

The importance of ethnically based parishes to the immigrants of the late 18th Century and early 19th Century cannot be overstated. Groups of people from European nations such as France, Ireland, Italy, and Poland made their way to the prosperous shores of America, only to be met with suspicion and discrimination. Laws and practices were instituted to make life more difficult for new immigrants. Their only recourse was to turn to those with whom they shared a heritage.

The focal point for many of these communities was the Roman Catholic Church. The bonds of ethnicity and language were strengthened by bonds of faith. By fostering the language and traditions of the old country, these parishes gave new immigrants something familiar to hold onto in the strange new world in which they had landed. The church offered support, education, and contacts in the business community that the new immigrants would not have had otherwise. The children of the immigrants were taught English as well as their native language, allowing them to assimilate more easily into the society at large.

Springfield, Massachusetts is blessed with a wide variety of ethnic groups, of which the Franco-American community is one. In 1873, the Reverend Louis Guillaume Gagnier, a 43-year-old missionary priest founded St. Joseph's Church in the Diocese of Springfield. From the masses held in parishioners' homes, to the basement of the church building, to the beautiful structure seen today, the mission of St. Joseph's, to faithfully serve its community, has remained the same. The church and the surrounding structures have seen hard times, but they have persevered. The widening of roads, explosions, hurricanes, and floods have rocked the buildings of St. Joseph's Church, but not the faith of its parishioners.

During the first 100 years of St. Joseph's Church, Reverend Gagnier's mission was continued by Reverend Joseph Bissonnette, Reverend Arthur Cayer, Father Albert Aubertin, Father Romeo Rheaume, and Reverend Gerald Lafleur. Throughout all of their tenures, the Pastors were aided by the unyielding support of the Sisters of Saint Joseph and the Sisters of the Holy Cross. The Sisters opened and ran the parish school, thereby fostering a sense of religious and social community in the neighborhood.

Mr. Speaker, historically, spiritually, and socially significant community centers such as Saint Joseph's Church need to be recognized and celebrated. Their contribution to the establishment of cities like Springfield cannot be measured. The effects of Saint Joseph's Church will be felt for many years to come in the Franco-American community and in the society at large. Mr. Speaker, the United States of America needs more positive social centers like Saint Joseph's Church and I hope that its members will continue their faithful service for at least another 125 years.

PAYING DOCTORS FOR QUALITY:
INTRODUCTION OF LEGISLATION

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, April 12, 1999

Mr. STARK. Mr. Speaker, I am today introducing legislation to reduce the ability of Medi-

care HMO's to use financial incentives to encourage doctors to deny care. Instead of letting HMO's just use the stick of payment denial, my bill encourages managed care plans to use the carrot of bonuses to improve health outcomes and provide more preventive care.

As a result of legislation I first passed nearly 15 years ago, the Secretary of HHS has the authority to limit the amount that an HMO can place a doctor at financial risk if he or she orders tests for a patient, refers to specialists, or otherwise provides extra care. Using this authority, the Secretary has limited the amount that a doctor can be liable for such extra care to 25 percent of compensation.

I have always thought that "25 percent" regulation provided too much power to HMO's to pressure doctors to deny care.

Would you fly on an airline which withheld up to 25 percent of their mechanics' pay if they spent too much time checking out the airplane? No? Well, we allow HMO's to pay doctors that way. My bill reduces the 25 percent amount to no more than 10 percent over a 3-year period.

In recent years, there have been a number of studies and reports that suggest the 25 percent figure is too high. Other reports have suggested that we encourage the payment of HMO doctors for quality of care, for the extent they provide preventive care services, and on how well their patients like the care they receive. These seem like commonsense ideas. They are ideas basic to any service type industry. But unfortunately, it looks like we need legislation to move HCFA and the industry in this direction.

I hope my legislation can be considered as we debate managed care reform proposals, both for Medicare patients and for the general public.

Following are some examples of how the current payment incentives may be bad for our nation's health—and how they can be improved.

In 1998, 57 percent of primary care physicians in managed-care organizations in California reported feeling pressured to limit referrals. . . . From 1943 to 1985, the duration of the average visit to a physician's office fell from 26 to 17 minutes. Among family practitioners, the average visit in 1985 lasted 14 minutes. Whether or not there have been large reductions in the time physicians spend with patients, 75 percent of primary care physicians in managed-care practices in California reported pressure to see more patients per day.—From "The American Health Care System," by Thomas Bodenheimer, in *The New England Journal of Medicine*, February 18, 1999.

In all capitation agreements, the amount of overall financial risk or gain based on "withholds" and bonuses should be small and should be structured to avoid unusually intense conflicts of interest in individual clinical decisions. . . . In a survey of managers of health maintenance organizations, nearly half believed that physicians' decisions regarding the ordering of tests, referrals to specialists, and elective hospitalizations could be noticeably affected at individual risk levels ranging from 5 to 15 percent of income [note, the HCFA regulation is 25 percent]. In keeping with these views, and in the absence of empirical data, it seems reasonable to consider an aggregate risk of more than 20 percent for an individual physician—or even a group of physicians—as unac-

ceptably high. Moreover, physicians should not be at risk of losing more money than is being withheld. Bonuses and distributions from withheld surpluses should be paid out in percentages of the targets achieved, in installments, or in other ways to avoid the possibility that the entire payment will depend on the health care costs of a few patients at the end of the contract year.—"Ethical Guidelines for Physician Compensation Based on Capitation," from *The New England Journal of Medicine*, September 3, 1998.

Our results suggest that the goal of providing high-quality care may be better approached by the use of limited financial incentives based on the quality of care and patients' satisfaction than incentives that reward physicians for restricting access to specialty care or for squeezing in a greater number of visits per day. Policies that emphasize the former approach may enhance satisfaction with the U.S. health care system on the part of both patients and their physicians.—"Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems," by Grumbach, et. al., in *The New England Journal of Medicine*, November 19, 1998.

. . . HMO managers believed that the impact of withheld accounts, bonus payments, and risk pools are subject to thresholds below which little or no effect is expected. For example, more than 90 percent of respondents reported no noticeable effect on the ordering behavior of physicians at risk as individuals if the level of withheld funds is below 5 percent of total HMO payment. Conversely, most respondents (nearly four-fifths) believed that there would be a noticeable effect when withholding represents 5-30 percent of total HMO payment. . . . "HMO Managers' Views On Financial Incentives And Quality," by Hillman, et. al., in *Health Affairs*, Winter 1991.

H.R. —

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. REDUCING THE MAXIMUM FINANCIAL RISK FOR PHYSICIANS PARTICIPATING IN MEDICARE CHOICE PLANS.

Section 1852(j)(4)(A) of the Social Security Act (42 U.S.C. 1395w-22(j)(4)(A)) is amended—

(1) by redesignating clause (iii) as clause (iv); and

(2) by inserting after clause (ii) the following new clauses:

"(iii) The organization does not operate the plan in a manner that places a physician or physician group at a financial risk that exceeds 20 percent as of January 1, 2002, 15 percent as January 1, 2002, and 10 percent of January 1, 2003, of potential payments.

"(iv) Potential payments mean the maximum payments possible to physicians or physician groups including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the Physician or physician group.

"(v) Potential payments do not include nuses and other compensation that are based on the quality of care furnished, improved outcomes preventive care rates, patient satisfaction or committee participation.