"(A) IN GENERAL.—If the administering Secretaries find, based on paragraph (1), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the program or demonstration project, the administering 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 of Veterans Affairs from the current medical care appropriation for the Department of Veterans Affairs to the trust funds; and

"(ii) under subparagraph (A)(ii) shall include lowering the amount of payment under the program or project under subsection (g)(1), and may include, in the case of the demonstration project, suspending or terminating the project (in whole or in part).

"(i) EVALUATION AND REPORTS.—

"(1) INDEPENDENT EVALUATION BY GAO.—

"(A) IN GENERAL.—The Comptroller General of the United States shall conduct an evaluation of the program and an evaluation of the demonstration project, and shall submit annual reports on the program and demonstration project to the administering Secretaries and to Congress.

"(B) FIRST REPORT.—The first report for the program or demonstration project under subparagraph (A) shall be submitted not later than 12 months after the date on which the Secretary of Veterans Affairs first provides services under the program or project, respectively.

"(C) FINAL REPORT ON DEMONSTRATION PROJECT.—A final report shall be submitted with respect to the demonstration project not later than 3½ years after the date of the first report on the project under subparagraph (B).

"(D) CONTENTS.—The evaluation and reports under this paragraph for the program or demonstration project shall include an assessment, based on the agreement entered into under subsection (b), of the following:

"(i) Any savings or costs to the medicare program under this title resulting from the program or project.

"(ii) The cost to the Department of Veterans Affairs of providing care to category A medicare-eligible veterans under the program or to category C medicare-eligible veterans under the demonstration project, respectively.

"(iii) An analysis of how such program or project affects the overall accessibility of medical care through the Department of Veterans Affairs, and a description of the unintended effects (if any) upon the patient enrollment system under section 1705 of title 38, United States Code.

"(iv) Compliance by the Department of Veterans Affairs with the requirements under this title.

"(v) The number of category A medicare-eligible veterans or category C medicare-eligible veterans, respectively, opting to participate in the program or project instead of receiving health benefits through another health insurance plan (including benefits under this title).

"(vi) A list of the health insurance plans and programs that were the primary payers for medicare-eligible veterans during the year prior to their participation in the program or project, respectively, and the distribution of their previous enrollment in such plans and programs.

"(vii) Any impact of the program or project, respectively, on private health care providers and beneficiaries under this title that are not enrolled in the program or project.

"(viii) An assessment of the access to care and quality of care for medicare-eligible veterans under the program or project, respectively.

"(ix) An analysis of whether, and in what manner, easier access to medical centers of the Department of Veterans Affairs affects the number of category A medicare-eligible veterans or C medicare-eligible veterans, respectively, receiving medicare health care services.

"(x) Any impact of the program or project, respectively, on the access to care for category A medicare-eligible veterans or C medicare-eligible veterans, respectively, who did not enroll in the program or project and for other individuals entitled to benefits under this title.

"(xi) A description of the difficulties (if any) experienced by the Department of Veterans Affairs in managing the program or project, respectively.

"(xii) Any additional elements specified in the agreement entered into under subsection (b).

"(xiii) Any additional elements that the Comptroller General of the United States determines is appropriate to assess regarding the program or project, respectively.

"(2) REPORTS BY SECRETARIES ON PROGRAM AND DEMONSTRATION PROJECT WITH RESPECT TO MEDICARE-ELIGIBLE VETERANS.—

"(A) DEMONSTRATION PROJECT.—Not later than 6 months after the date of the submission of the final report by the Comptroller General of the United States on the demonstration project under paragraph (1)(C), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

"(i) whether there is a cost to the health care program under this title in conducting the demonstration project;

"(ii) whether to extend the demonstration project or make the project permanent; and

"(iii) whether the terms and conditions of the project should otherwise be continued (or modified) with respect to medicare-eligible veterans.

"(B) PROGRAM.—Not later than 6 months after the date of the submission of the report by the Comptroller General of the United States on the third year of the operation of the program, the administering Secretaries shall submit to Congress a report containing their recommendation as to—

"(i) whether there is a cost to the health care program under this title in conducting the program under this section;

"(ii) whether to discontinue the program with respect to category A medicare-eligible veterans; and

"(iii) whether the terms and conditions of the program should otherwise be continued (or modified) with respect to medicare-eligible veterans.".

(b) REPEAL OF PLAN REQUIREMENT.—Subsection (b) of section 4015 of the Balanced Budget Act of 1997 (relating to an implementation plan for Veterans subvention) is repealed.

(c) EFFECTIVENESS CONTINGENT UPON ENACTMENT OF OFFSETTING OUTLAY REDUCTIONS IN VA PROGRAMS THROUGH RESTRICTION OF USE OF TOBACCO PRODUCTS TO QUALIFY FOR SERVICE-CONNECTED ENTITLEMENT.—(1) No payment may be made from the Federal Hospital Insurance Trust Fund or from the Federal Supplementary Medical Insurance Trust Fund for items or services furnished under the program or demonstration project established under section 1897 of Social Security Act, as added by subsection (a), before the date that the Director of the Office of Management and Budget determines that—

(A) legislation described in paragraph (2) has been enacted; and

(B) the net amount of the reductions in expenditures achieved by reason of such legislation during the 5-fiscal-year period beginning with fiscal year 1999, that is available to offset the net aggregate increase in outlays (if any) under the medicare program under title XVIII of such Act, is not less than the estimate of the amount of such net aggregate increase during such period.

(2) For purposes of paragraph (1), the legislation described in this paragraph is legislation that restricts entitlement to service-connected compensation under title 38, United States Code, for a disability that is the result of a veteran's use of tobacco products.

(3) The estimate described in paragraph (1)(B) shall be the estimate made by the Congressional Budget Office and contained in the report of the Committee on Ways and Means of the House of Representatives to accompany H. R. 3828 of the 105th Congress (the Veterans Medicare Access Improvement Act of 1998)), except to the extent that the Director of the Office of Management and Budget finds that the estimate is materially inaccurate.

(d) REPORT TO CONGRESS ON A METHOD TO INCLUDE THE COSTS OF VETERANS AFFAIRS AND MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN THE CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—The Secretary of Health and Human Services shall report to the Congress by not later than January 1, 2001, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs or the Department of Defense to medicare-eligible beneficiaries in the calculation of an area's Medicare+Choice capitation payment. Such report shall include on a county-by- county basis—

(1) the actual or estimated cost of such services to medicare-eligible beneficiaries;

(2) the change in Medicare+Choice capitation payment rates if such costs are included in the calculation of payment rates;

(3) one or more proposals for the implementation of payment adjustments to Medicare+Choice plans in counties where the payment rate has been affected due to the failure to calculate the cost of such services to medicare-eligible beneficiaries; and

(4) a system to ensure that when a Medicare+Choice enrollee receives covered services through a facility of the Department of Veterans Affairs or the Department of Defense there is an appropriate payment recovery to the medicare program.

I. INTRODUCTION

A. PURPOSE AND SUMMARY

Current law generally prohibits other government agencies from receiving reimbursements for providing Medicare-covered services to Medicare-eligible veterans. Subvention is the term given to proposals which would permit the U.S. Department of Veterans Affairs to receive reimbursement from the Medicare trust funds for care provided to Medicare-eligible beneficiaries at VA medical facilities. H.R. 3828 would establish a subvention program for low-income veterans and a demonstration project for other veterans so that the Department of Veterans Affairs may offer certain veterans comprehensive Medicare health care services.

B. BACKGROUND AND NEED FOR THE LEGISLATION

The Department of Veterans Affairs (VA) operates the nation's largest health care system, encompassing 172 hospitals, 439 outpatient clinics, 131 nursing homes, 206 readjustment counseling centers, and 40 domiciliaries. VA estimates 3.1 million individual patients were served through 827,000 inpatient admissions and 32 million outpatient visits during FY1997. About 96% of the services were provided free. VA employed 186,000 staff in the health care system during the year, 73% of whom were engaged in direct care of patients. Congress provided spending authority of $17.6 billion for FY1998.

All 26 million veterans are potentially eligible for some VA medical services, but in any given year, only about 10% of veterans receive such services. Many veterans have other health insurance, including Medicare, and seek medical services elsewhere. In FY1997, about 40% of veterans served in VA facilities had a service-connected condition, although their treatment may have been for a condition unrelated to military service. About 54% of all veterans receiving service qualified for free care because their income and assets were below VA's income and asset threshold.

During 1996, VA medical care was reorganized into 22 Veterans Integrated Service Networks (VISNs). Each VISN manages all re-

sources within a region, integrating services to avoid duplication and increase efficiency. VA's annual efficiency evaluations guide the allocation of resources among and within VISNs. Efficiency is measured according to the cost per patient of services (acute hospital, rehabilitative, psychiatric, residential, subacute). According to VA's budget, if program objectives are met, services will be provided more efficiently, at a savings averaging 30% per patient by FY2002. The budget also proposed permitting medical facilities to obtain 10% of their funding from nonappropriated sources, and Congress has enacted legislation which enables the VA to retain collections from insurance companies for care furnished insured veterans. VA claims that more efficient patient delivery and the additional sources of funds would allow 20% more veterans to be served without increasing annual appropriations.

Unlike Medicare, under which the services are provided to beneficiaries based on entitlement eligibility for them, VA medical benefits are available to veterans on the basis of a priority system which determines relative access to services at facilities in which resources may not be sufficient to provide services to all veterans who apply.

Categories of veterans are referred to as Category A and Category C, labels which formerly specified a distinction among veterans in VA law, and which are often still used in discussions of veterans' access to VA medical services.

Category A Veterans Defined. Veterans seeking treatment for service-connected conditions have the highest priority, followed by care for any condition for veterans with severe service-connected disabilities. Veterans with relatively lower priority, but still high enough to have a reasonable expectation of care are veterans with any degree of compensable service-connected conditions and veterans who have special, categorical priority, such as former prisoners-of-war.

As much as 60% of VA medical care goes to the largest remaining category eligible for free VA medical services, those who qualify for such free care as a result of having incomes and assets below a means threshold. For calendar year 1998, that threshold is $50,000 in assets, and $22,064 in income for single veterans, rising to $26,480 for married veterans, and with a $1,476 increase in the threshold for each additional dependent. Veterans report upon their ability to pay when they apply for care (or for enrollment in a new, regionally-based VA health care plan), and their reported income and assets are subject to verification through Internal Revenue Service or Social Security data.

Veterans presumed to have been exposed to environmental toxins, such as Agent Orange, nuclear radiation, or unknown disease elements in the Persian Gulf are also in Category A but have a priority status below the low-income veterans. Medical services provided to Category A veterans are often free of charge, with the exception of a $2 prescription co-payment requirement for some Category A veterans.

All of the above priority categories fit within the broad definition of a Category A veteran, as defined by the bill.

Category C Veterans Defined. The veterans who are not otherwise eligible and whose incomes or assets exceed the applicable thresh-

old are eligible for VA medical services, if resources are available, and if they agree to pay applicable copayments and deductibles. About 3–4% of the veterans VA serves are in this category, although the incidence of care provided them is not randomly distributed across the VA medical care system, but is concentrated in some regions more heavily than others. Copayments and deductibles are similar to payments required of persons covered by Medicare.

C. Legislative History

H.R. 3828, the Veterans Medicare Access Improvement Act of 1998 was introduced on May 12, 1998 by the Honorable Bill Thomas, Chairman of the Subcommittee on Health, along with seventy other Members of the House. On May 12, 1998, the bill was ordered favorably reported by the Ways and Means Subcommittee on Health, as amended, by voice vote. On May 14, 1998, the bill, as amended, was ordered favorably reported by a rollcall vote of 31 yeas to 1 nay (with a quorum being present).

II. EXPLANATION OF PROVISIONS

A. Section 1—Short Title

The provision provides that the bill would be cited as the Veterans Medicare Access Improvement Act of 1998.

B. Section 2(a)—Improvement in Veterans' Access to Services Under Medicare Program

Current law

In general, Medicare does not pay for services furnished by a federal provider of services or other federal agency. An exception is made if the Secretary of Health and Human Services (HHS) makes a determination that the entity is providing services to the public generally as a community institution or agency (for example, a veterans hospitals providing end-stage renal disease services to non-veterans). An exception is also made for facilities of the Indian Health Service. The law also specifies that payments may not be made for services that a provider or supplier is obligated to furnish at public expense in accordance with a law or contract of the United States.

The law has thus generally barred payments for services provided to military retirees at Department of Defense (DoD) facilities and for services provided at VA hospitals and clinics.

The Balanced Budget Act of 1997 (BBA 97, P.L. 105–33) authorized a 3-year demonstration project at six sites under which the Secretary of HHS will reimburse the Secretary of DoD from the Medicare trust funds for services furnished to certain Medicare-eligible military retirees and dependents. The demonstration project is to be established through an agreement entered into by the Secretaries. BBA 97 required the Secretary of HHS and VA to jointly submit to Congress a detailed implementation plan for a subvention demonstration project for veterans.

Explanation of provision

The provision would amend Medicare law by adding a new Section 1897 to the Social Security Act—"Improving Veterans' Access to Services."

New Section 1897(a)—Definitions

The new Section 1897(a) includes definitions for a number of terms.

"Administering Secretaries" would be defined as the Secretaries of HHS and VA acting jointly.

The provision would specify two categories of "Medicare-eligible veterans"—Category A and Category C. A "Category A" eligible veteran would meet the following conditions:

(1) A veteran who has been released or discharged from active duty in the Armed Forces under conditions other than dishonorable.

(2) A veteran who has priority access to VA health care because of a service-connected condition, by meeting the definition for inclusion in one of several special groups (such as ex prisoners-of-war, or veterans who were exposed to environmental contaminants), or by qualifying for such priority access on the basis of inadequate income and assets. The Category A veteran must also be entitled to Medicare Part A and enrolled in Part B.

(3) A veteran for whom the VA medical center closest to the veteran's place of residence is geographically remote or inaccessible.

The provision would define a "Category C" Medicare-eligible veteran as one who has been released or discharged from active duty in the Armed Forces under conditions other than dishonorable, and who is eligible for VA health care only if resources are available after serving the medical needs of veterans with a higher priority. Such veterans also must agree to pay applicable copayments and deductibles. In addition, a Medicare-eligible Category C veteran must also be entitled to Medicare Part A and enrolled in Part B.

The provision would specify that "program" refers to the program established for Category A Medicare-eligible veterans and "demonstration project" or "project" refers to the demonstration project established for Category C Medicare-eligible veterans.

New Section 1897(b)(1)—Program and Demonstration Project—General Requirements

The new Section 1897(b)(1) would establish the general requirements for the program and demonstration project.

(a) In General. The new Section 1897(b)(1)(A) would authorize the administering Secretaries to establish a program under which the Secretary of HHS would reimburse the Secretary of VA from the Medicare trust funds for Medicare health services furnished to Category A Medicare-eligible veterans. The section would also authorize the administering Secretaries to establish a demonstration project under which the Secretary of HHS would reimburse the Secretary of VA for Medicare health services furnished to Category C Medicare-eligible veterans.

(b) Agreement. The new Section 1897(b)(1)(B) would specify that the program and project would be established under an agreement

entered into by the Secretaries of HHS and VA. The agreement would be required to include the following items at a minimum: (i) a description of the benefits to be provided to program and project participants; (ii) a description of eligibility rules and cost-sharing requirements for the program and project; (iii) a description of the program's enrollment process (which may to the extent practicable be administered in the same or similar manner as veterans are enrolled in VA medical plans according to a priority schedule that accepts Category A veterans for enrollment before veterans meeting the definition of Category C; (iv) a description of how the program and project would satisfy Medicare requirements; (v) a description of the program and project sites; (vi) a description of how the reimbursement and maintenance of effort requirements established under this Act would be implemented in the program and project; (vii) a statement that all data of both the VA and HHS that the two Secretaries deem necessary to conduct independent estimates and audits of the maintenance of effort, annual reconciliation and other matters required under the program and project would be available to the Secretaries; (viii) a description of any Medicare requirements the Secretary has waived pursuant to the requirements of the Act; (ix) a requirement that the Secretary of VA undertake outreach and marketing activities, consistent with the program's capacity limits, for Category A Medicare-eligible veterans; (x) a description of how the administering Secretaries would conduct the required data matching program, including the frequency of updates to the data match comparisons; (xi) a statement by the Secretary of VA that the type or amount of services furnished under VA to veterans who are entitled to Medicare Part A or enrolled in Part B, or both, would not be reduced as a result of the program or project.

(c) Cost Sharing Under the Demonstration Project. The new Section 1897(b)(1)(C) would permit the Secretary of VA to establish enrollment fees and copayment requirements in order to maintain and broaden access to services, encourage appropriate use of services, and control costs. The section would require that enrollment fees and copayment requirements be consistent with Medicare+Choice requirements (except as waived by the Secretary of VA, as provided for under the Act). The enrollment fees and copayment requirements could vary by income.

(d) Health Care Benefits. The new Section 1897(b)(1)(D) would require the Secretaries of HHS and VA to prescribe the minimum health care benefits to be provided under the program and demonstration project. The benefits would include at least all health care services covered under Medicare.

(e) Establishment of Service Networks. The new Section 1897(b)(1)(E) would authorize the Secretary of VA to enter into contracts with entities (including private practitioners, preferred provider organizations, and health care plans) to provide services under the program or project. The Secretary would be required to take into account the existence of qualified practitioners and providers in the areas in which the program or project was conducted. As part of the contract or arrangement, the Secretary could require the entities to furnish information needed to carry out the program or project. This provision requires the VA Secretary, to the extent

possible, to use existing VA outpatient clinics in establishing service networks.

The providers which VA may contract with include former Public Health Service (PHS) hospitals that have been recently privatized. Several of these former PHS hospitals have a history of working with the Department of Defense and the Department of Veterans Affairs in providing care to the military and veterans families. Since being privatized, many of these former PHS hospitals continue to contract with the Department of Defense managed care program (TriCare). The Committee encourages the Administering Secretaries to consider the benefits that may be realized from contracting with such an entity in developing a service network under the program or project.

(f) Data Match. The new Section 1897(b)(1)(F) would provide for the establishment of a data matching program by the Secretaries of HHS and VA. The program would provide for an exchange of information between the two agencies which is necessary to identify veterans entitled to Part A, enrolled under Part B, or both.

The provision would require the two Secretaries, using the data matching program, to perform a comparison in order to identify veterans entitled to Part A, enrolled under Part B, or both. The comparison (to the extent deemed appropriate by the Secretaries) could distinguish among such veterans by category of veterans, by entitlement to Medicare or by other characteristics. The first comparison would have to be performed by October 31, 1998.

The provision would prohibit the Secretaries of HHS and VA from conducting the program, unless the Inspector General of HHS certified to the Congress that the Secretaries had established the data matching program and had performed the required comparison. The Inspector General would be required to submit a report to Congress containing the certification, or denial of certification, by December 15, 1998.

New Section 1897(b)(2)—Program and Demonstration Project—Program and Project Sites

The new Section 1897(b)(2) would establish the requirements for program and project sites. The provision would specify that both the program and project would be conducted in geographic service areas of VA, designated jointly by the Secretaries of HHS and VA after review of all the areas.

The provision would specify that the program could not be conducted in more than three sites with respect to Category A Medicare-eligible veterans. However, in a year beginning on or after January 1, 2003, the program could be conducted in additional areas designated jointly by the Secretaries of HHS and VA. Designation of additional sites would be permitted only if the Inspector General of HHS had made a certification to Congress that the Secretary of VA had improved its information management system so that the Secretary was able to identify costs incurred by the VA in providing Medicare health services to Medicare-eligible veterans.

The provision would limit the number of project sites to three with respect to Category C Medicare-eligible veterans. At least one of these would encompass the catchment area of a military medical facility which was closed pursuant to either the Defense Base Clo-

sure and Realignment Act of 1990 or Title II of the Defense Authorization and Base Closure and Realignment Act.

New Section 1897(b)(3)—Program and Demonstration Project—Restriction

The new Section 1897(b)(3) would specify that funds from the program or project could not be used for the construction of any VA treatment facility or the renovation, expansion, or other construction at such facility.

New Section 1897(b)(4)—Program and Demonstration Project—Duration

The new Section 1897(b)(4) would specify the durational requirements for the program and project. The program would begin on January 1, 2000 at the designated sites. If the required certification had been made by the HHS Inspector General, the program could be conducted at additional sites in years beginning on or after January 1, 2003. If in a year beginning on or after January 1, 2003, the program was conducted only at the original three sites, the aggregate number of Category A Medicare-eligible veterans provided services under the program could not exceed the number of veterans covered under the program on December 31, 2002.

The provision would specify that the demonstration project would begin on January 1, 1999 and end on December 31, 2001. The provision would permit the Secretaries of VA and HHS to implement the program and project through the publication of regulations that take effect on an interim basis after notice and opportunity for public comment have been provided.

New Sections 1897(b) (5) and (6)—Program and Demonstration Project—Reports

The new Section 1897(b)(5) would require the Secretaries of HHS and VA to submit to Congress, by September 1, 1998, a copy of the agreement establishing the program and project entered into by the two Secretaries. The Secretaries are to submit to Congress by September 1, 1999, a copy of the agreement establishing the program.

The new Section 1897(b)(6) would prohibit the Secretary of VA from implementing the program at a designated site unless the Secretary had submitted a report to the Congress and the Comptroller General containing certain information. The required information would be a description of the operation of the program at the site as well as steps taken by the Secretary of VA to prevent a reduction in the type or amount of health services furnished in the geographic service area by VA to veterans entitled to Part A, enrolled under Part B, or both. The report would be required at least 90 days before the implementation date and would be periodically updated.

New Section 1897(c)—Crediting of Payments

The new Section 1897(c) would specify that payments received by the Secretary of VA under the program or project would be credited to the applicable VA medical care appropriation (and within that

appropriation). Any payment received during a fiscal year for services provided during a prior fiscal year could be obligated by the Secretary of VA during the year the payment was received.

New Section 1897(d)—Application of Medicare Requirements

The new Section 1897(d) would specify that the program and demonstration project would be required to meet all requirements applicable to Medicare+Choice plans and related regulations and other requirements relating to Medicare payments. However, the prohibition on payments to federal providers of services would not apply.

The provision would authorize the Secretary of HHS to waive any of these Medicare requirements or approve equivalent or alternative ways of meeting a requirement, but only if the waiver or approval reflected the unique status of VA as a federal agency and was necessary to carry out the program or project.

The provision would require the program and demonstration project to comply with Medicare+Choice requirements relating to beneficiary protections and other matters to the extent not inconsistent with the program's enrollment process established under the agreement between the two Secretaries. The requirements include those relating to: enrollment and disenrollment, nondiscrimination, information provided to beneficiaries, cost-sharing limitations, appeal and grievance procedures, provider participation, access to services, quality assurance and external review, advance directives, and other areas of beneficiary protections that the two Secretaries determine were applicable to the program or project.

New Section 1897(e)—Inspector General

The new Section 1897(e) would specify that nothing in the agreement between the two Secretaries could limit the HHS Inspector General from investigating any matters regarding the expenditure of Medicare funds for the program and project, including compliance with Medicare requirements and all other relevant laws.

New Section 1897(f)—Voluntary Participation

The new Section 1897(f) would state that participation of either a Category A or Category C Medicare-eligible veteran in the program or project would be voluntary.

New Section 1897(g)—Payments Based on Regular Medicare Payment Rates

The new section 1897(g) would provide that the Secretary would reimburse the Secretary of VA for services provided under the program or project at a rate equal to 95% of the amount paid to a Medicare+Choice organization with respect to that enrollee. The Secretary would establish rules for computing equivalent or comparable payment amounts in cases where payment amounts could not otherwise be readily computed. The payment would exclude adjustments for direct and indirect medical education and dispropor-

tionate share payments. Also excluded would be a percentage of hospital capital payments as determined by the two Secretaries.

The provision would provide that payments would be made on a periodic basis, consistent with the periodicity of Medicare payments. They would be made in appropriate part, as determined by the Secretary of HHS, from the Medicare trust funds.

The provision would place an aggregate limit on the reimbursement amounts. With respect to Category A Medicare-eligible veterans, the amount would be $50 million in 2000, $75 million in 2001, and $100 million in subsequent years. However, if new sites were added in any year beginning January 1, 2003 or later, the cap would not apply in that year. The aggregate limit under the reimbursement project with respect to Category C Medicare-eligible veterans would be $50 million a year in 1999, 2000, and 2001.

New Section 1897(h)—Maintenance of Effort

The new Section 1897(h) would include maintenance of effort provisions. The provision would require the Secretaries of HHS and VA, in consultation with the Comptroller General, to closely monitor the expenditures made under Medicare overall for Category A and C Medicare-eligible veterans over the 3 year period beginning January 1, 1999. The monitoring requirement would continue to apply for Category A Medicare-eligible veterans in each subsequent year the program was conducted. The monitoring would compare expenditures for such veterans to those which would have been made if the program and project had not been conducted.

As specified under the general requirements for the agreement under new section 1897(b)(1), the Secretaries are to describe how the maintenance of effort requirement would be implemented in the program and project. The Act's maintenance of effort requirement reflects a recognition that the VA currently provides health care services to many Medicare-eligible veterans. To the extent that VA provides such individuals with Medicare-covered services, it subsidizes the Medicare Trust Funds. Projecting that level of effort involves estimating the amount by which Medicare spending would increase if the VA ceased to provide health care services to Medicare-eligible veterans. It is recognized that this calculation involves uncertainty associated with predicting future demand and accounting for well documented factors such as continued VA productivity improvements (including the ongoing trend of declining hospital admissions and increased number of outpatient visits) associated with outyear budget projections and the provisions of title I of Public Law 104–262, under which Congress revised VA law governing eligibility for care, and established an annual veteran-enrollment (and enrollment-prioritization) system to govern access to VA care. At the same time, the calculation must take account of the central concern underlying a maintenance of effort requirement—that the Medicare trust funds not subsidize the VA.

The Secretary of VA would be required to improve its information management system by October 1, 2001. The improved system would allow the Secretary of VA, for any year beginning on or after January 1, 2002, to identify costs incurred by VA in providing Medicare health care services to Medicare-eligible veterans for purposes of meeting the maintenance of effort requirement under the

agreement between the two Secretaries. The Secretary of HHS would provide such assistance as needed for the Secretary of VA to determine which health care services furnished by VA qualify as Medicare health care services.

The provision would permit the Secretary of VA to request the Inspector General of HHS to make a certification to Congress that the Secretary has improved its management information system so that the Secretary is able to identify costs attributable to providing Medicare health care services in a reasonably reliable and accurate manner.

The provision would permit the program for Category A Medicare-eligible veterans to be conducted in additional sites and cover additional Category A Medicare-eligible veterans only if the Inspector General made the certification. The Inspector General would be required to submit a report to Congress containing the certification (or denial of certification) within 60 days after requested by the Secretary of VA or June 1, 2002, whichever was earlier.

The provision would require the Secretary of VA, within 60 days of entering the agreement with the Secretary of HHS, to submit a report to Congress and the Comptroller General explaining the methodology used and the basis for calculating the VA level of effort under the program and project. Not later than 180 days after submission of this report, the Comptroller General would be required to submit to Congress and the Secretaries of HHS and VA a report on the Comptroller General's findings, conclusion, and recommendations with respect to the report. The Secretary would be required to submit a response to Congress within 60 days.

The provision would also require the Comptroller General to submit an annual report during each year the program and demonstration project were in operation. The report, to be submitted by December 31 of each year, would be submitted to the Congress and the Secretaries of HHS and VA. The report would specify the extent, if any, to which costs under Medicare increased during the preceding fiscal year as a result of the program or demonstration project.

The provision would require the Secretaries of HHS and VA to take certain steps if they found, based on the information obtained above, that Medicare expenditures increased, or were expected to increase, during a fiscal year because of the program or project. They would be required to take such steps as needed to recoup for Medicare the amount of the increase in expenditures and to prevent future increases. This would include payment of the amount of the increase by the Secretary of the VA from the current VA medical care appropriation to the Medicare trust funds. It would also include lowering the amount of payments made under the program or project. Further, the demonstration project could be suspended in whole or in part.

New Section 1897(i)—Evaluation and Reports

New Section 1897(i) would require the Comptroller General to conduct an evaluation of the program and an evaluation of the demonstration project. The Comptroller General would be required to submit annual reports on each to the Secretaries of HHS and VA and to the Congress. The first report for the program or project

would be submitted within 12 months after the date on which the Secretary of VA first provided services under the program or project, respectively. A final report on the demonstration project would be submitted not later than 3½ years after the date of the first report on the project.

The provision would provide that the required evaluation and reports would include an assessment of a number of items, based on the agreement between the Secretaries of HHS and VA. An assessment would be made of: (i) savings or costs to Medicare resulting from the program or demonstration project; (ii) the cost to VA of providing care to Category A Medicare-eligible veterans under the program or Category C Medicare-eligible veterans under the demonstration project, respectively; (iii) an analysis of how the program or project affects the overall accessibility of medical care through VA and a description of unintended effects (if any) on the patient enrollment system under VA; (iv) compliance by VA with Medicare requirements; (v) the number of Category A Medicare-eligible veterans or Category C Medicare-eligible veterans, respectively, opting to participate in the program or project instead of receiving benefits through another health insurance plan (including Medicare); (vi) a list of health insurance plans and programs that were primary payers for Medicare-eligible veterans during the year prior to their participation in the program or project and the distribution of their previous enrollment in such plans and programs; (vii) any impact of the program or project on private health care providers and Medicare beneficiaries not enrolled in the program or project; (viii) an assessment of the access to care and quality of care for Medicare-eligible veterans under the program or project; (ix) an analysis of whether, and in what manner, easier access to VA medical centers affects the number of Category A Medicare-eligible veterans or Category C Medicare-eligible veterans receiving Medicare health services; (x) any impact of the program or project on access to care for Category A or Category C Medicare-eligible veterans who did not enroll in the program or project and for other individuals entitled to Medicare; (xi) a description of the difficulties (if any) experienced by VA in managing the program or project; (xii) any additional elements specified in the agreement entered into between the two Secretaries; and (xiii) any additional elements that the Comptroller General determined appropriate regarding the program or project.

The provision would require the Secretaries of HHS and VA to submit a report to Congress, within 6 months of submission of the final report by the Comptroller General on the demonstration project. The report would contain their recommendations as to whether there is a cost to Medicare in conducting the demonstration project; whether to extend the project or make it permanent; and whether the terms and conditions should otherwise be continued (or modified) with respect to Medicare-eligible veterans. When the report was submitted on the demonstration project, the Secretaries would also be required to submit a report to Congress on the program. The report would contain their recommendations as to whether there was a cost to Medicare in conducting the program, whether to discontinue the program with respect to Category A Medicare-eligible veterans; and whether the terms and conditions

of the program should otherwise be continued or modified with respect to Medicare-eligible veterans.

Reason for change

To provide Medicare-eligible veterans an option to receive coordinated Medicare-covered services through VA medical facilities.

C. Section 2(b)—Repeal of Plan Requirement

Current law

Section 4015(b) of BBA 97 required the Secretaries of HHS and VA to submit to Congress a detailed plan for the implementation of a Medicare subvention demonstration project for veterans.

Explanation of provision

The provision would repeal Section 4015(b) of BBA 97.

Reason for change

Implementation of H.R. 3828 would make the detailed plan unnecessary.

D. Section 2(c)—Effectiveness Contingent Upon Enactment of Offsetting Outlay Reductions in VA Programs

Current law

No provision.

Explanation of provision

This provision would specify that the effectiveness of the Act would be contingent upon enactment of offsetting reductions in VA programs. Specifically, no payment could be made from Medicare trust funds for items and services furnished under the program or demonstration project before the date the Director of the Office of Management and Budget made a determination that federal legislation had been enacted that restricts entitlement to service-connected compensation for a disability that is the result of a veteran's use of tobacco products. The net amount of the reduction in outlays for VA programs for fiscal years 1999–2003 could not be less than the estimate of the aggregate increase in Medicare outlays attributable to the program and project.

The determination by the Director of the Office of Management and Budget would be based on estimates made by the Congressional Budget Office (CBO), except to the extent the Director found them materially inaccurate. The estimate of the aggregate increase in outlays would be determined by the CBO and included in the report by the House Committee on Ways and Means on this Act.

As part of its FY99 budget request, the Administration submitted a legislative proposal to reverse an internal VA decision which extended VA compensation for tobacco-related illnesses. As a result of a 1997 decision by the VA General Counsel, VA began paying service-connected disability compensation for tobacco-related illnesses. The General Counsel's decision held that, if a disease or death can be shown to be a result of nicotine addiction acquired in military service, service-connected compensation is warranted.

OMB estimated that the reversal of the VA General Counsel's decision would save $16.9 billion over the next five years. The Congressional Budget Office estimates savings from enacting such legislation to be only $10 billion over five years.

Reason for change

Funding for subvention is subject to OBRA90 "pay-as-you-go" procedures (also known as "Pay-Go") which require that increases in mandatory spending (such as subvention funding) must be paid for by equal reductions in other mandatory programs or by increases in receipts.

E. Section 2(d)—Report to Congress

Current law

No requirement.

Explanation of provision

The Secretary of Health and Human Services shall report to Congress by not later than January 1, 2001, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs or the Department of Defense to Medicare-eligible beneficiaries in the calculation of an area's Medicare+Choice capitation payment rates.

Reason for change

The report is necessary to assess the impact of these facilities on Medicare+Choice payment rates.

III. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the bill H.R. 3828.

MOTION TO REPORT THE BILL

The bill, H.R. 3828, as amended, was ordered favorably reported by a rollcall vote of 31 yeas to 1 nay (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X			Mr. Rangel	X		
Mr. Crane	X			Mr. Stark		X	
Mr. Thomas	X			Mr. Matsui	X		
Mr. Shaw	X			Mrs. Kennelly			
Mrs. Johnson	X			Mr. Coyne	X		
Mr. Bunning	X			Mr. Levin			
Mr. Houghton	X			Mr. Cardin	X		
Mr. Herger	X			Mr. McDermott	X		
Mr. McCrery	X			Mr. Kleczka	X		
Mr. Camp	X			Mr. Lewis			
Mr. Ramstad	X			Mr. Neal	X		
Mr. Nussle	X			Mr. McNulty	X		
Mr. Johnson				Mr. Jefferson			
Ms. Dunn	X			Mr. Tanner	X		
Mr. Collins	X			Mr. Becerra			
Mr. Portman	X			Mrs. Thurman	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. English	X	....	....				
Mr. Ensign	X	....	....				
Mr. Christensen	X	....	....				
Mr. Watkins	X	....	....				
Mr. Hayworth	X	....	....				
Mr. Weller	X	....	....				
Mr. Hulshof	X	....	....				

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the following statement is made: The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below.

B. Statement Regarding New Budget Authority and Tax Expenditures

In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee states that the provisions in the Committee bill, if enacted, would increase Medicare spending by approximately $470 million over the budget period Fiscal Years 1999–2003.

C. Cost Estimate Prepared by the Congressional Budget Office

U.S. Congress,
Congressional Budget Office,
Washington, DC, May 29, 1998.

Hon. Bill Archer,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 3828, the Veterans Medicare Access Improvement Act of 1998.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley.

Sincerely,

June E. O'Neill, *Director*.

Enclosure.

H.R. 3828—Veterans Medicare Access Improvement Act of 1998

Summary: H.R. 3828 would require the Secretaries of Health and Human Services (HHS) and Veterans Affairs (VA) to establish two systems—a program and a demonstration project—in which Medicare pays the VA on a capitated basis for Medicare-covered services furnished to certain veterans who are entitled to Medicare. The program would involve veterans who are entitled to certain types of free health care from the VA (Category A veterans), and the Demonstration project would involve veterans who are not entitled to free health care from VA (Category C veterans).

CBO estimates that H.R. 3528 would increase Medicare spending by about $20 million in fiscal year 1999 and by about $500 million during the 1999–2003 period. Because the proposal would affect direct spending, pay-as-you-go procedures would apply. The bill does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

Demonstration project and program

Both the demonstration project and program would operate in up to three geographic areas for a period of three years. The demonstration project would begin on January 1, 1999, and the program would begin on January 1, 2000. During these three-year periods, Medicare payments to VA would be subject to annual caps, with a cumulative limit of $150 million for the demonstration project and $225 million for the program.

The demonstration project for Category C veterans would be discontinued after 2001. The program for Category a veterans may be continued after 2002, with Medicare payments to VA capped at $100 million a year. However, the program may be expanded to additional sites, without caps on payments to VA, if the HHS Inspector General certifies that VA has established and is using a data system that can reliably and accurately measure the costs incurred by VA in providing Medicare-covered services to Medicare-eligible veterans

Participating sites

The bill defines a site as a geographic service area of the Department of Veterans Affairs, which CBO interprets to mean a Veterans Integrated Services Network (VISN). The Secretaries would jointly designate three sites to participate in the program and three sites to participate in the project. The same or different VISNs may be selected for the program and the project. At least one of the VISNs selected as a project site must include the catchment area of a military medical facility that was closed pursuant to a base closure and realignment act.

In general, VA sites participating in the program or demonstration project would be required to qualify as Medicare+Choice plans. However, the Secretary of HHS would be allowed to waive such requirements if the waiver reflects the unique status of VA and is necessary to carry out the program or demonstration project.

Eligibility and enrollment rules

Veterans must be enrolled in both Part A and Part B of Medicare to be eligible for either the program or the demonstration project. To participate in the program, a Category A veteran must live in an area that is geographically remote from the closest VA hospital.

Enrollment in either the program or the demonstration project would be voluntary. As with other Medicare+Choice plans, CBO assumes that veterans who enroll in the program or demonstration project would give up the ability to have Medicare pay for services furnished by providers outside the network established by VA.

Basis of payments

Medicare's payments to VA would equal 95 percent of the applicable payment to a Medicare+Choice plan, less amounts related to Medicare's medical education payments, disproportionate share payments, and part of capital-related payments to hospitals for inpatient services.

Maintenance of effort

The proposal is intended to have no net effect on Medicare spending. It would require the Secretaries to specify how VA's health care efforts for Medicare-eligible veterans would be monitored. The proposal would also require several analyses of VA's level of effort and the effect of the program and demonstration project on Medicare spending. If the Secretaries conclude that the program or demonstration project has caused Medicare spending to increase, the proposal would require VA to pay Medicare for increased spending already incurred by Medicare, and would require adjustment of the capitation rates paid to VA to avoid future increases in Medicare spending.

The proposal would require VA to develop data systems to measure the Medicare-covered services that VA furnishes to Medicare-eligible veterans. The first step would be the identification by October 31, 1998, of veterans who are eligible for Medicare. By October 1, 2001, VA would be required to develop a data system that would be able to identify the costs VA incurs in furnishing Medicare-covered services to Medicare-eligible veterans. The caps on the number of program sites and on annual Medicare payments to VA would be eliminated if the HHS Inspector General certified by June 1, 2002, that VA is able to identify those costs in a reasonably reliable and accurate manner.

Relation to compensation for use of tobacco

The bill makes implementation of the program and demonstration project contingent on enactment of legislation that restricts entitlement to VA service-related compensation for a disability that is the result a veteran's use of tobacco products and on a determination by the Director of the Office of Management and Budget that available savings from that legislation are sufficient to offset the increase in Medicare spending.

The restriction on entitlement to VA service-related compensation that is necessary to permit implementation of H.R. 3828 is included in H.R. 2400, the Transportation Equity Act for the 21st Century, which has been passed by both the House and Senate.

Estimated budgetary impact: CBO estimates that the proposal would increase Medicare spending through two mechanisms:

Favorable selection—that is, Medicare capitation payment rates for enrollees in the VA program or demonstration project that would be higher than what Medicare would spend if the participants received all of their care from non-VA providers; and

Changes in VA's level of health care efforts for Medicare-eligible veterans that result in higher Medicare spending for services furnished by providers eligible for Medicare payment.

The combined effect of favorable selection and changes in VA's level of effort would increase Medicare spending by about $10 million in fiscal year 1999, $500 million during the 1999–2003 period, and $1.8 billion over ten years. Changes in VA's level of effort would contribute more to higher Medicare spending than would favorable selection. (See Table 1.)

The estimate of the increase in Medicare spending due to favorable selection is based on the assumption that, compared to Medicare payments for enrollees in the fee-for-service sector, selection in VA plans would be at least as favorable as selection in Medicare+Choice plans.

The conclusion that Medicare spending would rise due to erosion of VA's level of effort is based on the inherent tension between VA's mission and satisfaction of the maintenance of effort requirement, the inability to establish a reliable measure of effort during the base period, the lack of an effective mechanism to monitor and enforce compliance with that requirement. Because measured effort is likely to exceed the level-of-effort target, the proposal would permit a substantial increase in Medicare spending while enabling the Secretaries to find that the level of effort criteria have been met. Erosion of VA's level of effort would be slowed, however, following implementation of a new data system to measure the costs VA incurs in furnishing Medicare-covered services to Medicare-eligible veterans.

Va has been unable to provide relevant data on the cost to VA of the Medicare-covered services furnished to Medicare-eligible veterans in the base year. CBO's estimate assumes that the base-period cost was $8 billion, or about half of the VA's health appropriation, and that, under current law, this cost would remain constant throughout the projection period. The estimate also assumes that VA initially would reallocate from its core mission nearly all (90 percent) of the incremental resources necessary to maintain its level of effort in the preceding year but that this proportion would decline in subsequent years. The estimate assumes that the proportion of incremental resources allocated to maintenance of the previous year's level of effort would return to 90 percent following implementation of the new data system.

TABLE 1.—INCREASES IN MEDICARE SPENDING DUE TO FAVORABLE SELECTION AND EROSION OF VA LEVEL OF EFFORT

	By calendar years, in millions of dollars—											
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	1999–2003	1999–2008
Increase in Medicare Spending due to:												
Favorable Selection	([1])	10	10	10	10	20	30	50	70	110	40	320
Erosion of Level of Effort	20	60	100	150	190	200	210	210	220	220	510	1,580
Total:												
By Calendar Year	20	60	110	160	200	220	240	260	290	330	550	1,890
By Fiscal Year	10	50	100	130	190	210	250	230	280	320	480	1,780

[1] Less than $5 million.

Note.—Numbers may not add to totals because of rounding.

The cost of this legislation fall within budget function 570 (Medicare).

Basis of estimate: The following sections elaborate on CBO's analysis of the effect of this proposal on Medicare spending. This analysis uses calendar years.

Costs of favorable selection

The estimate assumes that Medicare+Choice payment rates would be adjusted to remove half of the capital-related component, and that the resulting payment rates would average 92 percent of rates normally paid to Medicare+Choice plans. Average capitation payment rates for participating veterans would grow from about $5,500 in 1998 to $9,200 in 2008. (See Table 2.)

TABLE 2.—SUMMARY OF PROJECTED ENROLLMENT AND MEDICARE SPENDING IN PROPOSED VA PROGRAM AND DEMONSTRATION PROJECT

	By calendar years, in millions of dollars—									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Spending Cap:										
Category A Program	0	50	75	100	([2])	([2])	([2])	([2])	([2])	([2])
Category C Demonstration Project	50	50	50	0	0	0	0	0	0	0
Average Capitation Rate (Dollars)	5,500	5,700	6,000	6,300	6,700	7,200	7,700	8,200	8,700	9,200
Enrollment (Thousands):										
Category A Program	0	9	13	16	23	33	50	80	110	160
Category C Demonstration Project	5	8	8	0	0	0	0	0	0	0
Total Enrollment	5	17	20	16	23	33	50	80	110	160
Total Capitated Payments to VA	30	95	122	100	150	240	390	640	970	1,450
Change in Medicare Spending due to Favorable Selection	([1])	10	10	10	10	20	30	50	70	110

[1] Less than $5 million.
[2] The $100 million cap on annual Medicare payments to VA would be removed if the HHS Inspector General certifies that VA can reliably and accurately calculate cost of Medicare-covered services furnished to Medicare-eligible veterans.
Note.—Details may not add to totals due to rounding.

CBO assumes that VA would establish a separate Medicare+Choice plan in each region. Because of the caps on total capitated payments to VA, CBO also assumes that Medicare would waive the minimum enrollment requirement (5,000 enrollees for Medicare+Choice plans in urban areas) for at least the first four years of operation. CBO assumes that enrollment in the program for Category A veterans would grow from about 9,000 in 1999 to about 160,000 in 2008. CBO assumes that enrollment in the Category C project would rise from about 5,000 in 1999 to about 8,000 in 2001. CBO assumes that enrollment of Category C veterans would not be impeded by the prospect of the demonstration ending, because VA and many Category C veterans would act on the expectation that the project would be continued and expanded after 2001.

CBO assumes that selection of enrollees would be at least as favorable as selection in other Medicare+Choice plans under current law.[1] The increase in Medicare spending due to favorable selection

[1] Enrollees in Medicare risk plans have been estimated to cost 10 percent to 12.4 percent less than Medicare enrollees with similar demographic characteristics who remain in the fee-for-service sector. See R.S. Brown, et al., The Medicare Risk Program for HMOs—Final Summary Report on Findings from the Evaluation, Princeton, N.J.: Mathematica Policy Research, Inc., February 1993; and G. Riley, et al., "Health Status of Medicare Enrollees in HMOs and the Fee-for-Service Sector in 1994", Health Care Financing Review, 17(4), Summer 1996. Selection tends to be substantially more favorable for new enrollees in Medicare risk plans. In the six months

Continued

would increase from less than $5 million in 1999 to about $110 million in 2008.

Erosion of level of effort

Three factors contribute to CBO's conclusion that Medicare spending would rise due to erosion of VA's level of effort: an inherent tension between VA's mission and satisfaction of the maintenance of effort requirement, the inability to establish a reliable measure of effort during the base period, and the lack of an effective mechanism to monitor and enforce compliance with that requirement. Despite these impediments, CBO assumes that VA will allocate substantial resources to maintain its level of effort. In addition, the estimate assumes that erosion of VA's level of effort would be slowed substantially following implementation of a new data system.

Tension Between VA's Mission and Satisfaction of the Maintenance of Effort Requirement. According to VA, "The mission of the veterans healthcare system is to serve the needs of America's veterans. It does this by providing specialized care for service-connected veterans, primary care and related medical and social support services. To accomplish this mission, VHA (Veterans Health Administration) needs to be a comprehensive, integrated healthcare system that provides excellence in healthcare value, excellence in service as defined by its customers, and excellence in education and research, and needs to be an organization characterized by exceptional accountability and by being an employer of choice."

VA does not have sufficient resources to satisfy the health care demands of all eligible veterans. To carry out its mission within the resources available, the Congress and VA have established seven priority groups to specify the order in which veterans may stake a claim to VA health care services. The VA also allocates care by determining which services it offers, where it offer them, and the quantity it offers. Only by managing the set of services VA provides, and by managing the distribution of those services across the veteran population can VA best serve the needs of America's veterans within the constraint's imposed by limited resources.

The VA provides a full spectrum of medical care. However, some veterans have medical needs that are not well served by community providers. To satisfy these needs, the VA has developed special expertise in certain areas, including provision of low-cost pharmaceuticals and, for patients with chronic disabilities, rehabilitation and substance abuse/mental health service.[2]

To improve the VA's ability to carry out its mission, the Veterans Health Administration is pursing a "30–20–10" strategy: to increase efficiency by 30 percent, to increase the number of veterans served by 20 percent, and to generate 10 percent of funding from non-appropriated sources.

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before joining an HMO, new HMO enrollees have been estimated to cost Medicare only 63 percent as much as beneficiaries who remained in the fee-for-service sector. See "Geographic Adjustment of Medicare Payments", Annual Report to Congress, Physician Payment Review Commission, 1996.

[2] In general, the services in which the VA has developed expertise are not covered by Medicare. Medicare does cover some services in which VA has developed special expertise, and Medicare does not cover some services in which VA has not developed such expertise. The estimate refers to services in which VA has developed special expertise as Medicare-noncovered services.

One method by which VA intends to carry out its mission is by allocating more resources to those services in which it has special expertise. If the proposal did not require that VA maintain a level of effort out of nonMedicare funds, Medicare payments for Medicare-covered services would enable VA to redistribute some appropriated funds to provide more of the services in which VA has special expertise. Medicare spending would increase as Medicare pays VA or community providers for the Medicare-covered services that would no longer be funded out of VA appropriations.

By contrast, implementation of an effective mechanism to enforce maintenance of a level of effort out of nonMedicare funds would require that VA shift resources away from the services in which VA has special expertise to pay for providing additional Medicare-covered services to Medicare-eligible veterans who do not participate in the program or project. Because of the resulting tension between carrying out VA's mission and satisfaction of the maintenance-of-effort requirement, CBO believes it is unlikely that a fully effective maintenance of effort mechanism could be implemented.

Level of Effort during the Base Period and in Baseline. The level of VA outlays for Medicare-covered services furnished to Medicare-eligible veterans is currently unknown. VA staff have guessed that it is in the range of one-third to two-thirds of VA health outlays. CBO used the midpoint of this range as the basis for estimating that VA outlays for Medicare-covered services finished to Medicare-eligible veterans were about one-half of the $17 billion in VA health outlays in 1997, or about $8 billion. Under current law, CBO assumes that these outlays will be constant during the 1998 through 2008 period.

On a per-person basis, CBO assumes that VA will shift more of its appropriated resources to pay for the services in which VA has special expertise. However, this change in the allocation of VA's effort between Medicare-covered and noncovered services will be offset by growth in the share of veterans eligible for Medicare. The proportion of veterans who are at least 65 is projected to increase from 36 percent in 1997 to 41 percent in 2008.

Although CBO assumes that VA will spend $8 billion on Medicare-covered services furnished to Medicare-eligible veterans in 1998, the estimate assumes that Medicare would spend less than $8 billion if those veterans were to receive all Medicare-covered services from nonfederal providers eligible for payment by Medicare. CBO estimates that the value to Medicare of each dollar of VA outlays for Medicare-covered services furnished to Medicare-eligible veterans is about 85 cents in 1998. This assumption is based on research findings that VA delivers a substantial amount of nonacute care in relatively high-cost acute care settings.[3] CBO assumes that the gap between VA outlays and the value of Medicare of those outlays will close over six years, as VA implements its

[3] A recent VA study found that 38 percent of admissions to acute medical and surgical services were nonacute, and that 32 percent of inpatient days of care in these acute settings were for nonacute patients. (Smith, et al., "Overutilization of Acute-Care Beds in Veterans Affairs Hospitals", Medicare Care, 34(1), 1996, pp. 85–96.) These findings are consistent with the results of earlier studies. See, for example: Booth, et al., "Nonacute Inpatient Admissions to Department of Veterans Affairs Medical Centers", Medical Care, 28 (8 supp.), 1991, pp. AS40–AS50; and General Accounting Office, Better Patient Care Practices Could Reduce Length of Stay in VA Hospitals, GAO/HRD–85–92, 1985.

strategy to increase efficiency by 30 percent. Thus, CBO projects that the value to Medicare of VA outlays will increase from $6.8 billion in 1998 to $8 billion per year in 2004 through 2008.

Measuring, Monitoring and Enforcing Level of Effort. The proposal attempts to avoid increasing Medicare's costs by establishing a requirement that VA maintain a level of effort for Medicare-covered services furnished to Medicare-eligible veterans. The mechanism intended to achieve budget neutrality for Medicare requires that VA compensate Medicare for any change in Medicare spending for veterans compared to the amount of Medicare would have spent for such veterans if the program and demonstration project had not been conducted. However, this change in Medicare spending cannot be measured.

CBO assumes that the agreement between the Secretaries would establish a mechanism for approximating VA's level-of-effort during the 1999 though 2003 period. CBO also assumes that the VA would develop a data system that would be able to identify the costs VA incurs in furnishing Medicare-covered services to Medicare-eligible veterans, and that this data system would be used to recalculate the base level of effort during 2002 and to monitor compliance with the level of effort requirement in 2003 and subsequent years.

Until the new data system is implemented, attempts to measure level of effort would be hampered by weakeness in VA data systems. In addition, using existing VA data systems for monitoring compliance with the level of effort requirement—a purpose for which they were not initially designed—would produce substantial "measurement creep," that is, a tendency for measured effort to grow faster than real effort.

Weaknesses in VA Data System. Based on extensive discussions with staff from VA, HHS, and the General Accounting Office, CBO has concluded that VA does not have and could not quickly develop and implement data systems that would permit reliable measurement and monitoring of VA's level of effort. Without reliable measures of VA's effort, budget neutrality for Medicare cannot be enforced.

VA is only beginning to convert to industry-standard systems of categorizing many of the services and procedures it furnishes. Thus, VA cannot reliably distinguish the services that would be covered by Medicare from those that would not be covered. In many situations, VA would use the setting in which a service is furnished as a proxy for whether the service is Medicare-covered. In some settings, the costs of services are estimated using methods designed to allocate budgets. This cost-estimating methodology, in conjunction with VA's inability to categorize services adequately, prevents VA from measuring the costs of those services reliably.

Measurement Creep. Until the new data system is implemented, the Secretaries would use existing data systems as the basis for measuring, monitoring, and enforcing VA's level of effort, and for generating and justifying Medicare payments to VA. Data that are not required to generate payments are reported less completely than data that are audited and used for payment. When those data begin to be used for payment, the elements that qualify for higher payment will be reported more completely than when the data system was developed. Thus, the reported output will grow more rap-

idly than actual output. Based on Medicare's experience with "DRG creep" following introduction of the prospective payment system for hospital inpatient services in fiscal year 1984, CBO assumes that measurement creep would inflate VA's level of effort by 3 percent in 1999 but that the rate of inflation would gradually decline to 0.5 percent in subsequent years. This measurement creep would permit VA to satisfy level of effort requirements with little or no need to reallocate appropriated resources away from the Medicare noncovered services central to its mission.

Despite the inherent tension between carrying out VA's mission and satisfying the maintenance of effort requirement, and despite the contribution of measurements creep to reducing or eliminating the apparent need for VA to satisfy that requirement by reallocating appropriated resources away from services not covered by Medicare, CBO assumes that VA would reallocate substantial resources from its core mission to provide Medicare-covered services to Medicare-eligible veterans who do not participate in the program or demonstration project. Initially, VA would reallocate from its core mission 90 percent of the resources necessary to maintain the level of effort. In subsequent years, however, measured effort would substantially exceed the level-of-effort target, and VA would gradually reduce to 50 percent the reallocation of resources necessary to maintain the previous year's level of effort. After implementation of the new data system, VA would again reallocate from its core mission 90 percent of the resources necessary to maintain the level of effort. How erosion of VA's level of effort would affect Medicare spending is summarized in Table 3.

TABLE 3.—CHANGES IN VA LEVEL OF EFFORT AND MEDICARE SPENDING

	By calendar years, in billions of dollars—									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
VA Level of Effort, Baseline:										
Cost to VA	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Value to Medicare	6.8	7.0	7.2	7.4	7.6	7.8	8.0	8.0	8.0	8.0
Relative Value of VA Effort to Medicare (Percent)	85.0	87.5	90.0	92.5	95.0	97.5	100.0	100.0	100.0	100.0
Measurement Creep (Percent)	3.0	2.5	2.0	1.5	1.0	1.0	0.8	0.6	0.5	0.5
Proportion of Increment in Measured Effort Used to Maintain Effort (Percent)	90	80	70	60	50	90	90	90	90	90
VA Level of Effort, Proposed Law:										
Cost to VA	8.2	8.4	8.5	8.6	8.6	8.7	8.8	8.8	8.8	8.9
Value to Medicare	7.0	7.1	7.3	7.5	7.6	7.8	7.8	7.8	7.8	7.8
Increase in Medicare Spending due to Erosion of VA Effort	([1])	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2

[1] Less than $50 million.

Note.—Details may not add to totals due to rounding.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act establishes pay-as-you-go procedures for legislation affecting direct spending or receipts. The projected changes in direct spending under H.R. 2912 are shown in the table below for fiscal years 1999–2008. For purposes of enforcing pay-as-you-go procedures, however, only the effects in the current year, budget year, and the succeeding four years are counted.

SUMMARY OF PAY-AS-YOU-GO EFFECTS

	By fiscal years, in millions of dollars—									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Change in outlays	10	50	100	130	190	210	250	230	280	320
Change in receipts	Not applicable									

Intergovernmental and private-sector impact: H.R. 3828 does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal Cost: Tom Bradley. Impact on State, Local, and Tribal Governments: Marc Nicole. Impact on the Private Sector: Pete Welch.

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

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee states that the Committee believed this action is necessary due to its oversight of the Medicare program. The Subcommittee on Health held a number of general hearings on health care options for seniors, including: a hearing on February 13, 1997 regarding Medicare Provisions in the President's Budget; a hearing on February 25, 1997 regarding Medicare HMO Payment Policies; a hearing on April 29, 1997 regarding Coordinated Care Options for Seniors; a hearing on January 29, 1998 regarding Preparing the Health Care Financing Administration for the 21st Century; a hearing on February 26, 1998 regarding Assessing Health Care Quality; and finally a hearing on March 3, 1998 regarding Medicare Payment Policies.

B. SUMMARY OF FINDINGS AND RECOMMENDATIONS OF THE GOVERNMENT OPERATIONS COMMITTEE

With respect to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings or recommendations have been submitted by the Committee on Government Reform and Oversight regarding the subject of the bill.

C. CONSTITUTIONAL AUTHORITY STATEMENT

With respect to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, relating to Constitutional Authority, the Committee states that the Committee's action in reporting the bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States. * * * ").

VI. CHANGES IN EXISTING LAW MADE BY THE BILL AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 1897 OF THE SOCIAL SECURITY ACT

IMPROVING VETERANS' ACCESS TO SERVICES

SEC. 1897. (a) DEFINITIONS.—In this section:

(1) ADMINISTERING SECRETARIES.—The term "administering Secretaries" means the Secretary of Health and Human Services and the Secretary of Veterans Affairs acting jointly.

(2) PROGRAM.—The term "program" means the program established under this section with respect to category A medicare-eligible veterans.

(3) DEMONSTRATION PROJECT; PROJECT.—The terms "demonstration project" and "project" mean the demonstration project carried out under this section with respect to category C medicare-eligible veterans.

(4) MEDICARE-ELIGIBLE VETERANS.—

(A) CATEGORY A MEDICARE-ELIGIBLE VETERAN.—The term "category A medicare-eligible veteran" means an individual—

(i) who is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in paragraph (1) or (2) of section 1710(a) of title 38, United States Code;

(ii) who 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; and

(iii) for whom the medical center of the Department of Veterans Affairs that is closest to the individual's place of residence is geographically remote or inaccessible from such place.

(B) CATEGORY C MEDICARE-ELIGIBLE VETERAN.—The term "category C medicare-eligible veteran" means an individual who—

(i) 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

(ii) 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.

(5) MEDICARE HEALTH CARE SERVICES.—The term "medicare health care services" means items or services covered under part A or B of this title.

(6) TRUST FUNDS.—The term "trust funds" means the Federal Hospital Insurance Trust Fund established in section 1817 and

the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

(b) PROGRAM AND DEMONSTRATION PROJECT.—

(1) IN GENERAL.—

(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish—

(i) a program (under an agreement entered into by the administering Secretaries) under which the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to category A medicare-eligible veterans; and

(ii) a demonstration project (under such an agreement) under which the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to category C medicare-eligible veterans.

(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

(i) a description of the benefits to be provided to the participants of the program and the demonstration project established under this section;

(ii) a description of the eligibility rules for participation in the program and demonstration project, including any cost sharing requirements;

(iii) a description of the process for enrolling veterans for participation in the program, which process may, to the extent practicable, be administered in the same or similar manner to the registration process established to implement section 1705 of title 38, United States Code;

(iv) a description of how the program and the demonstration project will satisfy the requirements under this title;

(v) a description of the sites selected under paragraph (2);

(vi) a description of how reimbursement requirements under subsection (g) and maintenance of effort requirements under subsection (h) will be implemented in the program and in the demonstration project;

(vii) a statement that all data of the Department of Veterans Affairs and of the Department of Health and Human Services that the administering Secretaries determine is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the program and the demonstration project shall be available to the administering Secretaries;

(viii) a description of any requirement that the Secretary of Health and Human Services waives pursuant to subsection (d);

(ix) a requirement that the Secretary of Veterans Affairs undertake and maintain outreach and marketing

activities, consistent with capacity limits under the program, for category A medicare-eligible veterans;

(x) a description of how the administering Secretaries shall conduct the data matching program under subparagraph (F), including the frequency of updates to the comparisons performed under subparagraph (F)(ii); and

(xi) a statement by the Secretary of Veterans Affairs that the type or amount of health care services furnished under chapter 17 of title 38, United States Code, to veterans who are entitled to benefits under part A or enrolled under part B, or both, shall not be reduced by reason of the program or project.

(C) COST-SHARING UNDER DEMONSTRATION PROJECT.—Notwithstanding any provision of title 38, United States Code, in order—

(i) to maintain and broaden access to services,

(ii) to encourage appropriate use of services, and

(iii) to control costs,

the Secretary of Veterans Affairs may establish enrollment fees and copayment requirements under the demonstration project under this section consistent with subsection (d)(1). Such fees and requirements may vary based on income.

(D) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under the program and demonstration project to medicare-eligible veterans enrolled in the program or project. Those benefits shall include at least all medicare health care services covered under this title.

(E) ESTABLISHMENT OF SERVICE NETWORKS.—

(i) USE OF VA OUTPATIENT CLINICS.—The Secretary of Veterans Affairs, to the extent practicable, shall use outpatient clinics of the Department of Veterans Affairs in providing services under the program.

(ii) AUTHORITY TO CONTRACT FOR SERVICES.—The Secretary of Veterans Affairs may enter into contracts and arrangements with entities (such as private practitioners, providers of services, preferred provider organizations, and health care plans) for the provision of services for which the Secretary of Health and Human Services is responsible under the program or project under this section and shall take into account the existence of qualified practitioners and providers in the areas in which the program or project is being conducted. Under such contracts and arrangements, such Secretary of Health and Human Services may require the entities to furnish such information as such Secretary may require to carry out this section.

(F) DATA MATCH.—

(i) ESTABLISHMENT OF DATA MATCHING PROGRAM.—The administering Secretaries shall establish a data matching program under which there is an exchange of information of the Department of Veterans Affairs and of the Department of Health and Human Services as is

necessary to identify veterans who are entitled to benefits under part A or enrolled under part B, or both, in order to carry out this section. The provisions of section 552a of title 5, United States Code, shall apply with respect to such matching program only to the extent the administering Secretaries find it feasible and appropriate in carrying out this section in a timely and efficient manner.

(ii) PERFORMANCE OF DATA MATCH.—The administering Secretaries, using the data matching program established under clause (i), shall perform a comparison in order to identify veterans who are entitled to benefits under part A or enrolled under part B, or both. To the extent such Secretaries deem appropriate to carry out this section, the comparison and identification may distinguish among such veterans by category of veterans, by entitlement to benefits under this title, or by other characteristics.

(iii) DEADLINE FOR FIRST DATA MATCH.—The administering Secretaries shall first perform a comparison under clause (ii) by not later than October 31, 1998.

(iv) CERTIFICATION BY INSPECTOR GENERAL.—

(I) IN GENERAL.—The administering Secretaries may not conduct the program unless the Inspector General of the Department of Health and Human Services certifies to Congress that the administering Secretaries have established the data matching program under clause (i) and have performed a comparison under clause (ii).

(II) DEADLINE FOR CERTIFICATION.—Not later than December 15, 1998, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the certification under subclause (I) or the denial of such certification.

(2) NUMBER OF SITES.—The program and demonstration project shall be conducted in geographic service areas of the Department of Veterans Affairs, designated jointly by the administering Secretaries after review of all such areas, as follows:

(A) PROGRAM SITES.—

(i) IN GENERAL.—Except as provided in clause (ii), the program shall be conducted in not more than 3 such areas with respect to category A medicare-eligible veterans.

(ii) ADDITIONAL PROGRAM SITES.—Subject to the certification required under subsection (h)(1)(B)(iii), for a year beginning on or after January 1, 2003, the program shall be conducted in such areas as are designated jointly by the administering Secretaries after review of all such areas.

(B) PROJECT SITES.—

(i) IN GENERAL.—The demonstration project shall be conducted in not more than 3 such areas with respect to category C medicare-eligible veterans.

(ii) MANDATORY SITE.—At least one of the areas designated under clause (i) shall encompass the catchment area of a military medical facility which was closed pursuant to either 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) or title II of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526; 10 U.S.C. 2687 note).

(3) RESTRICTION.—Funds from the program or demonstration project shall not be used for—

(A) the construction of any treatment facility of the Department of Veterans Affairs; or

(B) the renovation, expansion, or other construction at such a facility.

(4) DURATION.—The administering Secretaries shall conduct and implement the program and the demonstration project as follows:

(A) PROGRAM.—

(i) IN GENERAL.—The program shall begin on January 1, 2000, in the sites designated under paragraph (2)(A)(i) and, subject to subsection (h)(1)(B)(iii)(II), for a year beginning on or after January 1, 2003, the program may be conducted in such additional sites designated under paragraph (2)(A)(ii).

(ii) LIMITATION ON NUMBER OF VETERANS COVERED UNDER CERTAIN CIRCUMSTANCES.—If for a year beginning on or after January 1, 2003, the program is conducted only in the sites designated under paragraph (2)(A)(i), medicare health care services may not be provided under the program to a number of category-A medicare-eligible veterans that exceeds the aggregate number of such veterans covered under the program as of December 31, 2002.

(B) PROJECT.—The demonstration project shall begin on January 1, 1999, and end on December 31, 2001.

(C) IMPLEMENTATION.—The administering Secretaries may implement the program and demonstration project through the publication of regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(5) REPORTS.—

(A) PROGRAM.—By not later than September 1, 1999, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) with respect to the program to Congress.

(B) PROJECT.—By not later than September 1, 1998, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) with respect to the project to Congress.

(6) REPORT ON MAINTENANCE OF LEVEL OF HEALTH CARE SERVICES.—

(A) IN GENERAL.—The Secretary of Veterans Affairs may not implement the program at a site designated under

paragraph (2)(A) unless, by not later than 90 days before the date of the implementation, the Secretary of Veterans Affairs submits to Congress and to the Comptroller General of the United States a report that contains the information described in subparagraph (B). The Secretary of Veterans Affairs shall periodically update the report under this paragraph as appropriate.

(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is a description of the operation of the program at the site and of the steps to be taken by the Secretary of Veterans Affairs to prevent the reduction of the type or amount of health care services furnished under chapter 17 of title 38, United States Code, to veterans who are entitled to benefits under part A or enrolled under part B, or both, within the geographic service area of the Department of Veterans Affairs in which the site is located by reason of the program or project.

(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Veterans Affairs under the program or demonstration project shall be credited to the applicable Department of Veterans Affairs medical care appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Veterans Affairs during the fiscal year during which the payment is received.

(d) APPLICATION OF CERTAIN MEDICARE REQUIREMENTS.—

(1) AUTHORITY.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the program and the demonstration project shall meet all requirements of Medicare+Choice plans under part C and regulations pertaining thereto, and other requirements for receiving medicare payments, except that the prohibition of payments to Federal providers of services under sections 1814(c) and 1835(d), and paragraphs (2) and (3) of section 1862(a) shall not apply.

(B) WAIVER.—Except as provided in paragraph (2), the Secretary of Health and Human Services is authorized to waive any requirement described under subparagraph (A), or approve equivalent or alternative ways of meeting such a requirement, but only if such waiver or approval—

(i) reflects the unique status of the Department of Veterans Affairs as an agency of the Federal Government; and

(ii) is necessary to carry out the program or demonstration project.

(2) BENEFICIARY PROTECTIONS AND OTHER MATTERS.—The program and the demonstration project shall comply with the requirements of part C of this title that relate to beneficiary protections and other matters, including such requirements relating to the following areas, to the extent not inconsistent with subsection (b)(1)(B)(iii):

(A) Enrollment and disenrollment.

(B) Nondiscrimination.

(C) Information provided to beneficiaries.
(D) Cost-sharing limitations.
(E) Appeal and grievance procedures.
(F) Provider participation.
(G) Access to services.
(H) Quality assurance and external review.
(I) Advance directives.
(J) Other areas of beneficiary protections that the administering Secretaries determine are applicable to such program or project.

(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the program and demonstration project, including compliance with the provisions of this title and all other relevant laws.

(f) VOLUNTARY PARTICIPATION.—Participation of a category A medicare-eligible veteran in the program or category C medicare-eligible veteran in the demonstration project shall be voluntary.

(g) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs for services provided under the program or demonstration project at a rate equal to 95 percent of the amount paid to a Medicare+Choice organization under part C of this title with respect to such an enrollee. In cases in which a payment amount may not otherwise be readily computed, the Secretary of Health and Human Services shall establish rules for computing equivalent or comparable payment amounts.

(2) EXCLUSION OF CERTAIN AMOUNTS.—In computing the amount of payment under paragraph (1), the following shall be excluded:

(A) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

(B) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

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

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

(B) in appropriate part, as determined by the Secretary of Health and Human Services, from the trust funds.

(4) CAP ON REIMBURSEMENT AMOUNTS.—The aggregate amount to be reimbursed under this subsection pursuant to the agreement entered into between the administering Secretaries under subsection (b) is as follows:

(A) PROGRAM.—With respect to category A medicare-eligible veterans, such aggregate amount shall not exceed—

(i) for 2000, a total of $50,000,000;

(ii) for 2001, a total of $75,000,000; and

(iii) subject to subparagraph (B), for 2002 and each succeeding year, a total of $100,000,000.

(B) EXPANSION OF PROGRAM.—If for a year beginning on or after January 1, 2003, the program is conducted in sites designated under subsection (b)(2)(A)(ii), the limitation under subparagraph (A)(iii) shall not apply to the program for such a year.

(C) PROJECT.—With respect to category C medicare-eligible veterans, such aggregate amount shall not exceed a total of $50,000,000 for each of calendar years 1999 through 2001.

(h) MAINTENANCE OF EFFORT.—

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

(A) IN GENERAL.—The administering Secretaries, in consultation with the Comptroller General of the United States, shall closely monitor the expenditures made under this title for category A and C medicare-eligible veterans compared to the expenditures that would have been made for such veterans if the program and demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require the Department of Veterans Affairs to maintain overall the level of effort for services covered under this title to such categories of veterans by reference to a base year as determined by the administering Secretaries.

(B) DETERMINATION OF MEASURE OF COSTS OF MEDICARE HEALTH CARE SERVICES.—

(i) IMPROVEMENT OF INFORMATION MANAGEMENT SYSTEM.—Not later than October 1, 2001, the Secretary of Veterans Affairs shall improve its information management system such that, for a year beginning on or after January 1, 2002, the Secretary of Veterans Affairs is able to identify costs incurred by the Department of Veterans Affairs in providing medicare health care services to medicare-eligible veterans for purposes of meeting the requirements with respect to maintenance of effort under an agreement under subsection (b)(1)(A).

(ii) IDENTIFICATION OF MEDICARE HEALTH CARE SERVICES.—The Secretary of Health and Human Services shall provide such assistance as is necessary for the Secretary of Veterans Affairs to determine which health care services furnished by the Secretary of Veterans Affairs qualify as medicare health care services.

(iii) CERTIFICATION BY HHS INSPECTOR GENERAL.—

(I) REQUEST FOR CERTIFICATION.—The Secretary of Veterans Affairs may request the Inspector General of the Department of Health and Human Services to make a certification to Congress that the Secretary of Veterans Affairs has improved its management system under clause (i) such that the Secretary of Veterans Affairs is able to identify the costs described in such clause in a reasonably reliable and accurate manner.

(II) REQUIREMENT FOR EXPANSION OF PROGRAM.—The program may be conducted in the additional sites under paragraph (2)(A)(ii) and cover such additional category A medicare eligible veterans in such additional sites only if the Inspector General of the Department of Health and Human Services has made the certification described in subclause (I).

(III) DEADLINE FOR CERTIFICATION.—Not later than the date that is the earlier of the date that is 60 days after the Secretary of Veterans Affairs requests a certification under subclause (I) or June 1, 2002, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the certification under subclause (I) or the denial of such certification.

(C) MAINTENANCE OF LEVEL OF EFFORT.—

(i) REPORT BY SECRETARY OF VETERANS AFFAIRS ON BASIS FOR CALCULATION.—Not later than the date that is 60 days after the date on which the administering Secretaries enter into an agreement under subsection (b)(1)(A), the Secretary of Veterans Affairs shall submit a report to Congress and the Comptroller General of the United States explaining the methodology used and basis for calculating the level of effort of the Department of Veterans Affairs under the program and project.

(ii) REPORT BY COMPTROLLER GENERAL.—Not later than the date that is 180 days after the date described in clause (i), the Comptroller General of the United States shall submit to Congress and the administering Secretaries a report setting forth the Comptroller General's findings, conclusion, and recommendations with respect to the report submitted by the Secretary of Veterans Affairs under clause (i).

(iii) RESPONSE BY SECRETARY OF VETERANS AFFAIRS.—The Secretary of Veterans Affairs shall submit to Congress not later than 60 days after the date described in clause (ii) a report setting forth such Secretary's response to the report submitted by the Comptroller General under clause (ii).

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

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

(A) IN GENERAL.—If the administering Secretaries find, based on paragraph (1), that the expenditures under the medicare program under this title increased (or are ex-

pected to increase) during a fiscal year because of the program or demonstration project, the administering 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 of Veterans Affairs from the current medical care appropriation for the Department of Veterans Affairs to the trust funds; and

(ii) under subparagraph (A)(ii) shall include lowering the amount of payment under the program or project under subsection (g)(1), and may include, in the case of the demonstration project, suspending or terminating the project (in whole or in part).

(i) EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION BY GAO.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct an evaluation of the program and an evaluation of the demonstration project, and shall submit annual reports on the program and demonstration project to the administering Secretaries and to Congress.

(B) FIRST REPORT.—The first report for the program or demonstration project under subparagraph (A) shall be submitted not later than 12 months after the date on which the Secretary of Veterans Affairs first provides services under the program or project, respectively.

(C) FINAL REPORT ON DEMONSTRATION PROJECT.—A final report shall be submitted with respect to the demonstration project not later than 3½ years after the date of the first report on the project under subparagraph (B).

(D) CONTENTS.—The evaluation and reports under this paragraph for the program or demonstration project shall include an assessment, based on the agreement entered into under subsection (b), of the following:

(i) Any savings or costs to the medicare program under this title resulting from the program or project.

(ii) The cost to the Department of Veterans Affairs of providing care to category A medicare-eligible veterans under the program or to category C medicare-eligible veterans under the demonstration project, respectively.

(iii) An analysis of how such program or project affects the overall accessibility of medical care through the Department of Veterans Affairs, and a description of the unintended effects (if any) upon the patient enrollment system under section 1705 of title 38, United States Code.

(iv) Compliance by the Department of Veterans Affairs with the requirements under this title.

(v) The number of category A medicare-eligible veterans or category C medicare-eligible veterans, respectively, opting to participate in the program or project

instead of receiving health benefits through another health insurance plan (including benefits under this title).

(vi) A list of the health insurance plans and programs that were the primary payers for medicare-eligible veterans during the year prior to their participation in the program or project, respectively, and the distribution of their previous enrollment in such plans and programs.

(vii) Any impact of the program or project, respectively, on private health care providers and beneficiaries under this title that are not enrolled in the program or project.

(viii) An assessment of the access to care and quality of care for medicare-eligible veterans under the program or project, respectively.

(ix) An analysis of whether, and in what manner, easier access to medical centers of the Department of Veterans Affairs affects the number of category A medicare-eligible veterans or C medicare-eligible veterans, respectively, receiving medicare health care services.

(x) Any impact of the program or project, respectively, on the access to care for category A medicare-eligible veterans or C medicare-eligible veterans, respectively, who did not enroll in the program or project and for other individuals entitled to benefits under this title.

(xi) A description of the difficulties (if any) experienced by the Department of Veterans Affairs in managing the program or project, respectively.

(xii) Any additional elements specified in the agreement entered into under subsection (b).

(xiii) Any additional elements that the Comptroller General of the United States determines is appropriate to assess regarding the program or project, respectively.

(2) REPORTS BY SECRETARIES ON PROGRAM AND DEMONSTRATION PROJECT WITH RESPECT TO MEDICARE-ELIGIBLE VETERANS.—

(A) DEMONSTRATION PROJECT.—Not later than 6 months after the date of the submission of the final report by the Comptroller General of the United States on the demonstration project under paragraph (1)(C), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

(i) whether there is a cost to the health care program under this title in conducting the demonstration project;

(ii) whether to extend the demonstration project or make the project permanent; and

(iii) whether the terms and conditions of the project should otherwise be continued (or modified) with respect to medicare-eligible veterans.

(B) PROGRAM.—Not later than 6 months after the date of the submission of the report by the Comptroller General of

the United States on the third year of the operation of the program, the administering Secretaries shall submit to Congress a report containing their recommendation as to—

(i) whether there is a cost to the health care program under this title in conducting the program under this section;

(ii) whether to discontinue the program with respect to category A medicare-eligible veterans; and

(iii) whether the terms and conditions of the program should otherwise be continued (or modified) with respect to medicare-eligible veterans.

SECTION 4015 OF THE BALANCED BUDGET ACT OF 1997

SEC. 4015. MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES.

(a) * * *

[(b) IMPLEMENTATION PLAN FOR VETERANS SUBVENTION.—Not later than 12 months after the start of the demonstration project, the Secretary of Health and Human Services and the Secretary of Veterans Affairs shall jointly submit to Congress a detailed implementation plan for a subvention demonstration project (that follows the model of the demonstration project conducted under section 1896 of the Social Security Act (as added by subsection (a)) to begin in 1999 for veterans (as defined in section 101 of title 38, United States Code) that are eligible for benefits under title XVIII of the Social Security Act.]

VII. DISSENTING VIEWS

Of course I want to provide the best care for our nation's disabled and low-income Veterans.

I also want to preserve the Medicare Trust Fund.

This bill does not provide the best care for Veterans in a cost effective manner, and it does drain the Medicare Trust Fund.

Basically, the Category A program sets up Veterans Department HMOs (mostly in rural areas), and Medicare will pay the providers who see these Veterans less than Medicare would normally pay. You get what you pay for, and if you pay less than what Medicare pays, you are likely to get less good care.

The bill basically would put disabled and ill Veterans in an HMO. Starting in 2002, Veterans will be locked into these plans for half a year, and in 2003 and thereafter, locked in for nine months of the year. Yet there is data that civilian HMOs don't always do a good job with the chronically and seriously ill—that they are underserved compared to fee-for-service Medicare. What makes the Members think that a government-run HMO under budget pressure will be any better than the rest of the HMOs—and that it may be hard for a Veteran to get a referral from a VA hospital to a private sector Center of Excellence?

The argument is made that the Veterans Department HMO will be able to offer more comprehensive benefits for little or no cost to the Veteran—just like many Medicare HMOs currently offer Medicare beneficiaries.

Good! I certainly want full coverage for our low-income and disabled Veterans, but is this the most efficient way? Look at the Congressional Budget Office analysis printed in this report. CBO notes that over ten years we will be paying about $330 million extra to the VA from Medicare, because the people who are likely to sign up for this program will be healthier than the average Medicare patient. The CBO also does not believe that the DVA will maintain its level of effort,[1] and thus Medicare Trust Fund money will be used to offset Appropriated funds. Under this bill, Medicare will be spending about $6,000 extra per enrollee. [For the exact amount in a particular year, use the CBO table, and divide the change in Medicare spending by the number of enrollees.] But Medicare is already covering these Veterans with the basic Medicare package. What does the Veteran get for all this extra Medicare expenditure besides being locked into an HMO? For the services that Medicare does not provide, we could buy a private comprehensive medigap policy for about $1,500 a year that would provide pharmaceuticals, copays, deductibles, etc., and the Veteran would be completely free

[1] To the extent the DVA does maintain effort, yet under the bill is providing care to thousands of new Medicare patients, its ability to serve its existing patient base will be stretched and compromised. For current DVA beneficiaries, this is not a good bill.

to seek care anywhere they wanted, not just from a VA's HMO facility.

In sum, there are much cheaper ways to provide the additional coverage that the VA HMOs will provide.

The bill does drain the Medicare Trust Fund of about $1.8 billion over the next ten years. It is "funded" with a pure budget gimmick (which by the way, has already been "spent" by others in other ways). The bill is contingent on legislation undoing a new entitlement to DVA care for smoking-related diseases. Undoing that entitlement "saves" the DVA from future mandatory obligations, but it does nothing to restore money to the Medicare Trust Funds.

As Members know, I have been the author of legislation to expand Medicare-type coverage to every American. I am the House lead sponsor of the Medicare Early Access Act (which would let people buy into Medicare at age 55). I would be happy to extend Medicare protection to all Veterans of all ages. But this bill is a wasteful inefficient way to improve health care coverage. Instead of building on the vast, under-utilized capacity of the private sector, it subjects Veterans to HMOs of questionable quality.

This bill is just a way to help the DVA bureaucracy grow. There are better ways to help and honor our nation's Veterans.

PETE STARK.