

Many hospitals need an incentive to take the kind of initiative shown by the Danbury Hospital. The effort and startup costs involved in organizing certain outpatient programs may provide a disincentive. Also, the transfer of patients to extended care facilities may already provide a cost-saving option for the hospital, leaving Medicare to bear the loss. Although not all patients with a particular condition are medically appropriate candidates for outpatient therapy in place of continued inpatient therapy, many patients are probably lingering in inpatient facilities who could more cost-effectively be treated as outpatients. Medicare policy needs to be modified to address this problem by providing incentives for inpatient facilities to initiate cost-effective alternatives.

One such incentive is the coverage of pharmaceuticals that facilitate the treatment of patients in the outpatient rather than inpatient setting. Currently for most home intravenous antibiotic therapy the hospital or beneficiary must shoulder the cost. This policy contains a built-in disincentive because the beneficiary may not have the means to pay for it, and the hospital may find it more cost-saving to use one of the strategies I outlined earlier resulting in a significant loss to Medicare. Adding a pharmaceutical benefit with appropriate payment safeguards could facilitate outpatient treatment and result in a gain to Medicare, the hospital, and the patient.

Are there other diseases besides infections for which an outpatient pharmaceutical benefit would provide an incentive for cost-effective outpatient therapy? I suspect there are. Some strategies may be implementable now; in addition, as new drugs and technologies are developed, more outpatient therapies might be possible in the future. I welcome a thoughtful evaluation of this issue by health experts. We need to develop a policy that is flexible enough to accommodate future cost-saving strategies as they are developed.

The bill I am introducing today provides the groundwork for determining how Medicare policy may be modified to facilitate shifts in health care from the inpatient to the outpatient setting, when medically appropriate. Inherent in the bill is a strategy to ensure that Medicare, not just the hospital, captures the savings. The bill directs the Secretary of Health and Human Services to review and report to Congress within 6 months, all disease categories for which inpatient payments might be able to be reduced if an outpatient pharmaceutical benefit is provided. Coverage for pharmaceuticals will include appropriate payment safeguards. The bill acknowledges that reimbursement not only for the drug, but also for supplies, appliances, equipment, laboratory tests, and professional services needed for appropriate outpatient treatment will need to be factored into the cost-effectiveness analysis.

Specifically, the bill directs the Secretary to report which DRG payments can be reduced by refining the DRG or adjusting the DRG weighting factor, if an outpatient pharmaceutical benefit is provided. Implementation of this strategy could take a variety of forms. For example, reductions in DRG payments could be accomplished by using a formula to discount the payment for an individual patient, and providing only the individual patient with the outpatient benefit. In this strategy, the hospital could request a discounted DRG payment for a particular patient via a billing code. Potentially, the hospital could also specify the

number of days of outpatient treatment it wishes to substitute for inpatient treatment. This substitution would ensure that Medicare's costs in providing the outpatient benefit do not exceed its savings in reducing the DRG payment. A financial incentive for the hospital can be built into the formula used for discounting the DRG payment.

Another strategy is to split certain DRG categories into one payment for patients who continue treatment in the hospital and a reduced payment for patients who continue treatment as an outpatient.

Alternatively, the DRG payments for all patients in a specific disease category could be reduced, even though some patients will remain hospitalized throughout their treatment while others will have a shortened hospital stay and continue treatment as outpatients.

Post-hospitalization outpatient therapies and home services are sometimes provided by the hospitals themselves, but may also be provided by independent agencies. When the inpatient and outpatient providers are the same, it will be easy to ensure that Medicare payments are contained. Outpatient reimbursement could be conditional on inpatient payment reductions, and a financial incentive for hospitals to choose the more cost-effective treatment could be built into the reimbursement. However, when the inpatient and outpatient providers are unrelated, it will be more difficult to ensure that Medicare payments will be less than they would have been if the patient had remained in the hospital. This is not, however, an insurmountable problem. One possible strategy that has been suggested is the use of lump sum payments per patient for the outpatient treatment of certain conditions. Certain DRG payments could be split into an inpatient component and a lump sum outpatient component; as long as the sum is less than the original inpatient payments, Medicare saves money. Medicare's inpatient payments for a disease category include the DRG payment, and any applicable outlier or extended care facility payments. Decisions about the percentage that should go to each provider, and incentives that lead to cost-effective care are difficult but potentially resolvable.

The bill also directs the Secretary to determine which outlier payments can be reduced in number, and the disease categories for which these outlier payments are made, if an outpatient pharmaceutical benefit is provided. Similarly, the Secretary is directed to determine whether patient transfers to post-hospitalization extended care facilities can be avoided, thereby reducing payments, if an outpatient pharmaceutical benefit is provided. Strategies similar to the ones I described for reducing DRG payments could potentially be applied to these payment areas.

By reviewing these types of payments, disease categories which have potential for Medicare cost-savings will be identified. As I described previously when I introduced a bill addressing outpatient parenteral antimicrobial therapy, certain infections are likely candidates. However, there may be a number of other areas of medicine, where cost-saving outpatient treatment could appropriately be substituted for inpatient treatment, now or in the future.

The bill directs the Secretary to determine the savings that can be obtained by reducing inpatient payments while providing coverage for beneficiaries' outpatient drugs and serv-

ices. In addition to potential savings from reduced DRG, outlier, or extended care payments, savings may accrue from the decreased risk of hospital-acquired infections. This is because the longer patients remain in an inpatient setting, the more at risk they are for a nosocomial infection which generally lengthen hospital stay, increase costs, and result in increased morbidity and mortality. Modernizing Medicare to provide incentives for cost-effective medically appropriate care holds promise for benefiting patients, providers, and Medicare.

TAIWAN'S 85TH NATIONAL DAY

HON. ROBERT A. UNDERWOOD

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. UNDERWOOD. Mr. Speaker, this coming October 10, Taiwan, the Republic of China, will commemorate its 85th National Day.

Eighty-five years ago, the Chinese people under the leadership of Dr. Sun Yat-sen successfully expelled centuries-old tyrannical rule. Dr. Sun's adoption of a political system dedicated to the ideals of democracy and based on the consent of the governed was a great victory for democracy in the continent of Asia which, until then, was widely known for tyranny and despotism. The Chinese people's efforts, under Dr. Sun's leadership has come to symbolize a people's aspiration, desire and capacity to stand their ground, take control, and choose their own destiny. This nation's rejection of tyranny and oppression announced to the rest of the world that the desire for freedom is not a concept unique to Western peoples. The people of Asia, as elsewhere, desire and deserve dignity and freedom.

Although Dr. Sun did not live to see the full fruition of his labors, capable leaders like Generalissimo Chang Kai-shek built upon his legacy and provided the essential leadership and guidance which enabled the newly created democracy to survive its toughest tests.

Taiwan has since become one of the wealthiest nations in the world. The last few years has seen the republic's economy grow at a spectacular rate. In addition to being one of our closest associates in Asia, Taiwan has steadily matured as an economic stronghold. Taiwan is currently the sixth largest trading partner to the United States.

As the delegate from Guam, I recognize the fact that the island and people that I represent share deep cultural and historical ties with Taiwan. As a matter of fact, my constituency includes Taiwanese immigrants. As in numerous other locales, these immigrants have integrated themselves with our island community over the years and have emerged as a vital force in the development and growth of Guam. In addition, Taiwanese tourists contribute to the island's economy. Made possible by the visa-waiver program recently implemented for Taiwanese citizens Guam has greatly benefited from the business these people bring.

On behalf of the people of Guam I would like to congratulate President Lee Teng-hui, Foreign Minister John H. Chang, Representative Jason Hu, Director-General Clark Chen and the Taiwanese all over the world in the commemoration of Taiwan's 85th National

Day. I join them in their celebrations and wish them continued prosperity.

TRIBUTE TO GREG RICE

HON. ROBERT W. NEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. NEY. Mr. Speaker, I commend the following to my colleagues:

Whereas Greg Rice has won the International Auctioneers Championship;

Whereas Greg Rice has brought the international title to Ohio for the first time in history;

Whereas Greg Rice has demonstrated a steadfast commitment to auctioneering; and

Whereas Greg Rice should be recognized for his outstanding victory and persistence; Therefore, be it

Resolved, That the residents of Coshocton, with a real sense of pleasure and pride, join me in commending Greg Rice for his hard work and dedication to his occupation.

IN HONOR OF MEdIGUARD PROGRAM TENNESSEANS FOR TENNESSEE

HON. BOB CLEMENT

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. CLEMENT. Mr. Speaker, I rise today to pay tribute to the fine men and women who participate in Mediguard/Guardcare, a unique health care delivery program provided by the Tennessee National Guard to provide critically needed health care to underserved populations in 39 counties across the State of Tennessee.

The idea for Tennessee's Mediguard Program began when former Tennessee Governor Ned McWherter saw the efficient system for health care delivery administered by National Guard troops in South America. Along with Representative JOHN TANNER, former Representative and now-Governor Don Sundquist and many State legislators and other members of the Tennessee National Guard, I was pleased to help develop the framework for a program called Mediguard, later named Guardcare. Approximately 3 years ago, a pilot program was established under the auspices of the NGB in 10 States with the objectives of relieving overburdened State public health facilities and boosting low physician-to-patient ratios in 39 Tennessee counties seriously deficient in receiving basic health care services. Many factors were used to identify the target counties, and the study was recently repeated to assure that current needs are still being appropriately addressed.

Supplies for Guardcare exercises are allocated from Guard pilot funds and equipment needs have been met through loans from Guard units and leasing. As of last year, the program operates on Federal funding—so we tell our communities they can see their tax dollars at work right at home. The best part of the program, in my opinion, is that we are able to provide these much-needed health care services to people who are desperately in need of them at absolutely no cost to the par-

ticipating individual. The TN Guardcare Program is administered as a component of a special projects unit aligned under the State Adjutant General Command. The functions and purposes of Guardcare in Tennessee are carried out through two teams: the Guardcare administrative team and a mobile health team. The mobile health teams used in Guardcare exercises changes from exercise to exercise. These teams are comprised of Army-Air physicians, nurse practitioners, physician assistants, nurses, dentists, lab specialists, and medical support personnel on split drill from their base units. Mobile health teams have been augmented by a wealth of local community health care personnel and other community volunteers. Without these volunteers from the host communities, Guardcare's success would have been seriously jeopardized.

Prior to the start of each program year, a training calendar is planned which focuses on 7 to 8 target communities from the 39 medically underserved communities. Counties must request Guardcare, and there is currently a 2-year waiting list.

It is my pleasure to salute the Tennessee Guardcare Program and the men and women who have made it an outstanding success over the past 3 years. Through their efforts, and through the support of many communities across the State, Guardcare has been able to demonstrate volunteerism at its finest; truly, Tennesseans for Tennessee.

PROSTATE CANCER AWARENESS MONTH

HON. RODNEY P. FRELINGHUYSEN

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. FRELINGHUYSEN. Mr. Speaker, in recognition of Prostate Cancer Awareness Month, I commend to your attention a patient education conference that was held earlier this year in the 11th Congressional District—Prostate Cancer: Today and Tomorrow. Cohosted by the American Foundation for Urologic Disease, Morristown Memorial Hospital and the Prostate Cancer Support Group of Morristown Memorial Hospital, it was an effective grassroots effort to warn and educate local residents on the importance of early detection of and continued research into prostate cancer.

According to the American Cancer Society, prostate cancer is the greatest cancer risk for American men, and over 317,000 males will be diagnosed with this type of cancer in 1996. It is vital that prostate cancer be recognized as a serious threat to American men and their families.

Increased awareness of health issues, improved detection and testing techniques, and national awareness programs for this disease have all played significant roles in increasing public knowledge of prostate cancer.

There are a number of individuals and organizations I want to recognize for holding such an important conference:

First, Honorable Dean A. Gallo, the former Congressman of New Jersey's 11th Congressional District, died of prostate cancer on November 6, 1994. His widow, Mrs. Betty Gallo, is now a trustee of the Dean Gallo Foundation and she instituted the Dean Gallo Prostate Cancer Research Scholarship Fund. This

scholarship fund will help fund career investigators who are committed to prostate cancer research in the State of New Jersey.

Second, I commend the American Foundation for Urologic Disease, a charitable organization, whose mission is to prevent and find a cure for urologic diseases through the expansion of research, education and public awareness. For over 20 years, the Research Scholar Program of the AFUD has funded over 300 urologic researchers as they established their scientific careers. Over 98% of the investigators have continued in these career paths.

Third, Morristown Memorial Hospital, a not-for-profit hospital serving northern New Jersey, for its leadership in the field. Founded in 1892, it has expanded in size and services to become a 599-bed medical center and the third largest in the state. It is a major teaching hospital, affiliated with Columbia University's College of Physicians and Surgeons. Its regional Cancer Center is affiliated with the Cancer Institute of New Jersey in New Brunswick and offers expertise in surgical, urologic, medical, radiation and gynecologic oncology specialties. Center highlights include clinical trials, cytogenetics and patient support programs.

Fourth, the Morristown Memorial Prostate Cancer Support Group which is chaired by Mr. Peter Doherty, a prostate cancer survivor. Over seventy-five persons, including physicians and medical professionals, prostate cancer survivors, their partners and families and friends gather to exchange information and provide support, encouragement and hope.

Finally, I would also like to commend the participants of Prostate Cancer: Today and Tomorrow, outstanding physicians and an organization whose research is making significant inroads in the field of prostate cancer. They include:

E. David Crawford, M.D., Professor and Chairman, Division of Urology of Colorado Health Sciences Center, Denver, CO. He is also chairman of the Prostate Cancer Education Council [PCEC], national sponsor of Prostate Cancer Awareness Week.

Charles Myers, M.D., was chief of the Clinical Pharmacology Branch of the National Cancer Institute, where he directed clinical trials of drugs used in the treatment of advanced prostate cancer.

William H. Hait, M.D., Ph.D., Director of the Cancer Institute of New Jersey.

Arthur Israel, M.D., is Chief Section of Urology, Morristown Memorial Hospital. Dr. Israel is a member of the American Foundation for Urologic Disease and the American Urological Association. He is currently president of the New Jersey Urological Society.

Schering Oncology Biotech, a corporation headquartered in Kenilworth, New Jersey and TAP Pharmaceutical, Inc. of Deerfield, Illinois for providing educational grants for prostate cancer research.

All those who participated in Prostate Cancer: Today and Tomorrow made a powerful impact on patients, physicians, medical institutions, research and educational foundations, and industry to collaborate and provide accurate medical information to prostate cancer victims, survivors and their families, I salute their work.