served as the chair of the Democrat-Farmer-Laborer party in Minnesota's 54th Senate District. In 1975, she sought and won the Fourth Ward seat on the Minneapolis City Council. By doing so, Rainville became the fourth woman to hold a City Council seat in the history of Minneapolis. She was re-elected every two years thereafter until she retired in January, 1998.

Although she was not Minneapolis' first female City Council member, Rainville became its first female City Council President. Becoming President in 1980, she led the Council until 1990—the longest tenure of any City Council President in Minneapolis. As President, Rainville played a major role in laying the groundwork for the new Minneapolis Convention Center, which opened in 1988. She worked with local officials and consultants on the initial plans and construction of this world-class facility, which is the largest public works project ever undertaken by the city of Minneapolis. She currently serves on the implementation team for a Convention Center expansion project and remains a valued resource for other development projects in the city.

Since Alice W. Rainville carved out her niche in Minneapolis politics in the 1970's, more and more women have entered politics and government service in Minneapolis. Today, including Mayor Sharon Sayles Belton, a majority of the Minneapolis City Council members are women. By proving to other women that they, too, can achieve success in what had once been a male-dominated political world, Alice W. Rainville is a true pioneer.

Mr. Speaker, I am pleased to honor Alice W. Rainville in celebration of Women's History Month. I thank her for her contributions to the city of Minneapolis, and I wish her continued successes in the future.

INTRODUCTION OF LEGISLATION TO SAVE MEDICARE LIVES AND MONEY

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, April 13, 1999

Mr. STARK. Mr. Speaker, today I am introducing the first in a series of bills to modernize Medicare for the future: the "Centers of Excellence Act of 1999." Not only will this legislation save Medicare money, it will save the lives of many of its beneficiaries.

Centers of Excellence has already been proven to decrease mortality and lower cost.

Centers of Excellence originated as a demonstration project in the early 1990's to evaluate the effect of volume on quality and mortality for coronary artery bypass graft (CABG) surgery. The Department of Health and Human Services selected facilities on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. They found that hospitals that do large volumes of a certain type of procedure tend to have better outcomes and quality. The demonstration resulted in an 8 percent average annual decline in mortality and saved Medicare an average of 14 percent on CABG procedures. This year, CBO has scored the Centers of Excellence proposal as saving $300 million over five years and $600 million over ten years.

Since the early 1990's, numerous reports have come out documenting higher quality care and lower mortality in facilities that perform a large volume of cancer treatments, cardiac surgeries, and transplants, among others. These conditions often require highly specialized care that should only be provided by the highest-rated facilities.

Centers of Excellence is currently being used in the private sector to improve quality and decrease cost.

Many private sector employers are requiring higher quality standards from their health plans. Not only are these employer groups able to improve quality through Centers of Excellence, they are also able to negotiate deeper discounts with high-volume facilities. Medicare should be given the authority to contract with certain hospitals for quality and volume—both to save money and to deliver better health care.

Centers of Excellence has already been approved by the House in the past.

The bill we are introducing passed the House in the 1997 Budget Reconciliation bill (H.R. 2015). H.R. 2015 would have made the Centers of Excellence program a permanent part of Medicare by authorizing the Secretary to pay selected facilities a single rate for all services, potentially including post-acute services associated with a surgical procedure or hospital admission related to a medical condition. As with the CABG demonstration, selected facilities would have to meet special quality standards and would be required to implement a quality improvement plan.

The amendment was dropped in conference because of resistance from the Senate. Some Senators from States where no hospitals were designated as Centers of Excellence felt that the program tended to cast into doubt the quality or excellence of non-designated hospitals. Mr. Speaker, the name of this program is not important—what is important is that it can save money and by encouraging beneficiaries to use hospitals that have high volume, quality outcomes, it can save lives.

Like Lake Wobegon, where all the children are above average, it is human nature for all Members of Congress to want their local hospitals to be above average. But not all hospitals are above average—and this is a serious matter. In fact, it is a matter of life and death.

Indeed, good health policy in this nation would prohibit hospitals from doing sophisticated procedures if they do not have sufficient experience. This principle is applied to liver transplants, for example, and ought to be applied to other complex procedures as well. We may all have pride in our local hospitals, but the fact is: some of them are killing people because they do not do enough of certain types of procedures and therefore are not skilled in those procedures.

I regret that this important provision has been subjected to pork-barreling by previous Congresses. I hope that this body will see that it is included in the next Medicare bill that moves through Congress.

Some members of the now defunct Medicare Commission are proposing radical and unnecessary changes to Medicare. Before we cut back benefits and ask beneficiaries to pay more, we should explore every possible cost saving in the system. This bill is a step in the right direction: it saves money and improves the quality of care provided to seniors and the disabled.

The 1999 Trustees report projects that the Part A trust fund will remain viable until 2015, one of the longest periods of solvency ever projected in the history of the program. Simple changes, such as the Centers of Excellence proposal, are all that are needed to improve Medicare for its beneficiaries.

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

[From the November 1995 Research Report]

CENTERS OF EXCELLENCE DEMONSTRATION

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

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

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

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

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

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

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

TRIBUTE TO NOU KA YANG

HON. BRUCE F. VENTO

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, April 13, 1999

Mr. VENTO. Mr. Speaker, I would like to submit for the RECORD this article from the