DOCUMENT RESUME

ED 265 471 CG 018 795

TITLE	Crisis in Health Care: The Missouri Experience. Hearing before the Subcommittee on Health and Long-Term Care of the Select Committee on Aging. House of Representatives, Ninety-Ninth Congress, First Session (Jefferson City, MO).
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
REPORT NO	House-Comm-Pub-99-503
PUB DATE	29 Mar 85
NOTE	57p.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*Delivery Systems; Hearings; *Medical Services; *Older Adults; *Public Health Legislation; *Rural Areas
IDENTIFIERS	Congress 99th; *Medicare; *Missouri

ABSTRACT

This is a report of a Congressional hearing held in Jefferson City, Missouri on the crisis in health care for the elderly in Missouri. Representative Ike Skelton's opening statement notes that the purpose of the series of hearings being held around the country, of which this is one, is to examine the effect of changes in the Medicare program on the quality of hospital care senior citizens receive in rural hospitals, and also to review the quality of the Peer Review Organizations (PROs) which are the watchdogs of the health care providers. This hearing focuses specifically on the activities of the Missouri PRO. The first panel of witnesses included the daughter of an elderly patient who had encountered health care delivery problems related to Medicare, the woman's physician who discussed his problems with the PRO, another Medicare beneficiary with medical problems, a health advocacy service coordinator for the elderly, and the president of the Missouri Hospital Association discussing his problems with the PRO and the Health Care Financing Administration. The second panel included two witnesses from the Missouri Patient Care Review Foundation (the PRO for Missouri) and the regional administrator of the Health Care Financing Administration. (ABL)

CRISIS IN HEALTH CARE: THE MISSOURI EXPERIENCE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

MARCH 29, 1985, JEFFERSON CITY, MO

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 99-503

U.S. GOVERNMENT PRINTING OFFICE

47-209 O WASHINGTON : 1985

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CRISIS IN HEALTH CARE: THE MISSOURI EXPERIENCE

FRIDAY, MARCH 29, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
Jefferson City, MO.

The subcommittee met, pursuant to notice, at 3 p.m., in the Senate lounge, State capitol, 100 East Capitol Street, Jefferson, MO., Hon. Ike Skelton (acting chairman of the subcommittee) presiding.

Members present: Representatives Skelton and Tauke.

Staff present: Peter Reinecke, research director, Subcommittee on Health and Long-Term Care of the Select Committee on Aging, and Greg Hodur, legislative assistant to Mr. Skelton.

Mr. SKELTON. The hearing will come to order.

This is a hearing by the Subcommittee on Health and Long-Term Care of the U.S. House Select Committee on Aging.

I thank the chairman of the House Aging Committee's Health and Long-Term Care Subcommittee, Congressman Claude Pepper, for convening today's hearing here in Jefferson City. No individual has done more for the Nation's senior citizens than Congressman Pepper and it's my privilege to chair this meeting in the absence of Congressman Pepper.

He has an opening statement, which, without objection, we will ask to be put in the record at this point.

[The prepared statement of Chairman Claude Pepper follows:]

PREPARED STATEMENT OF CHAIRMAN CLAUDE PEPPER

I am extremely pleased that the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, which I have the privilege of serving as chairman, is conducting this important hearing on the "Crisis in Health Care: The Missouri Experience." I am certain that the findings of this hearing will be extremely helpful to the subcommittee in its ongoing efforts to improve the quality and range of health care offered our nation's senior citizens through the Medicare program.

With the establishment of the Medicare and Medicaid programs in 1965, Congress confirmed a basic human right and established a sacred trust: Access to quality health care shall not be limited by age or income. Today the Congress and our subcommittee face a most difficult challenge. We must maintain and strengthen the quality of care offered through these programs while at the same time work to cut spiraling health care costs.

The new Medicare prospective payment system provides incentive for hospitals to reduce costs. Although no definitive data is yet available, we have heard reports from all around the country of Medicare beneficiaries being denied access to health care and being discharged prematurely from hospitals under this new system. We

must assure that cost cutting and Federal Government targets for reducing costs not become the formula for denying the elderly the care they need.

While I am unable to be with you today, I want to let you know that Congressman Skelton, in whose district this hearing is being held, is a most effective member of the Subcommittee on Health and Long-Term Care. He has been totally dedicated to meeting the needs of the elderly. He has done outstanding work with the subcommittee in pursuing badly needed legislative changes to help senior citizens.

I am also extremely pleased that my distinguished colleague, Congressman Thomas Tauke of Iowa is at these hearings. He has been a dynamic force within the Congress and one of the most active members of the House Select Committee on Aging.

I look forward to a complete report on the findings of today's important hearings.

STATEMENT OF REPRESENTATIVE IKE SKELTON

Mr. SKELTON. I also want to thank my colleague and friend from Iowa, Congressman Tom Tauke, for joining us. Congressman Tauke is one of the leaders in our effort to protect the rural health care system. He's been very active in that over the years, and his presence here today in the State of Missouri will contribute, I know, significantly to the success of our hearing.

This hearing is one of a series that's being conducted by the Aging Committee around the country to examine the effect of recent changes in the Medicare Program on the quality of hospital care our senior citizens are receiving. While we will be receiving testimony about problems facing Missouri senior citizens as a result of those changes that have been made, the subject of this hearing is of national importance. It's essential that Congress not allow efforts to control Medicare expenditures to endanger the ability of older Americans to receive high quality hospital care.

In an effort to help prevent Medicare from going bankrupt before the end of the decade, Congress changed the method Medicare uses to determine payments to hospitals. In the past, hospitals were able to pass on virtually any cost that they incurred by treating Medicare beneficaries to the Medicare system. But now hospitals receive a predetermined, fixed fee from Medicare that's based primarily on the diagnosis of each senior citizen that the hospitals treat. Because payments are no longer made on a per day basis, Medicare sets no limits on the length of time that a senior citizen may remain in the hospital. Hospitals have incentives to be more efficient because they may keep any excess that remains if their cost of providing care is below the fixed fee, while they must also absorb any loss if their cost is above that fee.

The new payment system, which is called the prospective payment system [PPS] has been a mixed blessing for the 30 million Americans who depend on Medicare. Just this week Congress learned that Medicare should remain solvent until the turn of the century; thanks largely to this payment system. However, recent studies by the General Accounting Office and the Aging Committee indicate that in many instances senior citizens are being discharged from hospitals quicker and in a poorer state of health than before the prospective payment system was implemented.

In fairness to hospitals, it must be noted that they're being unnecessarily squeezed because of the failure of the Department of Health and Human Services to allow Medicare to pay rates sufficient to enable them to well run their hospitals and to treat senior citizens without suffering a loss. This problem is most severe for

our rural hospitals because they provide care to large numbers of senior citizens, disproportionately larger. Some badly needed rural hospitals may be forced to close if Medicare payments are not equitable. Therefore, I recently introduced legislation that I believe will make Medicare payments to all hospitals through our nation fair and reduce the need for hospitals to cut corners in the care of senior citizens.

The main safeguard of the quality of our health care of our senior citizens is the Peer Review Organization Program. Peer Review organizations, known as PRO's, are groups comprised primarily of physicians that contract with the Federal Government to prevent Medicare payment for unnecessary hospitalizations and to assure the provision of high quality care. Today's hearing, ladies and gentlemen, will focus on activities of the Missouri Patient Care Review Foundation, which is the PRO, that is, the Peer Review Organization for the State of Missouri. Specifically, we'll try to determine whether that organization strikes the proper balance between assuring the quality of care and preventing unnecessary utilization of hospital services by Medicare beneficaries. The first panel of witnesses will be comprised of senior citizens and family members who've had personal experience with a PRO as well as representatives of senior citizens organizations and the hospital industry. The second panel will consist of the chairman of the Missouri PRO, its medical director, and the regional director of the U.S. Health Care Financing Administration, which is the Federal agency which oversees the Medicare Program.

I expect the testimony of these witnesses and witness statements submitted for inclusion in the record to bring valuable information about the performance of this very important program to the attention of our Congress.

It's a real pleasure for me to welcome you, our witnesses who will be testifying, and to welcome my colleague and my friend from just north of us, in Iowa, Congressman Tom Tauke. At this time I wish to introduce him and ask him if he has any opening remarks.

STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

Mr. TAUKE. Thank you very much. It is a great pleasure for me to come here to Congressman Ike Skelton's district to listen to what you have to say about rural health care.

I do have an opening statement, but I'm sure that it's better if I listen to you rather than if you listen to me. So I ask unanimous consent that that statement be included in the record.

Mr. SKELTON. No objection, we'll do that.

[The prepared statement of Representative Tauke follows:]

PREPARED STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

I commend my colleague and friend, Ike Skelton, for convening today's hearing on the question of the impact of the Medicare prospective payment system on the rural elderly's access to hospital services and on the quality of the hospital services they are receiving Ike and I have worked together for months now to encourage the Department of Health and Human Services to correct the serious inequities in the prospective payment system which threaten the survival of rural hospitals; threaten rural Medicare beneficiaries' access to high-quality, community-based health care services; and threaten the very fabric of rural health care in general.

The struggle has been long and frustrating. At first, it seemed to us and to many other members of Congress who have joined us in this effort that our voices were being lost to the overriding concern about cost-containment. Now, that is changing, and today's hearing will promote further change and responsiveness to the crisis the current prospective payment system is precipitating in rural health care. More and more members of Congress are listening to reports from hospital administrators, from Professional Review Organizations, from physicians, and most poignantly, from rural elderly constituents and their families that indicate a serious erosion in quality of care and access to care may be occurring.

How a hospital fares under the prospective payment system should depend upon its ability to offer high-quality, needed, affordable services. That's the concept underlying the prospective payment system, and I think we can all agree with this concept. But the reality is quite different—particularly for rural hospitals.

How a hospital actually fares under the prospective payment system is largely a matter of geography. The system reimburses hospitals in urban areas of the Midwest 25 percent more for standard labor costs and a staggering 54 percent more for the non-labor costs than rural hospitals receive for treating the exact same category of illness, or Diagnosis Related Group (DRG). Yet the urban hospital may be only a few miles apart, may be competing for staff in the same labor market and paying comparable wages, and may be buying supplies and experiencing other non-labor costs which are comparable. This system's urban rural differentials are resulting in the serious under-reimbursement of many rural hospitals and are making it impossible for rural hospitals offering high-quality, affordable, community-based services to compete with nearby facilities.

The labor reimbursement inequity is made yet more severe by the application to labor reimbursement rates of seriously flawed area wage indices. These area wage indices are based on data which penalize hospitals for cost-effective labor practices, such as utilizing part-time staff whenever possible to cope with fluctuations in admissions. Rural hospitals have traditionally followed this cost-saving practice. Now, they are paying for it dearly—and under a system which is supposedly designed to reward the cost-effective provision of hospital services. The irony is not only bitter, it is tragic.

Since July, Ike and I have been pushing the Department of Health and Human Services to issue the report on the revision of the area wage indices Congress mandated in the Deficit Reduction Act. That report was due September 1st of last year. The Department missed that deadline by at least a "country mile," as well as two subsequent December and February deadlines.

It appears that we will, finally, have the report in a few days. But rural hospitals may still have a long wait before the area wage indices are corrected and their reimbursement made equitable. For once the report is out, a rulemaking process is needed to put the indices in place. We've been urging the Department of Health and Human Services to initiate this process immediately after the publication of the report. Common sense, the will of Congress, and most importantly of all, the survival of rural hospitals and the rural elderly's continued access to high-quality, affordable, community-based care demand an immediate rulemaking. Ike and I didn't think we were asking for all that much when we asked the Department to respond with common sense, equity, and concern for rural hospitals and beneficiaries. Apparently, though, we were. We received word earlier this week that the Department has decided—in the interests of administrative convenience—to delay the correction of the area wage indices until October.

We find this conduct—this deliberate flouting of the will of Congress—this clear disregard for the fabric of this nation's rural health care system—outrageous. We will continue to do all that we can to reverse this latest decision to do nothing in a timely, sensible fashion.

You can help us. Let us hear, today, of your experiences under the current prospective payment system. Let us hear your thoughts on how effectively the Professional Review Organization can function, under the terms of its contract with Medicare, to truly carry out its responsibility to ensure beneficiaries' access to high-quality services. Does this contract emphasize cost-containment to the detriment of quality and access? Can any organization with ensuring access and quality carry out this function under an inequitable reimbursement system seriously underpaying hospitals for their services to beneficiaries?

The measure of a health care system is the extent to which it successfully balances quality of care, access to care, and cost of care. How does the prospective payment system measure up? That is the question before us today here in Jefferson City, and that is the question before Congress and this Nation.

Mr. TAUKE. I do want to tell you that as one who comes from the banks of the Mississippi River—I grew up in the city of Dubuque, on the banks of the Mississippi—it's good to be on the banks of the Missouri River here at your beautiful State capital.

With my colleague, Ike Skelton, over the past several months in particular, but over the past several years in general, we have been working together on a number of health care related issues, and as we have worked to try to insure the rural hospitals have a fair share of the prospective payments that should be given under Medicare, Ike Skelton has been a real champion of the cause. He is one of those people who when he commits himself to something, commits all the way. And so I feel a great pleasure at having the opportunity to come to his district and to be able to listen to you, the people he represents.

I believe that probably what is happening in my district is happening here in your area and across the country. And that is reflected, I think, by what I hear at town meetings. When I go to town meetings now people are saying to me, "How do I ensure that I get good quality care?" A year ago when I had town meetings they came and said, "How do I get less expensive care?"

But suddenly the emphasis has shifted from cost of care to the quality of care. And I think because of that shift in emphasis on the part of the people across the country, and because of the shift in their concerns, we in Congress are seeing a shift in emphasis.

A few years ago Congress worked very hard to restructure our Medicare Program and Medicaid Program and other health care programs to ensure that cost was held down and to provide the optimum incentives to reduce cost and to prevent excessive abusage. Well, now we fear that maybe some of that is going a little too far and reducing the quality of care.

There is a great need, of course, to contain cost, but there's also a great need to ensure that we have quality care and it's our job to try to ensure that we get the best possible balance between those two.

I know Congressman Skelton shares my view that we can have both a reasonable cost and high quality and that is what we seek. So we are interested today in hearing what you have to tell us about your experiences under the present system and any recommendations you may have for change that will allow us to have better quality care at a reasonable cost.

Thank you very much, Ike, for inviting me to the hearing. I am delighted to be here.

Mr. SKELTON. Thank you very much. I appreciate your joining us, your kind words, and especially we appreciate your pronouncing the name of our State Missouri correctly.

Our first panel is composed of Mrs. Jean Morrison of Independence, MO, accompanied by Dr. David Voshall of Blue Springs; Mr. Fred Thomas from Warsaw, MO; Mr. William Spinabella, Missouri Health Coordinator of the Association of Retired Persons; and Mr. Duane Dauner of the Missouri Hospital Association. We appreciate your being with us.

We ask that you limit your testimony to 5 minutes. If you wish to submit your testimony in full, you may do that. It will appear on

the record in full. If you wish to summarize it, we may speed through it a bit more.

PANEL ONE—THE PROBLEM IN HUMAN TERMS: CONSISTING OF JEAN MORRISON, INDEPENDENCE, MO; DR. DAVID VOSHALL, BLUE SPRINGS, MO; FRED THOMAS, WARSAW, MO; WILLIAM SPINABELLA, MISSOURI HEALTH ADVOCACY COORDINATOR, AMERICAN ASSOCIATION OF RETIRED PERSONS; AND C. DUANE DAUNER, PRESIDENT, MISSOURI HOSPITAL ASSOCIATION, JEFFERSON CITY, MO

STATEMENT OF JEAN MORRISON

Mrs. MORRISON. Gentlemen, my name is Jean Morrison. I would like to speak to you today about some problems related to the health care afforded my mother, Dora Evans.

First, I believe that some background on mother would be helpful. My mother has had a difficult life. There was much hard work. She was always the one in her family that had to shoulder the responsibility. During the depression years she started a small grocery business and worked long hours there until she was 65. At that time she retired. Mother and Dad were frugal people and they saved their money and thank heavens for that because of this last year.

Last March there was a great change in my mother. She was losing much weight, was quite agitated, always complaining about being hot or cold. This time she started having severe stomach pains and several times did call the police and the fire departments. They got to know us pretty well. Before this I'd never seen mother cry or heard her complain. So naturally when she said she was sick there was no reason to doubt her. And I still don't doubt her when she says she's sick.

On May 25, 1984, mother was admitted to the hospital with nausea, vomiting, and severe pains in her abdomen. Previously, in years past, mother had had diverticulitis, so I thought this was going to happen again. Tests were made and we were told mother would have to leave the hospital June 1, 1984. I was angry and upset that she had to leave the hospital because I felt she should be allowed more time there. My mother was even more confused and disoriented when we returned her to her home. At that time I was most fortunate to have a lady who could stay with her. Even though mother had constant care she still had pains with stomach and bowel problems were still with her. About this time we began receiving many Medicare communications—what was allowed, what was not allowed—some understandable to me, none understandable to people older than me, some not understood at all. Much paperwork plus the postage.

The same situation occurred in August. By now mother had lost 28 pounds and was still uncomfortable. She was the admitted to the hospital August the 1st and discharged August the 6th. She was admitted to a nursing home. About this time we received more Medicare information, much more, and words to the effect that her case would be reviewed. I was not too pleased with this. I could see my mother deteriorating so fast and the nursing home situation is not too good for all.

In September mother again entered the hospital, but this time she was also having heart problems. She was placed in intensive care, monitored, and at the end of the third day we were told she had some angina problems and was given medication for this and is still receiving the same medication. I feel that mother should have had more hospitalization then than she received.

She returned to the nursing home. Mother did not do well there because of her complete confusion by now.

After the nursing home experience, I was so fortunate to be able to place mother in a boarding home that we had known about for 4 years. There are 10 other ladies there that are similar to mom's condition. Some are as confused, some are not. But they are well cared for. They're clean, they're able to walk about this home as if they were in their own home. They're able to sit in the kitchen and watch one of the aides cook their dinner. They're even asked what they would like to have for dinner. And they get enough to eat. Mom's well enough now that I bring her home on Sunday to visit with the grandchildren.

I'm telling you these things because I feel my mother deserves all good things. Mother and Dad saved their money, paid taxes, took care of family and neighbors and were good citizens, gave an awful lot of credit during the depression years in the store. Do you realize that with all hospital expenses, nursing home expenses, medicine, and hiring people to care for her, that soon her life savings will be gone.

Now I have one other thing. This does not concern my mother but my husband, John Morrison, who was also ill in September. He had not been hospitalized since his college years, approximately 40 years ago. A year ago he had knee surgery and came home the same day so that he could be an outpatient. He's very used to pain. He's had a chronic phlebitis problem for many years. However, in September we called his doctor because of some severe pains that he was experiencing. We went to the doctor's office and was sent there from the office to the hospital. He was placed on antibiotics and IVs. He was kept at the hospital 5 or 6 days and then released. We soon heard from Medicare and assumed they meant he was not ill enough to be in the hospital because they were reviewing his case.

Several months later we did receive another letter that stated his case had been reviewed and the decision was reversed. So we felt that this was one small victory. The diagnosis on my husband was an inflamed and infected diverticulitis. I really don't see how we could have taken care of him at home.

In conclusion, I feel that the quality of care to our Nation's senior citizens should not be jeopardized simply because of Federal Government efforts to control cost.

Mr. SKELTON. Thank you, Mrs. Morrison. Dr. Voshall.

STATEMENT OF Dr. DAVID VOSHALL

Dr. VOSHALL. I'm David Voshall. I want to thank you for allowing me to speak here today. I'm an M.D. and the physician who cares for Dora Evans. I'm board certified in internal medicine. I also have a Ph.D. in biochemistry.

Mrs. Evans' history began in May 1984 when she was hospitalized for hyponatremia, which is low sodium, hypokalemia, which is a low potassium, fatigue, and weight loss. The patient also suffers with chronic congestive heart failure and peripheral vascular disease. After her main hospitalization, the patient was relatively stable until July 28, 1984, when she was seen in the office complaining of abdominal pain. She had outpatient tests, which suggested that she had a urinary tract infection, and they treated her appropriately.

She returned on July 30, 1984, continuing to complain of increasing abdominal pain. We did some additional tests and started outpatient therapy for gastritis. However, in spite of relatively intensive outpatient therapy, the patient continued to deteriorate, and on August 1, 1984, was admitted to the hospital for further evaluation. At the time we admitted the patient to the hospital she appeared acutely ill. She had severe abdominal pain. We admitted her and treated her appropriately, did the appropriate tests. When we felt that she was stable, she was discharged to the nursing home.

Her entire case is summarized in the letter which I have included to be submitted into the record.

This case was denied by PRO. Subsequent appeal was also denied by this group, stating that the hospitalization was unnecessary. This was based on retrospective analysis.

There are a number of problems with the current review system which I wish to review.

First, it's very difficult for me to tell perspectively how severe a patient's illness is. This is especially true in the elderly population where the usual indicators such as fevers, elevated white counts are absent. The patients may be severely ill and present only with confusion. In the case presented above, the patient was sick for about 4 weeks prior to admission. She had been getting progressively worse in spite of intensive outpatient care. Her admission followed good medical guidelines. We defined the problem. We effected a resolution to the problem. We effected a long-term stability.

In the statement, I detailed two other cases which I think point out the problem with retrospective analysis. S.A. was an elderly female with known coronary artery disease and diabetes, who presented to my office complaining of vomiting blood, having bloody stools, and having increasing pain. She was admitted to the hospital, stabilized. The PRO felt that her total hospitalization was unnecessary. She was in the hospital 3.5 days.

J.K. was an elderly white male who presented himself in the office. He was known to have coronary artery disease. He had recently been hospitalized for epigastric pain and found to have gall bladder disease. When he came to the office on October 6, 1984, he was complaining of nausea, abdominal pain, and chest pain similar to S.A. His admission was denied. I recommended that J.K. go into the hospital, he refused. The next morning he died at home of cardiac arrest.

I know of no way to differentiate these cases perspectively when I'm seeing the patient in the office.

Second, the current system is creating negative incentives toward the care of the elderly.

Included in the record is a denial letter which is sent to the patients. It states that a board of physicians has reviewed the record and feels that the patient's hospitalization was not necessary. This tends to make the patient shy away from further medical evaluation for similar types of pain. For example, a patient has chest pain, gets admitted to the hospital, is sent a letter saying that their chest pain was not severe enough to justify they be admitted to the hospital. The next time they're likely not to come in until their chest pain is quite severe, at which time they may have infarcted rather than still being in stable angina, in other words, treatable.

Second, the hospitals appear to me to be increasing pressure to discharge the patients at an earlier date. They do this by a number of mechanisms, recurrent reviews, ongoing reviews, by medical records reviewers, and by giving dates at which certifications will cut off. They're placing cost sheets on charts letting us know what the cost of the patient's care has been to a particular point in time and what the expected reimbursement will be for that. They also label all of the Medicare charts with large labels to let us know who's Medicare and who isn't.

The fixed reimbursement system is encouraging the hospitals to do only testing related to the patient's immediate problems.

As I have tried to detail in Ms. Evans' case, a lot of the patients have multisystem problems and multisystem diseases. Because of the reimbursement system we're encouraged only to address the most immediate problem, discharge the patient, readmit them for other problems at a later date.

Finally, the PRO denials are creating an environment where if you don't have a real clear idea as to the reason for admission, a lot of pressure is rendered upon you to get the patient out at the earliest possible date, with or without a diagnosis. But the fact that the hospitals which aren't adequately staffed have lost their waiver of liability, every PRO denial represents an absolute cash loss, I guess, to the hospital, and they want to minimize that loss.

I've detailed the patient who had severe disease, who was admitted to the hospital, preliminary tests were negative. When we discharged the patient from the hospital with instructions for further evaluation as an outpatient, PRO denied the initial hospitalization. The patient's reason for hospitalization was unstable angina. She subsequently had open heart surgery.

I want to thank you for allowing me to present these experiences to you.

[The prepared statement of Dr. Voshall follows:]

PREPARED STATEMENT OF DAVID L. VOSHALL, M.D., PH.D.

I am David Voshall. I wish to thank you for allowing me to speak before you today I am a M.D. and the physician who cared for Dora Evans. I am Board Certified in Internal Medicine and I also have a Ph.D. in Biochemistry.

Mrs. Evans' history began in May of 1984 when she was hospitalized of hyponatremia (low sodium), hypokalemia (low potassium), fatigue, and weight loss. The patient also suffers with chronic congestive heart failure and peripheral vascular disease. After this hospitalization the patient had remained relatively stable until 7/28/84 when she was seen in the office complaining of abdominal pain. The patient had tests done as an outpatient which suggested that she had a urinary tract infection and she was treated appropriately. The patient however returned on 7/30/84 complaining of increasing abdominal pressure and was treated for gastritis. However, the patient continued to deteriorate and on 8/1/84 was admitted to the hospital

for further evaluation At the time of admission, the patient appeared acutely ill with severe abdominal pain. The patient was admitted, treated appropriately, and when her abdominal pain was resolved, appropriate long term care was provided. This case was denied by PRO and a subsequent appeal was also denied by this group.

There are a number of problems with the current review system (at least as it is implemented in our area). These are listed below.

1. It is very difficult to tell prospectively how severe the patient's illness is. This is especially true in the elderly population where the usual indicators may be absent. In the case presented above, the patient was sick for about 4 weeks prior to admission and the patient's symptoms had been getting progressively worse. The adminission resulted in the definition of the patient's problems, appropriate care rendered and a long term solution resulted. Retrospectively however, the PRO feels that the patient did not have an illness acute enough to justify admission to the hospital.

Let me present a clearer example of the difficulty in determining outcome prospectively.

S.A. is an elderly female with known coronary artery disease and diabetes mellitus who presented to the office complaining of vomiting blood, having bloody stools, and having unstable angina. The patient was confirmed to have blood in her stools in the office and was admitted to the hospital. The patient was observed in the hospital and when I was sure she was stable, no significant bleeding was occurring and no further chest pain, the patient was discharged. The patient was in the hospital 3.5 days. The PRO denied this hospitalization and subsequent appeal.

J.K is an elderly white male with known coronary artery disease who had been hospitalized in early October 1984. The patient had been hospitalized at that time for epigastric and chest pain. The patient was admitted to the hospital where he was stabilized and appropriate studies done. The patient was found to have gallbladder disease. The patient was discharged home on 10/6/84. On 10/6/84, the patient returned to the office for follow-up. At that time the patient complained of abdominal pain, mild chest pain and nausea. I recommended that the patient return to the hospital. He refused. The next morning he died at home.

How do we differentiate these cases prospectively.

2. The current system is creating negative incentives towards the care of the elderly.

A The denial letter that is sent to the patient creates a negative incentive for the patient to seek medical care for the same problem at a later date, i.e. patient with chest pain.

B The hospitals appear to me to be increasing pressure to discharge patients at an earlier date. They do this by recurrent reviews, giving dates at which certification will end, and by placing cost sheets on the front of a Medicare patient's chart telling the physician the cost of the hospitalization and the expected amount of reimbursement.

C The fixed reimbursement system encourages the hospital to do only testing related to the immediate problem. Since additional reimbursement related to other problems is not compensated for, the pressure is to treat only the first problem then discharge the patient at a later date to pursue other medical problems.

D The PRO denials are creating an environment in which more extensive testing may need to be done to justify a patient's admission to the hospital. Consider the following case.

B.S presented to the emergency room with a history of severe epigastric pain. The patient had been having postprandial epigastric discomfort for the past month. The pain seemed to be getting progressively worse and the pain seemed to occur with eating. The patient was seen by a Board certified E.R. physician who felt that the patient was sufficiently severe to require the patient to be admitted to the hospital. The patient was admitted to the hospital where initial testing of the abdomen failed to reveal any abnormality. Since the patient was pain free, she was discharged to home with instruction to record her pain pattern. The patient was discharged with the diagnosis of gastritis. What the patient actually had was unstable angina but we did not know that until two weeks later when she returned to the office with her pain log which demonstrated a clear pattern of unstable angina.

The PRO has denied this hospitalization. They felt that the tests should have been done as an outpatient. If there was an error in her care, however, it was that I tried to practice cost-effective medicine. It was much less expensive to discharge the patient when she appeared stable then it would have been to keep her in the hospital until we were able to define her exact disease (which might have taken a long time since she was pain free after we placed her at bedrest). However, because we prac-

ticed cost-effective medicine, PRO ruled that the entire hospitalization was unnecessary.

3. There exists a multi-tiered medical system.

With the PPS and recent PRO rulings (keeping in mind that all of the hospitals in which I am on staff have lost their waiver of liability) pressure exists for treating the elderly to a level of care which would be substandard. There is pressure to do less tests on the hospitals then might be appropriate, to discharge the patient earlier, and to treat only the most immediate medical problem.

Thank you for allowing me to present my experiences before you today.

NORTHWEST-MISSOURI PROFESSIONAL
STANDARDS REVIEW ORGANIZATION,
Kansas City, MO, October 5, 1984.

To: Parties to reconsideration hearing conducted in Re Sylvia B. Allen, M.R. #108732; adm: 5/9/84; disch date: 5/12/84; date of denial: 9/18/84; St. Mary's of Blue Sprin.

From: Northwest Mo/PSRO—Virginia T. Gruendel, M.D., Medical Director.

Subject: Reconsidered decision in above referenced case.

Professional Review Organizations (PRO's) are organizations charged with the review of health care services provided to beneficiaries (patients) of Federal Health Care programs. This review is conducted to assure that Federal beneficiaries receive quality health care, and to insure that such care is medically necessary. Northwest Mo/PSRO is the designated organization for reviewing health care services in a 30-county area of Missouri that includes St. Mary's Hospital of Blue Springs, MO.

On September 26, 1984, Northwest Mo/PSRO received a verbal request from David L. Voshall, M.D., attending physician, for a reconsideration of the initial adverse decision relating to the admission denial issued to the above patient on 9/18/84 subsequent to hospitalization at St. Mary's Hospital of Blue Springs, MO. Additional physician members of Northwest Mo/PSRO, other than those involved in the initial adverse decision were consulted for the reconsideration. The medical record as available at the time of the denial and additional information provided by the attending physician were reviewed in the reconsideration process.

Following a review of the information available, it was determined by the physician reviewers that the initial determination would be upheld. The reviewing physicians, in evaluating the case and arriving at their decision, cited the fact that this patient did not need admission to an acute care facility for the treatment/services provided.

This decision upholding the initial denial of admission certification means that this admission will remain classified as not medically necessary. Medicare will receive a copy of this notification informing them that this admission was not certified for payment under the program guidelines relating to approved (certified) care.

The patient (or his/her legal representative), in the event of disagreement with this reconsidered determination, may request a review of the decision by the Reconsideration Evaluation Branch of the Health Care Financing Administration, if the services in question involve an amount greater than $100. An appeal of this further review must be filed within sixty (60) days from the date of the receipt of this notice The appeal request must be in writing and may be filed at or with one of the following: Northwest Mo/PSRO, 301 E. Armour Blvd., Suite 202, Kansas City, MO 64111 (Attention: Medical Director); John Barton, Chief of Reconsideration Evaluation Branch, HCFA, P.O. Box 770, Baltimore, MD 21203; or, at an office of the Social Security Administration.

If you have any questions about this matter or wish any additional information, please contact this office.

BLUE SPRINGS INTERNAL MEDICINE, INC.,
Blue Springs, MO, October 5, 1984.

Re denial on Sylvia Allen.

VIRGINIA T. GRUENDEL, M.D.,
Medical Director, Northwest Missouri PSRO, Kansas City, MO.

DEAR DR. GRUENDEL: This letter is to follow-up on our previous conversations concerning PSRO's denial of Sylvia Allen's hospitalization, May 12, 1984. As explained twice on the phone, this patient presented to the office complaining of multiple problems The patient had chest pain which was getting progessively worse requiring two nitroglycerines per attack, multiple attacks per day. The patient also gave a

history of significant vomiting for the past few days with hematemesis and a history of rectal bleeding.

The patient was admitted to the hospital for evaluation of these problems and stabiiization of her angina. Since you have the complete chart on hand, please note the admission nursing history note, 5/9/84, time: 1700, "78 year old white female in fair condition admitted with a diagnosis of angina". The record is wrong in that the nurses state that the patient was also admitted for hematuria. This was hematemesis. Quoting the nurses note, "The patient states in the past week or two she has had chest pains starting mid-sternum and moving to the left, going into the shoulder and down to the left arm. She states she takes nitroglycerin, sublingual, at home, usually one to two tablets will relieve the pain." This represented a significant change in the patient's angina symptomatologies and when associated with the history of her reported hematemesis and rectal bleeding it seemed essential, in my opinion, that the patient be hospitalized for evaluation and stabilization. This was done.

While I do not wish to imply that your reviewers do not know the medical literature, let me quote some common medical texts.

From "Harvey's Principle & Practice of Internal Medicine," copyright 1984, pp. 254. "It is not often appreciated that the balance between oxygen supply and demand in the myocardium may be so tenuous that a small reduction in blood HgB (i.e., a reduction of hematocrit by 5 or 6 points) may account for worsening of the angina."

In "McBride's Signs & Symptoms," copyright 1983, page 569. "In a patient with fairly marked atherosclerosis of the coronary arteries . . . the sudden development of acute blood loss anemia . . . may lower the oxygen tension in the myocardium below a critical level with resultant myocardial infarction."

You will also note at the time of admission, patient's vital signs were stable, and she was admitted to the telemetry unit. On admission the patient's hemoglobin was 11 5, the patient had had a hemoglobin done in the office on 3/27/84 prior to admission and the hemoglobin was 12.2. Since her vital signs were stable and demonstrated no significant orthostatic changes it was my feeling that she had not significant amounts of bleeding and therefore an IV was not started but the patient was closely monitored.

During her hospitalization, Mrs. Allen had no emesis or hematemesis. However, she did have some GI bleeding. Please note the nursing note on 5/10/84, time: 0100, "Approximately 75 cc's of dark brown stool with deep red flakes which are strongly guaiac positive". Please also note the nursing note of 5/11/84, time: 0310, "Passed moderate amount of soft brownish stool, moderately positive for blood". However, throughout her hospitalization the patient's blood pressures remained stable without significant orthostatic changes.

Thus to summarize this case, we have a lady with diabetes mellitus and known atherosclerosic heart disease who presented to my office complaining of vomiting with some hematemesis, rectal bleeding, and an increase in her angina. The patient was admitted to the hospital, her hemoglobin on admission was essentially unchanged from that done prior as an outpatient, the patient's vital signs remained stable, although she did develop some bradycardia, and while she had no hematemesis, she had documented guaiac positive stools. A very thorough evaluation at another hospital which included total colonic studies demonstrated no abnormalities. No further workup of her guaiac positive stools was done at this time. The patient's angina was stabilized and she was discharged to home to be followed closely as outpatient.

The PSRO review process has recently found this hospitalization to be medically unnecessary I find this decision to be totally inappropriate. I don't believe any practicing physician with an elderly patient with diabetes mellitus, unstable angina, a history of vomiting blood, and rectal bleeding would treat that patient on an outpatient basis How the PSRO reviewers and physician reviewer came to their conclusions I do not understand and have not understood after two conversations with you or your administrative assistant. As I mentioned in our conversation the policy of sending a copy of the letter of denial to the patient caused the patient's family extreme concern and in my opinion damaged the patient/physician relationship. Recently, I have learned, that based on this decision that the hospital has had it's waiver of liability suspended.

I think this represents a dangerous precedent where a non-involved physician makes a decision which even retrospectively appears to be an inappropriate decision I don't believe that you can support the decision for denial based either on the medical record or on the medical literature. I feel that sending a letter to the patient damages my relationship with the patient. Further, the loss of the hospital's

waiver of liability is an inappropriate consequence of this erroneous decision. I do believe that this record needs to be reviewed by competent physicians and if necessary I will be happy to attend the review to present aspects of this case as they pertain to medical necessity for admission.

Sincerely,

DAVID L. VOSHALL, M.D., PH.D.

INDEPENDENCE SANITARIUM & HOSPITAL,
Independence, MO, February 27, 1985.

Re Dora Evans—HIC #488364897D.
VIRGINIA GRUENDEL, M.D.,
Medical Director/Medical Consultant, Northwest Missouri Health Care Review Organization, Kansas City, MO.

DEAR DOCTOR GRUENDEL: This represents an appeal of your decision concerning Dora Evans, HIC #488364897D, and her hospitalization here at the Independence Sanitarium and Hospital. Reviewing the patient's case again for you, this elderly white female had been having abdominal pain for approximately two weeks. At that time, the patient was living with her daughter who works in the County Legislature. It was the opinion of the daughter that the patient's pain was getting progressively worse. She had been found to have a urinary tract infection as an outpatient, but her periumbilical and abdominal pain had gotten progressively worse and when the patient developed nausea and vomiting, with associated severe abdominal cramping, the patient was admitted for further evaluation. At the time she presented, the patient had stable vital signs. She was crying, she was hard of hearing, she was pointing to her lower abdomen stating that she was having severe abdominal pain. Please see nurse's note, 8/1 at 15:30. Her abdomen was distended, but there was no guarding or discomfort. The patient was admitted to the hospital.

The patient was placed on a clear liquid diet and appropriate laboratory studies were done. Soon after admission, the patient had no further abdominal pain. The patient had good oral intake. A barium enema did demonstrate sigmoid diverticulosis. Other laboratory was unremarkable, including an amylase of 46. As mentioned, the abdominal pain resolved. The decision was made, therefore, to place the patient into a nursing home because it was my opinion and the opinion of the daughter that the patient might be using her abdominal pain to manipulate the daughter at home. Arrangements were made and the patient was transferred to the nursing home.

Since being placed in the nursing home the patient has been essentially pain free and has required no additional significant intensive medical care.

Discussion: I would assume that your reviewers are familiar with the differential diagnosis of severe abdominal pain, especially severe abdominal pain in the elderly. When a patient appears to be in a good home situation, when she has close supervision by the family, and when her abdominal pain continues to get worse, I can see no alternative but hospitalization. To say that admitting laboratory does not support the hospitalization, then I would ask your reviewers to review the literature on geriatric medicine, which clearly demonstrates that patients with severe abdominal pending catastrophies may not have a fever, may not have an elevated white count, may not have abnormal abdominal x-rays, may indeed not have even an abnormal examination, and yet may have totally infarcted their bowel. The only alternative with progressive disease, is to admit the patient and observe the patient, and give appropriate care as the situation resolves. In the case of Dora Evans, the patient was having abdominal pain, and was apparently exaggerating that abdominal pain to manipulate her daughter. We demonstrated this early in the hospitalization (something we were not able to do in the two weeks of intensive outpatient therapy prior to hospitalization). With the demonstration of the resolution of abdominal pain and the need to place the patient in a more supervised, chronic care facility, the patient now has not required significant medical care. It has been my feeling in the past, and will be my feeling in the future, that your retrospective decisions concerning patients with abdominal pain, have been erroneous or not consistent with the literature, and do not represent decisions which are in the best interest in the care of the patient. I feel that this hospitalization was indeed justified. If you would like, I can get a certified letter from the daughter who is associated with the County Legislature, verifying her feelings of the patient's acute abdominal pain. Because the patient did not have an acute abdominal catastrophe, does not mean that it was not in the patient's best interest and her best medical care, to be hospitalized. If you any further questions, please feel free to call.

DAVID VOSHALL, M.D.

Mr. SKELTON. Doctor, thank you, Mr. Thomas.

STATEMENT OF FRED THOMAS

Mr. THOMAS. Good afternoon. My name is Fred Thomas. I'm a Medicare beneficiary and I live in Warsaw, MO. I would like to tell you of some problems I have encountered recently with the Medicare Program. It is my hope that coming to speak before you shortly will help others who might be encountering similar problems. Also, I hope holding this hearing will help end what I see as confusion among older folks in this area about what their rights are under Medicare, especially with the recent changes in how Medicare pays for our health care.

In February 1983 my wife had a severe stroke and was admitted to a hospital for treatment. After a week in the hospital her health was steadily deteriorating. She was not eating. The doctor told me that if I could take better care of her at home, I should. At home my wife made great progress and in 3 months she was walking with some assistance. However, after insisting on trying to walk by herself with a walker she fell and fractured her skull. She was rushed to the hospital and the doctors operated on her to remove a blood clot from her head and 18 days later she went into a severe coma. She was in a coma in the hospital for 7 weeks.

The doctor told me that my wife could stay in the hospital as long as they saw improvement in her. However, she was still in the coma and the day we moved her was the first day that she even tried to take hold of your hand or hold your hand when you'd take hold of it. My wife was discharged from the hospital and I put her in a very fine nursing home. After around 3 months in the nursing home, I was able to bring her back home with me.

In December, my wife developed an infection which soon worsened. She had to be admitted back to the hospital. It was at this time I was told by someone in the hospital—I believe it was a nurse—that my wife could only stay in the hospital for 2 weeks. The doctor said this infection might be severe and would have to be treated through IV's. So this did upset me a little bit. I asked him about this and he said not to worry about things, that he was taking care of it, and he would not dismiss the patient until she was ready. So at this time she was there approximately 2 weeks on that trip. I might add that while she was there I had a hearing scheduled with Medicare because they had refused to pay some of the things. The surgeons who operated on her had a $2,300 bill and the anesthesia was $1,500 and they had refused all of that, so she came out to the house, the Medicare lady came to the house, and gave me a hearing.

I will say that Medicare, the people who are in the office in the city, have been very fair with me to try to help me. She came out there and she stopped these doctors from sending bills because she said that they allow all that, they were able to pay them. So she stopped this so I didn't have to pay anymore.

The doctor, who had been very good to us, told me that if it was true that Medicare would pay only for my wife to stay 2 weeks, I didn't have to worry. And there was two times that he came to the house to see her while she was there. He didn't even charge for it.

Over the next few months, my wife was in and out of the hospital. Each time she stayed in 2 weeks and then was sent home. When she was in the hospital I was again told by someone in the hospital that Medicare would only pay for 2 weeks. One woman whose husband was recently in the hospital told me she didn't understand how my wife could stay so long, longer than 2 weeks. My doctor again told me that I didn't have to worry.

After several months of being in and out of the hospital my wife's infection got worse. She passed away this past October.

I want to say that I think the doctors and the hospitals that cared for my wife did all they could. They were always very concerned about my wife. They made every effort to help us in any way they could.

In my own mind I am certain that there is something to the pattern of people staying 2 weeks in the hospital. If there is not, there are a lot of senior citizens who are confused and scared about it. If this is related to effort by the Federal Government to cut costs, a lot of older folks are suffering for it. Something must be done to better explain to the people about this 2 weeks. Medicare is paying for our health care. I am lucky that I have some experience in dealing with Medicare, but I have the feeling that if you don't have this experience and you don't speak up for yourself, you'll get left out in the cold. I might add that I called my doctor before I came up here this morning and asked him to verify this 2 weeks. He said he had never known, they had never told him at the hospital, that 2 weeks is the longest anyone could stay.

Mr. SKELTON. Say it again.

Mr. THOMAS. He said he had never been told that 2 weeks was as long as a person could stay. He said because they knew he would leave them there until there was nothing to discharge anyhow. But he did get on the phone and call them. They said no, they had no such ruling as that, but that they did expect patients as soon as they were able to leave to be discharged.

They said now, of the changes since October, that if a person has a stroke and goes in there, they'll pay 80 percent for 60 days. They said it's never paid 80 percent. Now it's $3,500. In fact, just the week she was there they still paid the $3,500. If it's 60 days, they pay $3,500 and then they have to be discharged. If they come back again, then they'll be paying a part of it, but it won't be the full 80 percent.

I thank you for the opportunity to tell you this.

Mr. SKELTON. Thank you, Mr. Thomas.

Mr. Spinabella.

STATEMENT OF WILLIAM SPINABELLA

Mr. SPINABELLA. Thank you. Mr. Chairman.

My name is William Spinabella and I am the American Association for Retired Persons' health advocacy service coordinator for the State of Missouri. I am a volunteer. As a national membership organization of over 18 million persons of age 50 and older, AARP has nearly 400,000 members in Missouri. I am pleased with this opportunity to state to the subcommittee AARP's deep concern about

quality issues and health care and the ability of the Peer Review Organization to protect quality health care.

Over the course of the last two decades rising health care costs have begun to threaten this Nation's commitment to the provision of health care services to all of its citizens, young and old alike. AARP is committed to health care cost containment that restrains the rate of increase in national health care spending while restructuring the health care delivery system. A responsible program of health care cost containment must be distinguished from the administration's 1986 budget proposals for Medicare. These proposals do not reduce health care cost; they simply shift them to hospitals, doctors, and beneficiaries.

As part of the cost-containment effort, AARP supports the DRG prospective payment system. In fact, we would like to see the system extended to cover all patients, not just Medicare. But as strategies for effective containment of health care costs are being developed and implemented, the issue of quality of care becomes critical. The DRG prospective payment systems for Medicare establishes a new set of financial incentives for providers that differs from those found under both cost-based reimbursement and other kinds of prospective payment systems. The incentives to reduce the hospital cost of each inpatient stay and to increase the number of inpatient admissions may adversely affect the quality of care. It is important that the real need for quality assurance presented by the DRG payment be recognized.

The incentive to reduce the cost per case under the DRG payment system is predicated on the belief that hospitals can save money by operating more efficiently and by offering a more cost-effective mix of services. Of great importance socially and medically, however, is the potential for harm that cannot be justified by the cost savings achieved. Early discharge may produce a range of poor outcomes that runs from unexpected, avoidable, or premature death to disability or discomfort that would otherwise not have been experienced. Early discharge may increase the severity of illness at discharge, thereby intensifing the care needed by patients placed in nursing home beds and home-care settings.

Information from our memberships suggests that some patients are dismissed before they are able to care for themselves. Depending on the circumstances of the patient, the need for services may range from skilled nursing home care to a homemaker chore service. The demand for both nursing home services and home care services has skyrocketed at a time when there is Federal and State financial pressure to curtail the availability of these services. This problem may be particularly acute in rural areas where the availability of such services has always been significantly lower.

Appreciating the incentives in the DRG payment system, Congress mandated that all hospitals participating in Medicare contract with a Peer Review Organization. This mandate is intended, among other things, to provide a permanent institutional mechanism for maintaining the commitment to high quality care.

AARP supports a strong PRO Program, currently PRO's are the only mechanism for monitoring and maintaining the quality of care under the DRG system. A strong utilization review mechanism is necessary both to avoid unnecessary and costly increases in

admission and readmission and to protect patients from premature discharge and the underprovision of services.

Reviewing admissions will be a large part of the PRO's mission. As part of this review, preadmission screening presents real risks that must be appreciated. For example, determining which procedures are more appropriately handled, outpatient versus inpatient, is an extremely delicate issue, particularly in light of medical practice variations. Where a PRO designates a particular procedure as more appropriately performed on an outpatient basis, any attempt to hospitalize a patient for that procedure must be clearly documented or payment will be denied. There is the possibility that many patients over the age of 65 may not be good candidates for certain outpatient surgery. The emphasis on outpatient procedures has to be balanced in elderly patients but it can be done only when coexisting conditions necessitating hospitalization are carefully documented.

The Missouri PRO is attempting to reduce unnecessary admissions statewide by 10 percent under the objective that reducing the number of inappropriate or unnecessary admissions or invasive procedures by specific practicioners in specific hospitals. It is stated that this planned reduction is based on the PRO's review of physician practice patterns and a determination that a significant number of admissions are medically unnecessary.

In carrying out this admissions reduction the PRO must appreciate and be sensitive to the risks. On the one hand, for the past several years, researchers have been tracking variations in the use of medical care and have begun to discover systematic and persistent variations in the standardized use rates for common surgical procedures. On the other hand, strict adherence to the numerical goal of a 10 percent, or amounting to about a little over 65,000 admissions in the State of Missouri, reduction could result in a reduced access for patients who truly need care.

Both the preadmissions screen for the appropriateness of outpatient versus inpatient treatment and the reduction in the admissions by specific providers point to the need for a flexible PRO system. The Government's emphasis on numerical standards and costs should not overshadow the need to assure that the elderly receive quality care. Since the data backing up the numerical objectives that were negotiated between the PRO's and HCFA are questionable in some instances, there is a need for HCFA to be flexible in judging how successful the PRO's are in complying with the objectives.

Additionally the PRO's must be provided incentives to develop mechanisms to monitor the potential for harm and pinpoint actual instances and patterns of adverse outcomes. These mechanisms must go beyond the institutionally focused PRO quality objectives now in place. They must monitor the ambulatory as well as the extended care setting in order to adequately assess quality of care.

There is also a need to have some global objective by monitoring utilization review and quality of care. What mechanisms other than the reports from PRO's themselves does the Health Care Financing Administration have ready to collect information and analyze it regarding how well the system is working? What is the cur-

rent status of the super-PRO or PRO contract to perform medical reevaluations of PRO determinations?

The quality of care issue is the potential Achilles' heel of the prospective payment system. It is absolutely essential that we focus on quality issues at the same time that we pursue health care cost containment, for public support depends on making the two consistent. If quality suffers, public support for cost containment will quickly erode. It will take the concerted effort of Government, providers and beneficiaries to make the health care system once more efficient by cutting the cost and, more effective, by keeping the care, and hopefully we can all work together to achieve the best possible health care system for all.

Thank you very much.

Mr. SKELTON. Thank you. Mr. Dauner.

STATEMENT OF C. DUANE DAUNER

Mr. DAUNER. Thank you, Congressman Skelton.

It's a pleasure to be with you. I'm not going to read the 17-page statement that I've handed to you. I would like to cover some of the highlights with you.

Mr. SKELTON. We'll put it in the record.

Mr. DAUNER. OK. Thank you.

Missouri is unique and one of the few States—we rank fifth in the Nation with the percentage of people past 65, and the fastest growing foreign age group in our State is the over-75 population group. The elderly people that you have heard from are good illustrations of the challenges facing us as we are trying to deliver health care services.

I have two parents and a grandmother that are well over 65, and have seen this from a personal experience. We have been brought, since the passage of Medicare, to a philosophy of more and more care for more people. We developed a social system which provided high quality, high option care.

You have heard from these people who have testified today that we are now in the up with economic pressures that are forcing all of us to reevaluate how we provide care and how we receive services that are needed. Hospitals find themselves in the middle, the position to evaluate the patient before the admission and at the discharge. The patient has a perception of care needed and is experiencing pain and suffering, and we try to provide the services ordered by the physician. We also now are under an incentive oriented payment system which limits the amount on a per case basis by DRG.

If I could spend a moment about the PRO as Congressman Skelton has indicated that he would like to have some discussion about our PRO. The previous speaker referred to the 10 percent arbitrary reduction in admission. We believe that there was no scientific basis for that. The PRO's original application did not contain such a number. It was negotiated and insisted upon by the HCFA in Baltimore.

Mr. SKELTON. Now, HCFA, meaning the agency of the HHS; is that correct?

Mr. DAUNER. That's correct, the Health Care Financing Administration.

It has been treated as a quota, however, HCFA officials would say that it's really a target. According to the PRO's contract, which you will hear about later, that is spelled out as a requirement, as an objective, and unless there is some revision, would certainly be a measure by which the progress of the PRO is treated.

Denials have been a problem, you've heard about those, reconsiderations and appeals are lengthy and most of the time they are rejected. The waiver of liability affects hospitals, originally it was 2.5 percent of the number of admissions reviewed or three cases, whichever is the least. Missouri's rural hospitals have a particular problem here because well over half of their patients and nearly three-fourths of their patient days are rendered to Medicare beneficiaries and two cases or in some instances one case can throw them into intensified review. We were able to get that clarified. It is now 2.5 percent or three cases, but again, it's highly restrictive on a rural community institution, whose primary patients census is the elderly.

Copies of record are expensive and becoming more expensive as PRO's on the PRO increased. They were unable to make many of these reviews onsite, therefore, making demands on the hospitals to send copies in to a centralized office.

Records have been recoded for payment purposes. The physicians believe that those codings are contrary to the condition of the patient in the hospital. It affects our payment for Medicare. Normally the recodings are such that the DRG number produces a lesser payment to the hospital than would otherwise have been the case had the coding been kept, that was put in by medical records based on what the physician had indicated on the medical record.

At the national level, HCFA has not provided for the process when issuing the PRO regulations.

It has placed great pressure on the PRO of Missouri, as well as hospitals and physicians that are trying to operate under it because we don't know what the rules are. In many instances they were issued through transmittals without interim or final rules, before the regional office did and, again, placed everybody in a state of confusion.

Many older people just don't understand what's happening. In fact, I'm not sure that younger people sometimes understand. We do know this, as we change the focus and the incentives, from care as we traditionally knew it, to incentive oriented payment and competing medical systems, we will find more and more pressure to reduce the number of admissions, reduce cases, reduce the length of stay, find alternative services to provide out of the inpatient setting.

Now, some of that certainly is constructive and we all support a more cost-effective system. But if we get so hung up on the cost that we ignore dignity and respect for people, we are doing a great disservice to this country and undermining some values which are strong, on which the country has grown.

I believe that we have a good relationship in Missouri among the PRO, the regional office of HCFA that administers the PRO Program, hospitals and patients. But there are pressures, and those

pressures are going to intensify as the payment pressures are continued to be asserted in greater and greater force.

We would recommend that the Congress engage in comprehensive oversight hearings of the PRO Program and the impact on people and on hospitals to ensure that the congressional intent is met, that people are cared for when they need it, and that payments made to hospitals are fair, equitable and adequate to cover the care that's being demanded.

The availability of alternate, services in rural communities was mentioned. In 1981, Congress passed the swing bed legislation. Thirty-nine Missouri hospitals can qualify for swing bed participation and thus far, 36 have been certified. The average length of stay is less than 15 days in those units and they do provide the needed level of interim recuperative care for older people, that under the Medicare Program, before they can go to the nursing home or back their own home setting.

With respect to the prospective pricing system of Medicare, the Missouri hospitals support market placed incentives. We believe that we can improve the effectiveness of the system and, in fact, if you look at the experience in Missouri in the past 2 years there has been phenomenal progress in Missouri hospitals.

But we believe that we will reach a point at which you can no longer provide more for less, and when we reach that point, quality will suffer or rationing of services will occur. In the minds of the patients at this point, we know some already believe that rationing is occurring and patients are being discharged prematurely.

The national urban and rural rate system that's currently in law is flawed. It penalizes rural hospitals and certain other urban hospitals. The area wage index with which both of you are intimately familiar has not been corrected and we understand that HCFA is going to prospectively build that into the DRG prices on October 1, 1985. That is contrary to existing law which you've enacted.

The current payment system as it is handled by HCFA does not reflect the changes in intensity within a given DRG and among the regional referral centers have been approved, none of them qualify in Missouri.

We believe that changes in these areas must be made.

Congressman Skelton, we applaude your leadership in introducing H.R. 1682, the bill you referred to. It provides that Medicare would eliminate the rural urban difference, would pay hospitals on the basis of a coefficient of variation that does recognize intensity of services. It's based on a price blending mechanism that is more reflective of the care actually provided to Medicare beneficiaries and hospitals and we certainly stand ready to help you with the enactment of that much needed legislation.

The previous speaker mentioned the fiscal year 1986 budget. We concur that a flat freeze on physician fees or hospitals or just arbitrarily transferring costs to the beneficiary are not constructive. They are regressive ways of trying to control Federal deficits.

We sincerely appreciate your interest and stand ready to help you in working toward this. Thank you.

[The prepared statement of Mr. Dauner follows:]

PREPARED STATEMENT OF C. DUANE DAUNER, PRESIDENT, MISSOURI HOSPITAL ASSOCIATION, JEFFERSON CITY, MO

Mr. Chairman, members of the committee, I am C. Duane Dauner, president of the Missouri Hospital Association. I am pleased to offer testimony today on behalf of the hospitals in Missouri.

Since 1965, federal health programs have had a significant impact on hospitals and Medicare beneficiaries. However, the federal changes since 1982 are having a much more profound effect and are altering the basic fabric of our health care delivery system. Peer review organizations (PROs) and a Medicare diagnosis-related group (DRG) prospective payment system (PPS) launched a new era—payment incentives for hospitals are reversed from previous policy and clamps to control utilization are in place. The opening Medicare payments to health maintenance organizations (HMOs) and other competitive medical plans (CMPs) also will alter the historic practice of fee-for-service care.

The Medicare beneficiaries in Missouri are fortunate in many respects. We have excellent hospital facilities and the number of physicians is increasing. Hospital prices in Missouri are at the national average and a strong network of primary, secondary and tertiary hospitals exists. Nevertheless, a health care system driven by economic pressures will cause untoward consequences for our aging population.

Cost containment is becoming an obsession in some circles. An attendant view is that more care can be provided at less cost. Even though hospitals and physicians are making dramatic changes in the ways they deliver services, cost effectiveness and low option health care do not change the fact that there are more aged people, placing greater demands on the health care system.

Missouri is fifth in the country in the proportion of its population age 65 and over, and the elderly are the most rapidly growing segment of our population. Moreover, the proportion of Missouri's population age 75 and over is 6 percent higher than the national average. The need for health care services increases throughout the 65-and-over population, with those 85 and over twice as likely as those 65–74 to be hospitalized.

PEER REVIEW ORGANIZATIONS

In 1972, Congress enacted the professional standards review organizations (PSRO) program. Its purpose was to monitor utilization of hospital services for Medicare beneficiaries. That program was replaced in 1982 with the passage of a law to establish peer review organizations (PROs).

Missouri is among the highest States in the country in the number and percentage of Medicare admissions to be reduced as a result of the PRO program. The contract between the Health Care Financing Administration (HCFA) and the Missouri Patient Care Review Foundation, the State's PRO, calls for a reduction of 73,511 Medicare admissions over the course of two years. A recent analysis by the American Hospital Association (AHA) of state PRO contracts places Missouri in the top five States in the percentage of Medicare admissions to be reduced over the two-year period of the first PRO contracts (copy attached).

One of the statistics cited by HCFA to support targetig Missouri for such a disproportionate impact is the fact Missouri's 1982 Medicare admission rate was 16 percent above the national average. Yet there are at least six other states whose 1982 Medicare admission rates surpassed that of Missouri but whose objectives are more moderate in the area of reduced admissions. Moreover, if the same comparison is made on the the basis of percentage increases in the absolute numbers of Medicare admissions for the period 1978–82, there are at least 23 states higher than Missouri whose targeted reductions are less stringent than Missouri.

This raises at least two questions: (1) Does the 10-percent per year reduction reflect a documented and identifiable level of medically unnecessary care to Missouri Medicare beneficiaries? (2) To what extent to these admission reduction objectives constitute targets or quotas?

Regarding the question of the level of medically unnecessary care in Missouri, the fact is that no one knows. An across-the-board 10-percent reduction in admissions of Missouri Medicare beneficiaries was not in the original proposal submitted by the PRO in response to the federal request for proposal (RFP). It was a negotiated figure reflected more, we believe, of HCFA's insistence on reducing admissions. The contract target was not based upon care as determined by the state review organization knowledgeable of the local situation. Moreover, the validation of the 10-percent reduction objective contained in HCFA document released last September on PRO contract summaries provides weak justification for that level of reduction. (The statement follows in full.)

"Based on discussions with physicians in the area and review practice patterns of physicians, the PRO determined that a significant number of admissions are medically unnecessary. For example, a study performed in St. Louis revealed a problem (15 percent) with unnecessary admissions for transurethral resection of the prostate. Given the national admission rate per 1,000 enrollees of 449.92, the PRO believes that there are other unnecessary admissions to reduce."

Much has been said whether the reduction objectives contained in the PRO contracts are quotas or targets. While HCFA has made public statements to the effect that the objectives are targets, we are concerned about the lack of explicit recognition in the contracts or in transmittals, directives or regulations regarding this policy. The PROs have every reason to expect, based on their experiences in negotiating these contracts, that they will be held to these objectives when evaluated for contract renewal. If they believe the contract requires what it says, PROs will be under pressure to ratchet admissions down to a predetermined number based on an unknown level of medically unnecessary care. This in turn results in pressures on physicians to avoid admitting patients when there is any uncertainty about whether the admission will be judged medically unnecessary or inappropriate (based on setting) by the PRO.

This raises another issue, "Are the best interests of our elderly population being served by this kind of system?" We think the answer is no. While Missouri's PRO has attempted to implement the program in a reasonable fashion, the organization's survival may be dependent on significantly reducing Medicare admissions. The PRO system should be structured to ensure that needed, high quality health care is provided to the elderly. While cost effectiveness is a mutual goal of providers, payers and government, the emphasis of PROs should be directed toward quality, appropriateness of services and setting, and utilization management rather than arbitrary reductions in patient services.

In passing the Peer Review Improvement Act as part of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA), Congress envisioned at that time a PRO program that would be streamlined, cost-effective, cost-efficient, make maximum use of limited dollars, be performance based and uniform yet tailored to local conditions. Instead, we feel HCFA has used the statutory authorization in TEFRA and in the subsequent 1983 amendments to the Social Security Act to create a rigid, highly prescriptive program that entails an unnecessarily high level of routine review. This approach represents an inefficient use of PRO personnel and additional unreimbursed expenses to hospitals under the Medicare prospective payment system (PPS).

One of the most efficient uses of PRO dollars would be to permit delegation of review to hospitals able to demonstrate an effective in-house utilization review program. Yet, despite lack of statutory prohibition against delegating review, HCFA made the decision—not Congress—that delegated review under PPS represented a conflict of interest. Now, we are experiencing a review of one in every three Medicare cases. Moreover, we can expect that rate of review to increase as additional hospitals come under intensified (usually 100 percent) review. Even a good performing hospital—one whose denial rate each quarter is less than 2.5 percent—can expect 20 percent or more of its records to be reviewed by the PRO because of the way HCFA has structured the program.

We feel a system should be structured that emphasizes focused review on identified problem areas; that allows good performing hospitals to escape a routinely high level of review; that permits delegated review to hospitals able to demonstrate effective utilization management; that provides for a gradient of intensified review, for example, from a 5-percent to 20-percent sample rather than a 100-percent review based on a denial rate that may be no more than 3 to 4 percent; that provides a more reasonable denial rate threshold; and that relies more heavily on physician education such as the work by Dr. John Wennberg on variations in medical practice.

We feel HCFA has made progress in a number of areas. The review function has been centralized at the state level resulting in more uniform application of policies, criteria and procedures among areas of the state; the program is performance based; recent HCFA transmittals reflect greater sensitivity to the concerns of PROs and hospitals, for example, in going from 100-percent to 50-percent review of outliers and in allowing more notice to hospitals regarding specific records to be pulled for a DRG validation site visit. The Region VII office of HCFA in Kansas City has been exemplary in its receptivity to hospital concerns and in timely response to us on questions affecting hospitals. Nevertheless, we feel the program as structured at the national level is considerably flawed in design and that more is needed than piecemeal policy modifications to assure the kind of effective and efficient program envisioned by Congress.

In its haste to implement the PRO program, HCFA took several shortcuts. One of the most significant was to ignore due process.

It has been nine months since the Missouri Patient Care Review Foundation became the State's PRO and the four sets of regulations implementing the program—those on confidentiality, reconsiderations and appeals, conduct of review and sanctions—still have not been released in final form. While we understand part of the difficulty in facilitating publication of these regulations relates to the Office of Management and Budget (OMB), HCFA has implemented the program in a way that circumvents the public comment process and has created unnecessary confusion and frustration among hospitals, PROs, fiscal intermediaries and HCFA's own regional offices.

It was nearly a year after TEFRA became law in October 1982 before HCFA published proposed rules on establishment of PRO areas and eligibility criteria for review organizations. From that point forward, HCFA has never maintained the public comment process in line with the implementation of the program. Instead, major program and policy changes were made by HCFA via transmittals and policy directives to PROs and fiscal intermediaries. In February 1984, five months before any PRO contract was in effect, HCFA issued PSRO Transmittal No. 107 to PSROs. This directive, insulated from public comment or hospital and physician industry input, imposed many of the requirements of PROs before anyone knew exactly what PROs were going to be doing. This action occurred in the presence of a then underfunded PSRO program. The lack of any provision by HCFA for planning and implementation of the new requirements left many hospitals—as it did PSROs—confused and often "holding the bag." Suddenly, hospitals were subjected to a 2.5-percent denial rate threshold, to DRG validation on short notice from the PSRO and for the cost of copying additional medical records. Compounding the difficulty at that time was the fact there were five PSROs making different interpretations in different areas of the state with no means for centralizing and making uniform the review process.

None of the four sets of proposed rules implementing the program was published for comment prior to the issuance of RFPs for PRO contracts, and all had 30, not the usual 60-day comment period. Two sets were published in April 1984; the other two were released in July 1984. Promises from HCFA that the final rules would be released prior to November 15, 1984, the statutory deadline for hospitals to have agreements with PROs governing the conduct of review, were not kept. Nevertheless, hospitals were asked to sign a memorandum of understanding (MOU) with PROs without full knowledge of the final rules of the game. And the failure to publish final rules persists today even though HCFA issued earlier this month a 63-page interim manual instruction that specifies how PROs are to conduct review. This manual is essentially an enhancement of its predecessor, PSRO Transmittal No. 107, published prior to the proposed rules on conduct of review. The process HCFA employed violates the Administrative Procedures Act, and the American Hospital Association has filed suit to challenge HCFA's lack of compliance with federal law.

The failure by HCFA to implement the program in an orderly and publicly accountable fashion has at times produced continuous communication and coordination problems. When HCFA released the proposed rule in the February 12, 1985, Federal Register to change the waiver of liability rules, it neglected to notify its regional offices in advance. A Hospital Manual transmittal (HIM-10) issued a year ago made clear that the denial threshold for loss of a hospital's favorable waiver was 2.5 percent or three cases, whichever is greater. But a copy of the transmittal had never been sent to the Missiouri PRO. Based on information the PRO had received from HCFA, it was using a straight 2.5 percent which disproportionately impacted small and rural hospitals. The PRO subsequently cleared up the situation and restored hospital waivers that had been rebutted where appropriate, but the confusion resulted in additional unnecessary work on the part of the PRO and hospitals.

In January of this year, HCFA sent a letter to all HCFA regional offices indicating that PPS and non-PPS hospitals may now issue letters of noncoverage to patients on a preadmission basis. Previously, only PPS hospitals could issue letters of noncoverage on a concurrent basis. The policy directive from HCFA was effective immediately. However, it is not clear how PROs are to monitor these letters of noncoverage, and the Missouri PRO has raised several significant questions regarding implementation of the new policy which are as yet unanswered by HCFA. Because the PRO is not comfortable advising hospitals how to comply with the new policy, hospitals are in effect being discouraged from using it, knowing their actions will be subject to retrospective review under yet undefined parameters.

The confusion resulting from this kind of system is an unfair burden on hospitals as well as on the PRO and the regional offices. Ironically, these examples exist in a state characterized by a high level of good will and cooperation among the hospital association, PRO and HCFA regional office.

We believe that the PRO, HCFA regional office and hospitals have performed well under adverse conditions. Every effort is being made to keep communications open and provide high quality, medically necessary care to Medicare beneficiaries. Most of the problems we have encountered in Missouri can be traced to the HCFA offices in Washington. We recommend that Congress conduct oversight hearings to ensure that the program is brought into line with Congressional intent.

PROSPECTIVE PAYMENT SYSTEM (PPS)

When TEFRA was enacted in 1982, Congress established a case payment system for Medicare, reversing the traditional per-day payment system of Title XVIII. Then in 1983, further revisions were made with the passage of the Medicare diagnosis-related group (DRG) prospective payment system.

Hospitals are in the midst of phasing in the PPS program. By October 1, 1986, Medicare will be paying hospitals according to national and urban rates by DRG. There is little doubt that HMOs, PPOs, Medicare PPS, Medicaid initiatives and other competitive medical plans are revolutionizing the health care delivery system. As these forces produce a marketplace environment, health care will move from a seller's to a buyer's market. The result will be a more price-sensitive system, affecting patients, third-party payers and providers.

Financing and payment systems will determine the quantity and quality of care delivered, as well as the methods of delivery. It is possible to improve the system by these forces; however, negative results are inevitable if economics play a disproportionate role in health policy.

The problems facing hospitals in Missouri are unique in several respects. More than 13 percent of Missourians are past age 65, compared to the national average of approximately 11 percent. Between 1970 and 1980, Missouri's over-65 population grew 15.6 percent versus 5.1 percent growth for the total population.

Population projections show that the fastest growing age group in the state are persons between 80 and 84. This group will have increased by an additional 15 percent between 1980 and 1985, and is expected to increase 43 percent between 1980 and 1995, at which time Missouri's 65-and-older citizens will account for 15 percent of the state's population.

Hospital admission rates per 1,000 population and per capita health care costs are substantially higher for the over-65 population. Per capita expenditures for this age group are approximately $3,336 as compared to $837 for the 45-to-64 age group. Further, the rate of hospitalization for persons past age 85 is double that of people between age 65 and 74.

Treating the elderly is a complex undertaking. As people age, multiple health problems become chronic. Their longer life expectancy, which is the direct result of medical advances, creates demand for more and more health care. When Medicare was enacted in 1965, the average life expectancy for an adult was 68; now it is 75. As life expectancy lengthens and as more people enter the over-65 age category, the Medicare "universe" increases at compounding rates.

How we care for our elderly population must be addressed. In the Spring 1984 issue of the Health Care Financing Administration's (HCFA) "Health Care Financing Review," HCFA reported, "Fully 28 percent of Medicare reimbursements were for enrollees in their last year of life." The report further states that ". . . a high proportion (46 percent) of costs in the last year of life are spent in the last 60 days."

Clearly, we cannot abandon our elderly; on the other hand, we cannot afford to ignore the amount and kind of resources which are consumed at the end of life. The interrelationships of ethical, medical, religious and societal issues must be weighed against the economic resources the nation is willing to devote to health care under Medicare.

Medicare represents 48 percent of an average Missouri hospital's patient days. In many rural hospitals, however, Medicare patients account for 75 percent or more of the patient days. Consequently, Medicare's portion of total patient revenues is significant. The impact of any third-party payer that represents such a high proportion of a hospital's patient mix cannot be ignored.

Missouri hospitals support marketplace health care and the principles underlying prospective pricing systems. While Missouri hospitals support the use of marketplace health plans, we measure payments from such plans by the standards we

apply to all payment systems. When we put the Medicare prospective hospital payment system against these standards, it falls short.

Medicare PPS had several crucial flaws at the time of its adoption, and they have not been corrected.

The closer PPS moves to national urban and rural rates, the farther it gets from realities under which the hospitals operate. Some institutional differences are not considered, including capital commitments, energy costs, malpractice insurance variations, local market conditions, severity of cases treated and service differences among hospitals.

The prospective payment system ignores intensity of services and severity of conditions within DRG classifications. This inequity must be corrected if certain hospitals are to survive. Studies by the Department of Health and Human Services (HHS) and the American Hospital Association (AHA) verify that intensity and severity are higher in hospitals that treat large numbers of indigent patients.

We believe that is possible for the Medicare PPS to provide incentives for hospitals to manage efficiently and still be institution-specific. One solution may be "price blending." The American Hospital Association has developed a system which allows for institution-specific differences when the variance with national prices per case is significant. Missouri hospitals support such a modification to the Medicare prospective payment system. Congressman Ike Skelton introduced H.R. 1682 on March 21, 1985, to establish a price-blending system that will minimize distortion in the payment system. We support the enactment of this important legislation.

We raise for your consideration two remaining areas of concern for rural hospitals under Medicare PPS:

Restrictive and unrealistic requirements for rural regional referral centers have precluded all large rural referral hospitals in Missouri from qualifying. The definition of a regional referral center must be practical and reasonable; otherwise, rural referral hospitals will be severely penalized.

Use of an inaccurate area wage index results in inequitable payments to rural and other Missouri hospitals. The Secretary of Health and Human Services has taken initial steps to correct this flaw but, to date, an equitable resolution has not been approved or implemented.

During the 99th Congress, you will have the opportunity to make a short-term choice that will affect the long-term status of elderly Missourians and the hospitals that serve them. The Reagan Administration's Fiscal Year 1986 Medicare budget proposal is particularly disturbing to Missouri hospitals. A "freeze" on hospital inpatient payments will not serve the best interests of Missouri's elderly. Already, in the last three fiscal years, hospitals have been the victims of $24.6 billion in Medicare cuts.

Three years ago, a Congressional budget authorization was made for Medicare prospective payments to hospitals and we urge Congress to adhere to its actions set in motion at that time. Reductions in the guise of a "freeze" would be arbitrary, and they would fall unfairly on Missouri hospitals that serve a growing elderly population. Hospitals simply cannot continue providing the quantity or quality of services currently available if such severe cuts are made.

In addition to these specific payment problems, rural communities and hospitals continue to experience difficulties in recruiting physicians. Physicans are reluctant to locate in rural areas for many reasons. While an excess of physicians is projected nationwide by 1990, we anticipate that many rural areas will continue to be medically underserved. Shortages exist in nursing and other professional categories of skilled personnel. For this reason, we urge Congress to maintain current levels of funding that provide for medical and nursing education.

It is our joint responsibility to be cost effective, but we must protect the values on which this nation is founded. Our aging population must be treated with respect and dignity. We cannot permit short-sighted solutions such as freezes or arbitrary rationing of services simply to meet targets of the Administration.

MHA appreciates your interest and efforts to improve the PRO and PPS programs. We look forward to working with you toward that end.

SELECTED STATES BY MEDICARE ADMISSIONS TO BE REDUCED VIA PRO CONTRACT AND BY RATIO OF STATE TO U.S. MEDICARE ADMISSIONS RATE FOR 1982 AND PERCENT CHANGE IN MEDICARE ADMISSION RATE 1978–82

	Total 2-year admission reduction	1 year equivalent as percent of 1982 admissions	Ratio State to U S admission rate	Percent increase admission 1978–82
State				
Missouri	73,511	11 3	1.16	17
Tennessee	108,405	18 1	1 28	27
Mississippi	41,622	12.9	1 27	18
North Dakota	10,703	11 4	1 36	15
Oklahoma	38,659	11 1	1.11	17
Maryland	31,623	10 0	0 91	36
Nebraska	17,533	8 3	1.21	17
Texas	114,787	8 3	1.19	20
Arkansas	27,646	8 2	1 24	17
South Dakota	7,199	7.8	1 20	15
Alabama	26,395	5 5	1.21	28
West Virginia	13,248	5 2	1.18	25
Nevada	3,727	5 3	1 05	40
Florida	71,455	5 0	1.01	27

Note—Figures are based on 1982 baseline data, PRO contract evaluated against 1983 baseline

Mr. SKELTON. Thank you very much. Mr. Tauke.

Mr. TAUKE. Thank you Mr. Chairman. You have given us a lot of material to cover. Let me ask a few questions to try to get into a couple of subject areas that have been raised. Dr. Voshall, is that the way you pronounce the name, Voshall?

Doctor, you indicated to us that there were some significant problems with the way in which you were being asked to make judgments about the medical needs of some of your patients. I wonder if you could tell us how the PRO and the Prospective Payment System have changed the way in which you practice medicine.

Dr. VOSHALL. Yes. I haven't changed my practice of medicine because I think that my medicine is based on the literature and when I write the appeals I try to quote the literature with the letters which I've included to approach the literature. The problem that I have is with the whole issue of their denials.

If a patient comes in with chest pain, how am I going to become more reluctant to admit that patient to the hospital when I don't have good documentation as to the cause and is that going to then lead me to make a mistake sending a patient home who subsequently comes back in dead for a similar situation.

Mr. TAUKE. Do you now have a system in Missouri where by if you have several patients denied during the course of a month that you get on a list where all of your patients are reviewed prospectively before admission to a hospital?

Dr. VOSHALL. Not that I know of

Mr. TAUKE. OK. So there's no, in Iowa we have a system where if two of our admissions are denied later on then the doctor goes on a list. You don't have that kind of a situation in Missouri. So if you admit patients that are later denied, there's no penalty for you?

Dr. VOSHALL. No, not for me. There is for the hospital because the three hospitals I've had have lost their waiver of liability which

apparently means they have to refund the money for that hospitalization. It's no longer paid for.

Mr. TAUKE. Do you get into a struggle with the hospital administrator then over the admission of your patients?

Dr. VOSHALL. You get a lot of pressure to either be absolutely sure as to what you're dealing with or to get the patient out without determining what's wrong. Now I think our position is that their denials are inappropriate. The utilization review committee reviewed that the PRA came in and reviewed 241 Medicare admissions. They rejected 11 of those admissions or 4.5 percent, which is about the acceptable rate. This was with 11 different physicians.

The utilization review committee poured over those charts and tried to as objectively as they could make a determination if in their opinions the physician used good medical judgment in admitting the patient to the hospital, by concentrating their efforts on the first 48 hours of admission. And they felt that 10 of those 11 denials were justifiable admissions. It's our feeling that PROs denying patients, denying needs to hospitalizations and to patients who do need to be hospitalized, whose symptoms do justify hospitalization and if we were to go along with their decisions I think we would be compromising the elderly population.

Mr. TAUKE. How does the PRO do the review in your State?

Dr. VOSHALL. They come in four or five months after the discharge and after Medicare has paid for the hospital bill.

Mr. TAUKE. Excuse me for interrupting. But when you say they come in, is it a team of physicians?

Dr. VOSHALL. No, it's usually medical chart reviewers.

Mr. TAUKE. Medical chart reviewers, what's their background?

Dr. VOSHALL. I think the one we had in our hospital was a nurse.

Mr. TAUKE. And there's one, a nurse, one person comes in and pulls the files?

Dr. VOSHALL. One person comes in and pulls the chart. At the Sand they had so many charts that they'd bring in three or four people. They then pulled, since all of the hospitals are in a 100-percent review now, again because they've lost their waiver of liability. They have to pull all the Medicare charts for the time period specified. These people then go through the charts and anything that falls out they take the chart, they xerox the chart, take it back to the PRO office where they have physician reviewers then look at the chart and make a determination as to whether they feel the patient needed to be in the hospital or not.

Mr. TAUKE. So the on site reviewer, who in your experience is a nurse, takes any questionable charts back to the home office, if you will, and there some physicians go over the charts and on the basis of that they make a judgment. And that's how the 11 were denied?

Dr. VOSHALL. Yes, sir.

Mr. TAUKE. If you would pursue the same standards that apparently the PRO is using in evaluating your patients what would happen to your liability insurance or would you be able to get any?

Dr. VOSHALL. I wouldn't be able to get any because, I suppose the best parallel would be appendectomies, everybody's familiar with appendectomies. In the medical literature you should perform 10 or 15 percent appendectomies with normal tendencies. You should operate on people because the risk of not operating is a perforated

appendix and has a higher morbidity and mortality. By PSRO standards, we would not operate on anybody who did not have an obviously inflamed appendix or obvious parafinitis because to operate on a normal appendix does not require medical care. You see the parallel there?

Mr. TAUKE. I guess I'm feeling that you're caught kind of between the rock and a hard place. If you provide the service, then you're in trouble with hospital administrator, the PRO, and the system. If you don't provide the service, the care, you're going to be dragged into court potentially.

Dr. VOSHALL. You have the potential to be dragged into court.

Mr. TAUKE. Liability problem.

Dr. VOSHALL. I tried to use examples of the two coronary cases, that were virtually identical in their presentation in the office prospectively. One admitted to the hospital, denied by the PRO, one refused hospitalization and died the next morning at home from cardiac arrest. If I were to send chest pains that PRO didn't feel were medically necessary home, I would think I would be in serious trouble.

Mr. TAUKE. I would think you would be, too. Mr. Thomas I appreciated very much your testimony. You indicated that there was considerable confusion among senior citizens, about the current payment system under Medicare. Where do you get information about the Medicare payment system?

Mr. THOMAS. This is something I don't quite understand where they get their rumor right, but it's pretty well rumored around Warsaw that if you go to the hospital and you're in there for several days and they don't run you out, then you have to pay it yourself. Now I have heard several who say they did. Now just an instance that I didn't mention for my wife. I brought her back from the nursing home, I brought her back about 10 days earlier, she was allowed 100 days in the nursing home. And she was getting where I was able to feed her, so I took her to the hospital for a week before, so the doctor there could be able to check her and know what to do before we took her home. This was 85 miles. They refused to pay for the $129 the ambulance charged to take her back to Clinton to the hospital, where they paid $170 to take her 12 miles to Kansas City. I finally, after three hearings I got the thing settled in February of this year. That was the 12th day of October of 1983 when they first heard of the problems.

Mr. TAUKE. I think you misunderstand my question a little bit. I understand that you're getting some information from rumors, but I want to know that if you hear something via the rumor mill, how do you know where to check it, or do you know where to check it out to see if it's true? Where do you go for reliable information?

Mr. THOMAS. That's the reason I went to the doctor this morning, cause I have a few topics. For instance, once when she was in the hospital right after this nurse told me that there would be a possibility they'd put her out within 2 weeks, Dr. Waller told me that the infection had cleared up and I recommended then, that was about 3 days before the 2 weeks were over, I recommended then he let me take her home, to take care of her.

I feel that I saved Medicare probably $10,000 or $20,000 by having her home because I took care of her myself. She had to be

turned every 2 hours, both night and day. So Dr. Waller told me then not to worry about it. He said she has had enough sick time that we're not going to put her out.

Mr. TAUKE. So you rely on your doctor for information. Suppose the Medicare payment is denied, do you think most of your friends and neighbors who are senior citizens would know that they have a right to appeal?

Mr. THOMAS. We have probably several national council senior citizen groups, and we've tried to stress this. Of course, in the last 18 months I haven't had a chance to be with anybody to, but I have told on several occasions when they mentioned that, that they did have the right to appeal. I find that Medicare, when you ask for an appeal. they will take care of it. And it says on your statement, they send you out this statement showing what they've paid. And it says on the bottom that if you have, you have a right to appeal this charge if you are not satisfied and it gives you a telephone number of where to call. But yet some of the senior citizens don't understand that. But I will say this, you've got to be pretty much on your toes if you get anything done when you do appeal.

Mr. TAUKE. Thank you, Mr. Thomas. Mr. Dauner, is that the way you pronounce your name?

Mr. DAUNER. Yes.

Mr. TAUKE. Thank you. This business about 10 percent reduction in admissions, both Mr. Spinabella and you, mentioned that the PRO had not just a goal but seemingly a mandate for 10 percent reduction in admissions. I don't think this is legal. What is going on here?

Mr. DAUNER. Well the officials from the PRO will be on and they can testify. We know this, that the pressure on the hospitals and the denial rates, appear to be tied to external pressure generated from the PRO, from their contract with HCVA that they have to show reduction in admissions. And many hospitals have appealed those and the appeals generally come back denied because of the pressure that's existing on the PRO's. I'm not necessarily blaming the PRO. I think that the original contract which calls for 10 percent reduction was not based on scientific fact and was an arbitrary figure that HCFA insisted be put into the contract.

Mr. TAUKE. So it's, to the best of your knowledge, it's in the contract that PRO has to reduce admissions 10 percent?

Mr. DAUNER. Yes, the contract calls for reduction in 10 percent over a 2-year period; yes sir.

Mr. TAUKE. We'll take that up with the next panel. What about hospital liability in all of these situations? I hear Dr. Voshall saying that hospital administrators are under the gun to hold down admissions and to get people out of the hospital as quickly as possible. I would assume that you would feel that you would have some serious potential liability problems by refusing to admit patients or by pressuring doctors to send the patient home. How do people handle this?

Mr. DAUNER. We operate our own insurance company through the hospital and so you could be assured that we feel that pressure from two points. One at the hospital level, and the fact that we operate the insurance company to protect hospitals from getting malpracticed. Hospitals receive the amount of payment for a given

DRG and once that amount is expended it is all lost for the institution, as you know. Therefore, the hospital has an incentive to encourage the physician to discharge the patient and they do. The physician is under similiar pressures because of the reviews that have been described earlier.

The combination of those may expose both physicians and hospitals to liability that previously was not present when these new incentives were not in force. I believe that there definitely will be an increase in exposure; the degree that results in actual litigation is unknown. You don't have enough experience. The potential is there.

Mr. TAUKE. You took my next question away. You don't know of any studies or anything on this question about—of additional cases being filed. One more question, I think we should get on the record, and maybe it's in your statement, what's happened to hospital admissions in Missouri over the last couple of years and what's happened to length of stays in hospitals in Missouri over the last several years.

Mr. DAUNER. In the last 3 years, the admissions have leveled off and have actually had a slight decrease, which is contrary to the experience since the passage of Medicare. Second, length of stay has gone down dramatically over the last 3 years; therefore patient days have dropped significantly.

Virtually no Missouri hospital staffs all of its licensed beds, because of occupancy having dropped to the lowest level since before Medicare was enacted. In 1984, the occupancy rate statewide dropped below 70 percent, and that has not occured since Medicare was passed in 1965.

Hospitals have reduced their number of employees in Missouri by more than 6,000 in the last 2 years. Hospitals are cutting back on their expenses, they are reducing the number of people employed, they are witholding expenditures for certain kinds of capital projects, in an attempt to live within the unit city payment system.

That is a way of life in hospitals today. I believe that there will be more changes in the health care system in the next 10 years than we've experienced in the last 50.

Medicare opened the door with the payment system, but the new incentive actually changed the fabric of which health care is financed, and therefore delivered. We just don't how it is going to shake out in the next 4 or 5 years. It is difficult for me to project even in 2 years, while I observe the changes that have ocurred just in 1984 and 1985.

Mr. TAUKE. Thank you, and to all of you, very much.

Mr. SKELTON. Thank you, Mr. Tauke. Mr. Dauner, you said a few moments ago that HCFA, that is the agency of the Federal Government that workd under HHS of the Federal Government, directed a target of a 10-percent reduction for the State of Missouri hospitalizations; is that correct?

Mr. DAUNER. Yes, sir.

Mr. SKELTON. I have in front of me a contract, page 19 of the 48 pages, admission objective No. 3. I'll read it. All objective targets are reductions from the actual admissions during calendar year 1983, as determined by HCFA. For evaluation purposes, the most

recent population change factor, as determined by HCFA, will be applied by HCFA to the baseline and target to adjust for changes in migration in the Medicare-eligible population. Reduce admissions statewide by 65,328. Is that what you are referring to?

Mr. DAUNER. Yes, sir.

Mr. SKELTON. Do you have personal knowledge as to how this came about?

Mr. DAUNER. I was not involved in those negotiations. The information I received was from people involved. I do know from reviewing a draft that it was not included originally in the proposal.

Mr. SKELTON. In other words, the Missouri physicians that run this didn't propose this; did they?

Mr. DAUNER. That's correct.

Mr. SKELTON. The Federal Government proposed this reduction of some 65,328; is that right?

Mr. DAUNER. Yes sir.

Mr. SKELTON. Mr. Thomas, you used in your testimony, the phrase "confused, that older people are confused and scared." I'm concerned about that. Do you think that most senior citizens understand the way Medicare pays for hospital care sir?

Mr. THOMAS. No, I don't. I think an awful lot of them, really don't go to the hospital or less ask to go to the hospital because of the fact they don't quite understand. We have a lot of people down there, especially widows, they're trying to get by on about $3,600 a year cause many of them don't have very much more than $300 a month under Social Security. A lot of those people are confused about it. Now this one lady who I said had her husband in the hospital, she told me that the hospital where her husband was at told her that she would have to have him out in 2 weeks. He also had an infection and he was an invalid in his legs. But I have a nerve in my left hand that's tied, and I've begun to lose the use of my hand. I was going in there to have that taken out. I had the same thing happen in 1977 to my right hand. I wanted to go in as an outpatient. Dr. Whitter said he wouldn't let me, he said I had to stay over night because there could be complications. This was all set up when they called out and told the doctor that I couldn't stay over night, I'd have to be an outpatient, have to come in and get it done and go back home. So some of the things that are changing this sort, I don't quite undertand. This is one of the things that has a lot of the people confused.

I know of several who have gone in as they're diabetics, and they've had to go back in to get their sugar down. I've known very, very few of them to stay in 2 weeks before they're put out of the hospital or taken out of the hospital. As soon as we can get our meetings back together again, I'm going to try to get someone down there to explain and see if we can't get the senior citizens in and talk to them about this thing. Because I know a lot of people would probably have better care if they knew what they were talking about.

Mr. SKELTON. Thank you.

Mr. Dauner, take two comparable cases, one a 4 year old, pick a simple illness, and someone who's 75 years old. The 4 year old, it might be that what ever the symptom maybe, may be treated by the physician as an outpatient care, but the 75 year old, the doctor

feels that person should receive hospitalization because of the person's age and the possible complications. Does this pose a problem for the doctors and for the hospitals to receive payment under Medicare?

Mr. DAUNER. Well if the patient was admitted by a physician and was determined that that admission was medically necessary, the Medicare DRG payment would be made. But, as it's been pointed out, the physician has to look at that very carefully because of the second guessing that takes place on medical necessity questions, more appropriate to say of the delivery of that care.

The answer to your question is yes. It does create a new awareness. Now why is that consciousness and price sensitivity is valid with quality care and assessibility, then I think we end up with a better system. But when economics play too great a role and we ignore those other factors, then I believe that we're doing a disservice to this country.

Mr. SKELTON. Thank you very much. We appreciate, ladies and gentlemen, your being with us.

We'll now go to our next panel. Thank you again.

Mr. SKELTON. Our second panel consists of Dr. Jerry Theis, Dr. Mohammed Akhter, and Mr. Gene Hyde. The first two witnesses being with the Missouri Patient Care Review Foundation, which is the PRO for the State of Missouri. Mr. Hyde is the Regional Administrator of the U.S. Health Care Financing Administration. Dr. Theis.

PANEL TWO—THE FEDERAL AND STATE RESPONSE: CONSISTING OF DR. JERRY THEIS, MISSOURI PATIENT CARE REVIEW FOUNDATION: DR. MOHAMMED N. AKHTER, MISSOURI PATIENT CARE REVIEW FOUNDATION; AND GENE HYDE. REGIONAL ADMINISTRATOR, REGION VII, U.S. HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DR. JERRY THEIS

Dr. THEIS. Congressman Skelton and Congressman Tauke, it's a great pleasure to be able to testify before this committee.

I am the chairman of the board of directors of the Missouri Patient Care Review Foundation which is PRO for Missouri, or the PRO. I am also the chairman of the board of directors of the Northwest Missouri Health Care Review Organization which is subcontractor for the PRO for the northwestern part of Missouri. I am a family physician. I live in Oceola, which is a town of 900 people in the foot hills of the Ozarks. I am a country doctor.

I can identify with both parties concerned in this situation in that my practice is comprised predominately of people over 65. The small hospital in which I practice has 47 beds and more than two-thirds of its admissions are Medicare admissions. The counties in which I practice are old-aged counties by ranking high nationally with percentage of old people or people over 65.

The PRO legislation and the DRG legislation or the method of PPS has placed hospitals and physicians in an adversarial position. There is pressure on the hospitals to get the patients out fast, who in turn have to put a pressure on the physicians to get the patient out fast. The physician is dedicated to good quality care. That says

nothing about how long it takes to accomplish that. I would like to express my thanks to Mr. Spinabella, the gentleman from AARP. As he said most of the things that I need to say to you. Indeed, the PRO has many attributes, especially in bringing about a method of review of quality care.

The foundation in Missouri is comprised of a board of directors, 14 members, who are all physicians, all practicing in the State of Missouri, of various specialities. They are appointed by the organized medicine in Missouri, Missouri State Medical Association in Missouri, and the Ostheopathic Association.

The organized medicine works closely with the foundation. We are dedicated to good quality of care. We have the onerous task also of enforcing the regulations directed towards us by the Health Care Financing Administration. It puts me in a particularly onerous position of having to chair a board whose job is to carry out these directives and at the same time administer them to patients who for the most part are in the Medicare age group.

Because several points have been brought up already, I'm going to skip over them and get to some rather specific points that I think might add more. For instance, a DRG, a Diagnosis Related Group, allows a certain amount money to be paid.

Mr. SKELTON. Excuse me. For those present, give us an example of a DRG. Some know what they are, but maybe the other folks don't.

Dr. THEIS. A DRG, which means Diagnosis Related Group, is a designated diagnosis, a number is applied to which, all diagnoses, of all possible illnesses, presumably, have been appointed. In other words, everything that can happen to you has a name and number. And that is called the DRG for that disease. There is a number for a micardioinfarction, there is a number for an inguinal hernia, a number for appendicitis, so forth. It is broken down even even farther, that there is a number for a direct inguinal hernia, and a recurrent inguinal hernia. So, a diagnosis related group is that number that designates that particular dsease.

Someone has figured the amount of money that it costs a hospital to care for that particular disease, and then an average cost for that is derived, and hospitals are told that is what they will receive in payment for that particular diagnosis.

If a patient is hospitalized with that particular diagnosis, obviously the hospital already knows what it is going to get paid for that. In order for them to maximize their profit, or minimize their expenses, a hospital is going to try and get that patient well and out as fast as possible. They are going to push the doctor to do that, as well.

In a big city hospital, where there is much less contact between hospital administration and the physician, the hospital administration can be rather cold and forceful, and has an amount of pull on the physician. In a rural hospital, the physician finds himself more sympathetic with the administration's point of view. I know that in my area, if I don't keep that hospital solvent, by decreasing their expenses, then there is a good chance that that hospital will go under. If we lose that hospital, not only is that a great loss to me, but it is a great loss to the community.

Numerous hospitals in Missouri are in that same situation. They are embarrased by this DRG reimbursement program. It does not take into consideration the fact that people in the age group that it is administering frequently have more than one illness. In fact, the rule is that people over 65 have more than one disease.

I'll cite you a for instance. I recently admitted a patient who has a pacemaker, she is 82 years old. Her pacemaker had ceased functioning properly, and she developed a cardiac abnormality in its rhythm, and she developed heart failure as a result. I hospitalized her for that problem, to correct her heart failure. I found that the heart failure, upon correction, was itself preciptating the abnormal rhythm, which in turn was following the pacemaker. So upon correction of that problem, we corrected the other problem. It looked fine, and it only took three days to do. The DRG for that particular illness allowed for *x* number of dollars, the amount of which is based on *x* number of hospital days that it takes to get that particular diagnosis well. So, it worked out that probably the hospital was going to make money on that problem. This lady was 82 years old. She had degenerative arthritis. She had obstructive lung disease, she's had CVA, and a stroke in the past. She suffered a stroke in the hospital, possibly because of the stress of her illness, possibly because a blood clot flipped out of this abnormally beating heart. In any case this was a common complication to an ordinary hospitalization, an ordinary disease. She suddenly had another reason for hospitalization. She'd been recovering from the stroke for about three days, she had difficulty swallowing, she aspirated food, and developed pneumonia. This third problem increased her hospitalization even longer During that period of time, her oxygen level was so low that her brain ceased functioning properly, she lost continence of her urine and a catheter had to be placed. Thus, prolonging her problem and intensifying her care level. The DRG would reimburse *x* number of dollars for the first diagnosis. A complicating diagnosis will add one hospital day expense to that. If you work it out mathematically, the DRG would allow for about six and a quarter days, the stroke would add one more day. It took the patient three weeks to get on her feet, to where she was well enough to be transferred——

Mr SKELTON. Let me interrupt if I may. Had she been discharged right before her stroke, then she had a stroke at home, you could have put her back in for how many days?

Dr. THEIS. For whatever the DRG allotment for that is.

Mr. SKELTON. For the stroke?

Dr. THEIS. Right.

Mr. SKELTON. But the fact that happened in a hospital penalized her, is that correct?

Dr. THEIS. Right. If indeed that had happened, that she'd been sent home and came back in one day, her case would have been reveiwed by the PRO as a questionable quality of care. That complication shouldn't have happened. I'd like to talk about a couple of other things.

The reimbursement for the rural hospital is not on a par with the city hospital. It is a ridiculous premise that it costs less, or care for the elderly is worth less, in Oceola than it is in Kansas City. I understand some attempts at correcting that situation are being

made, so I won't dwell on it, but obviously you can see the implications of it.

Mr. SKELTON. Congressman Tauke mentioned that we know about that one. We are trying to correct that.

Mr. TAUKE. For your information, the area wage index report has been released this afternoon. Now that means the report is out as to what should be done to correct the reimbursement to hospitals, particularly rural hospitals. The reimbursement change won't be made until October 1, 1985, unless we can get our friends at the Health Care Financing Administration to move more rapidly than they currently plan.

Dr. THEIS. While we're on that subject, another unanswerable question is why is the physician in Oceola, MO, reimbursed less for caring for the same elderly patient as the physician in Kansas City, and why is the physician in Kansas City reimbursed less than the physician in New York City? There is no answer, I won't ask.

Mr. SKELTON. Probably the same reason that hospitals are allowed less in rural America than they are in the big city.

Mr. TAUKE. We've talked before and I made the suggestion that if Medicare would reimburse physicians exactly the same amount for each illness, in other words, a DRG for each problem, then not only would your Medicare expenses decrease, but you would solve the physician shortage problem in the rural area.

Dr. THEIS. Two other things I'd like to touch on.

This board is dedicated to physician controlled peer reveiw. In other words, we feel very strongly that peer reveiw should be done by peers, and peers means other physicians in our same area and in the same specialty. We bend over backward to see that that is done. We have numerous consultants on our staffs who are part-time staff members who are used as referring physicians, as consulting physicians. A genuine attempt is made that each case review is made not only by a physician, but by a physician in that same specialty, especially by a physician in that same area.

We feel there has been very little professional or physician input into this program at the Federal level. Here we find ourselves involved in a program that apparently had very little physician input at the beginning, and there is no professional contact with it under way. In fact, we find ourselves playing in a game for which we haven't even seen the rules and regulations yet. But I'll let Dr. Akhter touch on that a little bit more.

I'd like to see something done about medical liability. Just briefly, because it has been touched on before, it is a great problem. The physician is pushed to discharge patients early. Tremendous pressure can be brought on him. I don't feel the liability as much in the country as the doctor in the city. Apparently the tendency to sue physicians is greater in urban areas than it is in rural. I suppose that is because of our close contact with the patient. Nonetheless, it puts them at a tremendous disadvantage and at a tremendous risk, and I think that the Federal Government needs to address that problem of medical liablity that has been increased by these laws and regulations.

STATEMENT OF DR. MOHAMMED N. AKHTER

Dr. AKHTER. Thank you, Mr. Chairman, Congressman Tauke. It is a great pleasure to be here to present to you the problem. I especially appreciate your taking the time to come down here and be present at this hearing.

The problems that I am going to speak to you about the PRO's are: No. 1, my own perspective here in Missouri and, No. 2, that I'm also the chairman of the medical directors for all of the PRO's in the United States.

And so I have considerable information, and if I start telling you the whole story, it would not accomplish anything, so my information is going to be something like an aggregate information from other areas, and particularly from this State, my own personal experience.

Also let me make one other observation about myself. Prior to getting into this, I was the director of health for the State of Missouri, for a couple of years before I got into this business. So I know the State, I know the physicians, and I know the need of the rural population for accessability and availability of services.

From those prospectives let me start with the fundamental thing that we have here in Missouri and for the PRO's in general. When the Congress passed this law, the intent was to reduce the cost of care, to monitor the DRG Implementation Program, and to see that the quality of care is maintained.

But we have a basic problem with the way this program has been implemented. It's been absolutely a prescriptive type of deal, where we were told what to do, right from the start when we start negotiating the contract. Since that time, as Mr. Dauner pointed out and others have pointed out, there was no open communication and participation in the rules- and regulations-making process and the rules and regulations were never issued, in fact, under which we play this game.

To complicate the picture more, it's not only the public comment, but there has not been adequate medical input in the development of those directives under which we operate right now. The program is off and running, in every State, but where is the medical input? Who are the physicians in HCFA who write those things?

All the panel that was just here with comments, I agree with those things. Those are the real problems. They are presenting you the real live stories, and the reasons behind those is that there was no medical input when some of these were put together and then they were handed over to us in the form of a letter that arrived directly to us without even saying——

Mr. SKELETON. What you are saying is some omnipotent someone who is not a physician, in the great city of Washington, drew up some rules and regulations for you to live by; is that what you're saying?

Dr. AKHTER. Oh, I wish there were rules and regulations on which there was some public comments. There was not even that. It was just a directive, a piece of paper that said "you will do this, effective immediately," on the sheet of this piece of paper, and that's the way this program was run. Now we have great cooperation from the regional office, our good friends here, Gene Hyde,

Greg Leer. These people have cooperated with us tremendously, but our hands are tied in the way we proceed with this process.

So, gentlemen, if I could emphasize to you one point, and that is that the public input, especially the physician input, in the development of these directives and these rules and regulations has not been there. I would urge you to take it back and present it to Margaret Heckler, the Secretary, to make sure there is adequate medical input present when these rules and regulations are developed or are modified. Let me proceed with the real life problem.

As a physician myself, and being concerned with the quality of care, and the citizens of this State, who I consider that I'm in this job to serve, we have not only the responsibility to see that the Medicare dollars are spent appropriately, but also to see that the care is delivered and is of a quality that our senior citizens deserve.

The No. 1 problem in this State is the denial of admission to a patient who lives far away and who needs a diagnosic test. If you live in Kansas City or St. Louis, you could go down and get on a bus and come back home. But if you live 60, 70 miles away from the hospital and you need to have a diagnosic test done, you live alone, you are poor, there is no transportation available, you have only two choices. Either not to get help at all, not to get medical care at all, or go down there and your doctor has to put you in the hospital.

Some of our rural physicians in this State have been spending 20 to 30 percent of their time making arrangements with their Uncle Charlie, where this patient will stay overnight, so that he can get diagnosic tests done. Because rural hospitals are already in financial difficulty; they can't afford to have another denial if they put this patient in.

Gentlemen, here we are, physicians caught in the middle, and the PRO caught under the directive that says only medical necessity. There is a social need and medical need and sometimes it becomes very difficult to draw a clean line. It is very difficult. We want to maintain the quality of care for our patients. Therefore, I have written a letter to Congressman Skelton and the other Missouri delegates, asking that we look into the possibity of HCFA paying somewhere between $25 and $30 for the one night motel stay for these people whose cases we are denying, so they could at least stay overnight with diginty, and get the test done next day. If they need to go into the hospital, get admitted, get the care. If they don't need to have the test done, then they could go back home. That's the No. 1 problem in terms of quality care. That's where most of our denials are made in the State. We are denying about 3 percent of these cases. For every case that we deny, we have an appeal mechanism, where the appeal is provided by another physician.

No. 2 problem here in this State for our patients is that HCFA requires that every time we deny a case, we send a letter out to the beneficiary with patient identifying information. The physician information is on this and we say, "your admission was unnecessary." It creates a confusion that the gentleman sitting here in my place was talking about.

They don't understand what is going on, why it's being denied. They scare the hell out of doctors, my colleagues, because this

could be used by a sharp attorney to file a lawsuit claiming that this was not necessary.

Actually, the cases that we are denying involve good practicing physicians. They are better practicing physicians, as a matter of fact. They want to take care of their patients the best they can. It doesn't effect their way of reimbursement, but they want their patients in. The only problem is that they did not follow the HCFA guideline of absolute medical necessity of putting these patients in.

I think this is another example where we are unnecessarily burdening these older people by sending these letters out, as we are required by HCFA regulation, to do, informing them that the care was denied.

It also creates a problem with the confidentiality, and everybody is concerned about that, frankly by the lawsuits and the malpractice insurance and everything else.

The third item that I would like to present to you today deals with malpractice insurance, a very interesting subject when you start to look at Medicare patients. Gentlemen, when we go through and we look at the care delivered to Medicare patients, some of it is absolutely essential. But some of it is borderline, it's called defensive medicine. Somewhere between 15 to 25 percent of the money is spent practicing defensive medicine so that the doctor shouldn't be sued. When a patient gets into the hospital, if we are truly concerned about the cost of health care, let's look at the ways how this could be handled.

Our board review of this situation, and again we wrote letters to Congressman Skelton, and we are going to submit it for the records, Medicare is a Federal program and we ask that you look, carefully, and provide the same kind of coverage that you provide for other medical programs within the Federal system, like Veterans' Administration. VA physicians have certain kind of coverage, like the military physicians, like the State provides its' physicians when they provide the services to the Medicare patient's.

I will give you an example of this. If a physician worked part time in his private practice and part time taking care of VA patients, he is covered under the VA system. If a physician practices part time seeing the private patients and part time seeing State patients, he is covered by State insurance or state coverage. It is much easier to find that kind of coverage, so people should not be forced into practicing defensive medicine and unnecessarily adding to the cost of care in the State.

There are several other problems that are here, but I'd just like to close as not to take too much of your time. The common concern expressed by most of the medical directors and PRO's in the United States, is that at some point in time, Congress really ought to take a look at this whole program. There are DRG's that are erroneously assigned, there are hospitals that are misassigned to different categories, and there are problems that need to be corrected at some point in time, to make sure that the intent of the Congress is followed by the bureaucracy.

Gentlemen, I thank you very much for this opportunity and would be very glad to answer any questions that you may have.

Mr. SKELTON. Thank you very much. Mr. Hyde.

STATEMENT OF GENE HYDE

Mr. HYDE. I'm Gene Hyde, Regional Administrator of the Health Care Financing Administration for region 7, which includes the States of Iowa, Kansas, Missouri, and Nebraska.

I'm pleased to be here today to discuss the activities of the Peer Review Organization Program and how it functions as an integral component in our plan to assure the appropriateness and quality of care provided under the new medicare hospital prospective payment system.

I have submitted a statement for the record and with your permission I would like to summarize that statement.

We share the interest of this subcommittee in assuring that only high quality care continues to be delivered in this country and that payments for such care are appropriate.

Our early experiences with PRO's such as the Missouri Patients Care Review Foundation indicates that they will be effective mechanisms that will enable us to achieve our objective of insuring high quality care under the prospective payment system.

As you know the Social Security amendents of 1983 changed the method of payment for Medicare inpatient hospital services from a cost-based retrospective reimbursement system to a prospective payment system based on diagnosis related groups. This new payment system dramatically changed provider incentives from what they were under retrospective cost based reimbursement and encourages efficient use of hospital days and resources.

Working in partnership with prospective payment is the Peer Review Organization. Programs in changing the incentive under which hospitals provide services, both the Congress and the administration we're aware that medical review had to change from its historical form under the Professional Standard Review Organization Program, which as you know focused primarily on the use of unnecessary days, extended lengths of stay, unnecessary services, and so forth.

That focus had to change to one where the focus is on admissions and quality of care. The PRO amendents and the Tax Equity and Fiscal Responsibility Act of 1982 set a firm foundation for this redirection.

PRO's are required to conduct reviews to determine the medical necessity, appropriateness, and quality of health care services provided to Medicare patients.

We believe that the PRO Program will not only redirect but will enhance peer review under Medicare. The intent of the new provisions in the 54 PRO contracts we have awarded is to direct review activities specifically toward those quality, costs, and utilization areas most likely to be affected by the prospective payment system.

Our conduct of the contract negotiations and the details of some of the contracts we have signed has caused some concern within the hospital community and elsewhere.

It has been suggested that we have been overly demanding and specific in the negotiations, that PRO's will impose quotas on admissions which will reduce access to care, and that our approach is overly regulatory and relies too heavily on denials to achieve its purposes. Let me address each of those concerns briefly.

First, we were indeed demanding in our negotiations. The PRO Program, with its emphasis on up front negotiations of objectives in body and a performance based contract, will allow us to evaluate how well PRO peer review works.

Mr. SKELTON. Let me interrupt you right now if I may.

Mr. HYDE. Yes, sir.

Mr. SKELTON. The admission objective No. 3. Are you familiar with that?

Mr. HYDE. Yes sir.

Mr. SKELTON. Part of that is to reduce admissions statewide 65,328. Now, where in the world did you get that figure and why did you do that? I understand the proposal made by the Missouri PRO group did not have that in there but that you insisted that that figure be in there; is that correct?

Mr. HYDE. I think that I would answer that by backing up first of all and saying——

Mr. SKELTON. Just answer my question first and then you can explain it. Did you insist that that figure be in there?

Mr. HYDE. Not to my knowledge. Now, may I explain first of all that we're talking only about——

Mr. SKELTON. Did you do the negotiating on this contract?

Mr. HYDE. No, I did not.

Mr. SKELTON. All right.

Mr. HYDE. But let me comment on objective No. 3 which is focused only on unnecessary admissions and not admissions overall.

There was an indication at the time of the negotiations of this contract that the Medicare admissions in the State of Missouri were high, I think ranked 11th in the country from the standpoint of admissions per 1,000 Medicare enrollees.

The PRO contracts are competitive procurements, requests for proposals were published, outlining exactly what it was that we were attempting to purchase. It had areas in there which indicated that we would expect in general terms that we would expect any proposer seeking to be a PRO to have at least three admission objectives with the details being left to those organizations that were proposing to be PRO's. We had areas in five quality areas that we expected that the proposer would offer at least one objective. The responses to those proposals were then evaluated and negotiated and it's my understanding that objective No. 3, which is over a 2-year period would require reductions of some 56,000, is simply based on the doubling of the number of Medicare admissions in 1983 and an assumption that at least 10 percent of the admissions were unnecessary. That then became the target, not a quota.

Mr. SKELTON. Let me follow this if I may.

In testimony before the full Aging committee last month in Washington, an HCFA official stated that all admission objectives focused only on unnecessary and inappropriate care, not on reductions in overall admissions. Now, in light of that, do you believe the admission of objective No. 3 is appropriate?

Mr. HYDE. Yes, I do, because again we are talking about only reductions on unnecessary admissions. I think that——

Mr. SKELTON. How do you know that some 65,328 admissions are improper?

Mr. HYDE. I think that there is an indication that that may be the case and again the number—maybe I didn't make it clear where it came from.

In 1983, I believe, and I have the number of Medicare admissions in the State of Missouri, in 1983 were 326,624.

As a baseline that was double for the 3-year period covered by the PRO contract. There has been an indication that, in some quarters, that maybe as high as 19 percent of the admissions are unnecessary throughout the country.

There is some indication in Missouri that the admission rate has been higher than it should have been on a national basis. For example, the national admission per thousand Medicare beneficiaries in 1982 was 383 per 1,000 Medicare enrollees. In Missouri it was 450 per 1,000 enrollees or 17½ percent higher.

Mr. SKELTON. I hate to belabor the point and interrupt your testimony like this, but I would like to follow through, if I may.

Are other States, do they have an admission objective comparable to this? Reducing admissions by x numbers?

Mr. HYDE. There are 12 other States including Missouri that have objectives that focus on overall reductions——

Mr. SKELTON. And that is a HCFA requirement, is that correct?

Mr. HYDE. A HCFA requirement? No, sir.

Mr. SKELTON. Then why is it there? You know these gentlemen are not going to ask it to be there.

Mr. HYDE. I'm not sure how to answer the question other than, if it were a HCFA requirement, I think it would be represented in 54 contracts and not just 12.

Mr. SKELTON. Yes; go ahead Mr. Tauke.

Mr. TAUKE. What happens if they only reduce admissions by 46,000?

Mr. HYDE. Well, again I should point out that the numbers in the contracts are targets and not quotas and I would not anticipate that any contracts would be canceled, or not renewed on the basis of failure to achieve one or more of the objectives.

I think we would have to look at a whole variety of things, including the performance overall of all the objectives and why, if there is failure to meet one of them, why that occurred, maybe the numbers are wrong.

I think we have made it also clear on a continuing basis that we're willing to renegotiate with the PRO's on the objectives that they have, at anytime that they feel that the data on which they base their initial objective is inaccurate, on the basis that they feel that there may be other areas of problems that they should be looking at that are over and above those, or in addition, or in lieu of, those that are in the current contracts.

So, I think it's clear that we have done everything we can do to make it known that we are willing to renegotiate these objectives, and that the numbers in these objectives are targets, not quotas, and that the failure to meet a specific target will not be cause for nonrenewal.

Mr. TAUKE. I thank the chairman for yielding.

Mr. SKELTON. Go right ahead, sir.

Mr. HYDE. I think that, by and large, the questioning just covered the rest of my testimony, but let me pick up in a couple of different points.

We required, and this goes back somewhat, we required the PRO's to set specific objectives. We believe this approach is inherent in the statute, in the statutory mandate, that rather than become involved in the day-to-day operation and management of the PRO that we have objectives, and that we hold them accountable for results, rather than taking a strict regularity approach where we are in effect trying to tell them how to do PRO review, which is what we were wanting to get away from in the first place by developing the concept of peer review.

As a practical matter, it's not possible to monitor progress against the objectives that do not have specific targets, even though we were specific in the contracts, as I did mention earlier. We do not intend to be rigid or inflexible, but we learned during the course of the contract that the objectives or the numbers should be modified.

Again, for the record, I will state that we are willing, always willing to renegotiate with the PRO's if we or they learn, for example, that they have overstated the nature of the particular problem, that they have identified a more pressing problem for review, or that the statistics used to develope the objectives in question were incorrect.

Again, I would have to say that the admission objectives in the PRO contracts represent each PRO's own estimate of the amount of impact it can have on unnecessary and inappropriate admissions in this area.

I think we have established the foundation for performance based contracts and published in the scope of work.

Again, I would say that we left to the PRO bidder the responsibility to specify what particular utilization and quality issues would be addressed locally. It is also the PRO's responsibility to propose the quantifiable performance objectives for addressing these issues.

Each PRO is obligated to conduct meaningful review and achieve significant impact on the quality of care furnished to Medicare beneficiaries in its area. We believe that the PRO's can meet this challenge and become an integral part of the total health care system.

Clearly, and I think we would all ascribe to this. There is much to learn as experience with prospective payment and medical review rose, and we expect that as our experience increases that there will be substanial improvement in both programs. I can assure you that the Health Care Financing Administration has set a high priority on developing and implementing effective medical review systems which will have a positive impact on both the quality and the cost of the care.

I thank you for the opportunity of being here today and I will try to answer any questions that you might have.

[The prepared statement of Mr. Hyde follows:]

PREPARED STATEMENT OF GENE HYDE, REGIONAL ADMINISTRATOR, REGION VII, HEALTH CARE FINANCING ADMINISTRATION

I am pleased to be here today to discuss the activities of the Peer Review Organization (PRO) program and how it functions as an integral component in our plan to assure the appropriateness and quality of care provided under the new hospital Prospective Payment System (PPS). The Health Care Financing Administration (HCFA) shares your interest in assuring that only high quality medical care continues to be delivered in this country and that payments for such care are appropriate. Our early experiences with PROs, such as the Missouri Patient Care Review Foundation (MPCRF), indicate that they are effective mechanisms that will enable us to continue our commitment toward this objective.

INITIATION OF PROSPECTIVE PAYMENT

As you know, the Social Security Amendments of 1983 (P.L. 98-21) changed the method of payment for Medicare inpatient hospital services from a cost-based, retrospective reimbursement system to a prospective payment system based on Diagnosis Related Groups (DRGs). This new payment system dramatically changed provider incentives from what they were under retrospective cost-based reimbursement, and encourages efficient use of hospital days and resources. Hospitals began phasing into PPS during the year beginning October 1, 1983, at the start of their respective cost-accounting periods. All hospitals, except those exempt from the system, were under PPS by September 30, 1984. Based on results from sixteen months of monitoring the system, we are confident that the goals of PPS are being achieved.

PRO PROGRAMS

Working in partnership with PPS is the new Peer Review Organization program. In changing the incentives under which hospitals provide services, both Congress and the Administration were aware that medical review had to change from its historical form under the Professional Standards Review Organization (PSRO) program which focused primarily on unnecessary days of care (that is, long lengths of stay) and unnecessary services, to one where the review focus is on admissions and quality of care. The PRO amendments in the Tax Equality and Fiscal Responsibility Act of 1982 (P.L. 97-248) set a firm foundation for this redirection.

As you know, the law requires PROs to be medical review organizations composed of a substantial number of actively practicing licensed physicians or organizations that have access to a sufficient number of physicians to assure adequate peer review. PROs are required to review the medical necessity, appropriateness and quality of health care services provided to Medicare patients.

The intent of the PRO provisions, our regulations and the 54 contracts we have awarded is to direct review activities specifically toward those quality, cost, and utilization areas most likely to be affected by the new PPS.

CONTRACT NEGOTIATIONS

Our conduct of contract negotiations with PROs, and the details of some of the contracts we have entered into, have caused some concern within the hospital community and elsewhere. It has been suggested that we have been overly demanding and specific in the negotiations; that PROs will impose "Quotas" on admissions which will reduce access to care; and that our approach is overly regulatory and relies too heavily on denials to achieve its purposes. Let me address each of these concerns briefly.

First, we have indeed been demanding in our negotiations. The PRO program—with its emphasis on "up-front" negotiation of objectives embodied in a performance contract—allows us to evaluate PRO performance in a precise manner, which was not the case with PSROs. In fact, we have been surprised at the ambitious objectives many of the bidders have proposed. Meeting the utilization and quality objectives in the PRO contracts will certainly require the PRO's best efforts. However, we and the PROs believe they are achievable.

The scope of work for the PRO contracts comprises generic areas relating to the review of admissions, utilization and quality of care. In this way, we set the foundation for performance-based contracts, but let the PRO bidders specify particular utilization and quality issues to be addressed locally. The PRO also proposed quantifiable performance objectives for addressing these issues.

We required PROs to set specific objectives. We believe this approach is inherent in the statutory mandate to hold PROs accountable against objectives, rather than become involved in day-to-day monitoring of PRO management. As a practical

matter, it is simply not possible to monitor progress against objectives that do not have specific milestones (E.G., one could not monitor a contract in which a PRO agreed to eliminate inappropriate admissions for cataract procedures that could be performed on an outpatient basis without having an idea "up front" of how many admissions are unnecessary).

Even though we are being specific in the contracts, we do not intend to be rigid or inflexible if we learn, during the course of the contract, that the objectives should be modified. We are always ready to renegotiate with the PROs if we or they learn, for example, that they have overstated the nature of a particular problem, that they have identified a more pressing problem for review, or that the statistics used to develop the objective in question are incorrect.

I also want to assure you that these specific objectives are not "Quotas." All admission objectives focus only on unnecessary and inappropriate care, not on reductions in overall admissions. PROs will deny no admissions that are necessary and appropriate based on local and regional standards of practice for the PRO area. The admissions objectives in the PRO contract represent each PRO's own estimate of the impact it expects to have on unnecessary and inappropriate admissions in its area. Certainly, HCFA has insisted that the PROs "stretch" themselves in developing these objectives, but the specific structure of the objectives and the numerical goals have been developed by the PROs.

QUALITY OBJECTIVES

The PROs must achieve significant improvement in the quality of patient care quality. At least one outcome-oriented quality objective, tailored to practice patterns in the local area, is required in each of the following areas:

Reduction of hospital readmissions resulting from substandard care provided during the prior admission. Denial of payment for the inappropriate care may result.

Assurance of the provision of medical services which, if not performed, would have "significant potential" for causing "serious patient complications";

Reduction of the risk of mortality associated with selected procedures and/or conditions requiring hospitalization;

Reduction of unnecessary surgery or other invasive procedures; and

Reduction of avoidable post-operative or other complications.

In Missouri, for example, the PRO is attempting to meet these objectives by reducing hospital readmissions resulting from medical mismanagement and premature discharge. They have also set specific numerical goals for reducing inappropriate use of antibiotics, avoidable deaths due to nosocomial infections and unnecessary gastrectomies.

ADMISSION OBJECTIVES

PROs must also have admission and procedure objectives which address:

Reduction of admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting or on an outpatient basis. An example is cataract surgery which may often be performed safely on an ambulatory or outpatient basis. We expect preadmission review in this area will result in a shift of a significant number of procedures to an outpatient setting.

Reduction of the number of inappropriate or unnecessary admissions or invasive procedures for specific diagnosis related groups.

Reduction of inappropriate or unnecessary admissions or invasive procedures by specific practitioners or in specific hospitals demonstrating aberrant utilization patterns.

Again using Missouri as an example, the PRO is attempting, for thirteen procedures, to reduce unnecessary admissions statewide by 10 percent for patients who had a hospital stay of two days or less and had a single procedure performed. The Missouri PRO has also set goals of a 15 percent reduction in the number of unnecessary admissions for non-radical hysterectomies on patients over 70 years of age and a 10 percent reduction statewide in admissions for unnecessary care.

In addition to admission and quality objectives, which are based on problems identified in a PRO area, the contract also require a number of activities designed for the prospective payment system including: Admission review, preadmission review, invasive diagnostic and therapeutic review (e.g., review of all cardiac pacemaker implantations), outliers review, DRG validation, and review of every hospital transfer.

Many knowledgeable people believe there is serious over utilization in hospital care today. At a recent National Academy of Sciences Seminar there was consider-

able discussion of the wide variations in the type and frequency of medical treatment with no apparent justification. One researcher observed that nationwide studies of Medicare have indicated that up to 19 percent of hospital admissions are unnecessary. We believe that physicians in the local medical community are best able to judge what practice variations may be problems within a particular community, how to approach those problems, and how much impact it is possible to achieve.

PROGRAM MONITORING AND EVALUATION

PROs will be evaluated using three retrospective measures which will identify the dollar savings achieved by meeting predetermined objectives in admission review, outlier review, and DRG validation. The PRO's ability to influence the overall admissions in its area will also be a significant factor in our evaluation. In this regard we will use the objective targets to compare actual PRO performance with that agreed upon in advance. We will also look at other activities of equal importance which have no direct monetary measure, (i.e., quality review, and fraud and abuse actions).

In Missouri, the PRO contract was awarded on August 1, 1984 to the Missouri Patient Care Foundation. As of January 1985, the Missouri PRO had completed review of over 41,000 admissions, which included random sampling of hospitals under intensified review, preadmission review and other required review cases. Overall, the Missouri PRO is reviewing approximately 26 percent of admissions, which is very close to HCFA's review estimates and expectations.

To date we have made two on-site monitoring visits to the Missouri PRO, which revealed that the hospital phase-in of PRO review has gone smoothly and that the Board and Staff are committed to the success of the PRO.

CONCLUSION

We believe that the vast majority of physicians and hospitals provide high quality and appropriate care. However, it is our responsibility to assure that this continues to be the case. In order to assure that necessary and appropriate care of high quality is provided, the Congress created a strong mechanism, the PRO program. The PRO program was further strengthened when the Prospective Payment System was enacted to assure continued appropriateness and quality of care. Each PRO is obligated to conduct meaningful review and achieve significant impact on care furnished to Medicare beneficiaries in its area. We believe that the PROs can meet this challenge and will become an integral part of the total health care system.

Clearly, there is much to learn as experience with prospective payment and medical review grows, and we expect the program to improve with time. But this I assure you: the Health Care Financing Administration has set a high priority on developing and implementing an effective medical review system which will examine both the cost and quality of care.

Thank you for the opportunity to appear here today and I will be happy to answer any questions you may have.

Mr. SKELTON. Thank you so much. Mr. Tauke.

Mr. TAUKE. Thank you very much Mr. Chairman.

Doctors, did either of you mention the 10-percent reduction of admissions in the PRO contract, that is an issue that came up in the first panel and obviously we discussed in Mr. Hyde's testimony.

Do you think the 10-percent reduction in admissions is a reasonable goal? Is it a problem for the PRO?

Dr. THEIS. Personally, I have never felt that the 10 percent is an absolute requirement. I have been told over and over by our local HCFA representative, Greg Leer, not that it's negotiable, but it is not a definite goal, but it's something that they would like to see. But that the failure or the success of a contract is not based entirely upon that.

On the other hand, that's the figure that goes to the newspaper and that's the figure that the doctors and the patients throughout the State hear, and that's the figure that they're always complaining to me about. So, it has caused us more political grief, if that's the way to say it.

Mr. SKELTON. Will the gentleman yield at this point? It very clearly says reduce admissions statewide by 65,328. It doesn't say attempt to reduce admissions by around 65,000. They give you down to the patient on this, that's what concerns me.

Dr. THEIS. Dr. Akhter was present at the negotiations and I'll let him tell a little more on it.

Dr. AKHTER. Thank you, Dr. Theis. Mr. Chairman, I was present on the day the negiotations took place, although I was not the employee of the PRO at that time, but in a different capacity.

The people during the negiotations were very adamant about putting the 10 percent in, and that's the way this got in the HCFA folks. There is no question it was at a later date after the cries from everybody else that we just can't stand this, that the position was then modified to say, well these are targets. From the prospect of Missouri, we have so far——

Mr. SKELTON. But there is no addendum to the contract. It still says reduce admissions statewide by 65,328.

Dr. AKHTER. That is truly correct. They could come in tomorrow and say you have not reduced admissions by 10 percent, therefore, this is the end of it.

Mr. SKELTON. So, they are telling you now, oh, we didn't really mean it. Is that correct?

Dr. AKHTER. That's correct. But so far in our State here the denial rate has been less than 3 percent, between 2.7 or 2.9 percent, because we do not impose quotas neither by hospitals, nor by regions, nor by anything else. We said, "Is the admission necessary?" If it is necessary, admit, if it is not necessary, you know the denial will be made.

Mr. TAUKE. So, the contract provision doesn't have anything to do with the way you conduct your work at the PRO?

Dr. AKHTER. During the past 6 months that's the way it has been. This is a physician-oriented group and no way that this group, and now two other members are both sitting here, Dr. Hart and Dr. Rawl, there is no way that this board of 14 physicians and myself would go along to say this is the quota and this is what we're going to fulfill. It's an open question of medical needs and necessity.

Mr TAUKE. Is that the way you pronounce it, Theis?

Dr. THEIS. Yes.

Mr. TAUKE. Dr. Theis, is that your perspective also that the target figure doesn't make any difference in the way the PRO is conducting its business?

Dr. THEIS. Blame it on political naivete, perhaps, but physicians are accustomed to dealing on a handshake basis, or a word-of-mouth basis. If we come to an agreement, it does not necessarily have to be written down. On the other hand, the people from HCFA have been straightforward with us, and helping us and guiding us in developing the program, and when they tell me that that is not a goal that has to be met, then I believe them when they say that.

Mr. TAUKE. Let me ask the question again. Does the presence of that figure, quota, whether it's a soft quota or a hard quota, does it make a difference in the way in which you conduct your business?

Dr. THEIS. No.

Mr. TAUKE. But you think it causes you political problems, why is that?

Dr. THEIS. It is an uncomfortable position as a physician, being the chairman of a board that has the job of peer review, in any case, because physicians tend to be rather rugged individualists, and have been trained in such a way that they are not only independant, but feel very self-sufficient. The idea that someone is going to come and tell them how they should practice is foreign to them. That's so that the entire peer review method is distastful to a large percentage of physicians just by their very nature. And my own, I don't differ from them. So, that is difficult enough, but add to it the idea that there's a quota of an arbitrary number of 10 percent and that makes it very difficult for them to swallow. We get a lot of complaints about that, a lot of discussion about that.

Mr. TAUKE. Thank you. Doctor, you indicated in the course of your testimony three objectives or three things that you think should be done and I appreciated that specific list. The overnight fee sounded like a kind of a good idea to me because I have run into that same problem quite frequently in my own congressional district, and the fact is that in many of the smaller communities there isn't much in the way of overnight accommodations, and I certainly identify with the malpractice insurance problem which has been present with us for some time.

I wasn't sure that I understood the second point you made about notification to the patient. I understand the problem but I wasn't sure what your recommendation was. Are you suggesting that we do away with the notification to the patient?

Dr. AKHTER. The patient in this particular instance is an innocent bystander and we are trying to reduce the cost of care and maintain the quality of care. It is between the PRO, the physician, and the hospital. Why doesn't this thing just stay within the medical community where we could wrestle it out and come to some sort of agreement? Why should I send a letter out to a patient telling him that his stay in the hospital was unnecessary? The patient gets all worked up, starts crying, calls somebody else, "What's going to happen to me? Are the police going to arrest me? Are they going to put me in jail, are they going to sell my house?" Then, 2 days later when we have a chance to talk to our doctor, we figure out that this was an inappropriate denial, we overturned that denial, and then we send another letter out to this patient saying we discussed this and we overturned the denial.

The patient gets worried about how his doctor is going to get paid, what's going to happen. I mean these elderly people don't understand all the intricacies, all the process that's involved in this. And they just get very upset when they get a letter like this. I personally don't see any need for any letter like this.

Mr. TAUKE. Do you think we just ought to eliminate this?

Dr. THEIS. I think we ought to eliminate this, and this is the consensus nationwide.

Mr. TAUKE. Now one other point that was made quite forcefully, I thought, by both of you, was this business of no input in the rules from the medical community. First of all, I wasn't aware of the fact, and maybe I'd been sleeping at the switch, but I wasn't aware of the fact that normal rulemaking procedure wasn't in effect

when they came to the guidelines for the PRO's. Has there been no normal rulemaking procedure for PRO's? Maybe, I should ask Mr. Hyde, what's the story here?

Mr. HYDE. Based on the knowledge that I have there are four pieces of regulations that have not been published, that would have been ideal to have had published a year ago, they still have not done so.

Mr. TAUKE. How do your counterparts get away with that? Do you have any explanation, maybe we should ask them, not you, that. How can they put out directives and not follow the normal rulemaking procedures?

Dr. THEIS. It's been very difficult to get the regulations cleared through the department and through the executive OMB, and yet we have the pressure of the statute to get on with implementation of the peer review program.

Mr. TAUKE. We can certainly identify with the difficulty in getting things cleared through the department.

Mr. SKELTON. They just aren't done.

Mr. TAUKE. As one of my colleagues from Kansas said yesterday, we're sick and tired of being sick and tired, and that's kind of the way it is with the waiting on some of the changes in the obvious flaws in the reimbursement formula for rural hospitals.

We know that there are some major problems in the area wage index and we've been hollering and screaming about that, Congressman Skelton, and I and many others for some time. We've mandated a change in the law, and a new report had to be out by September and that deadline came and went. The secretary said, "Well, it will be December 31." The New Year came and still no report; then she said that it would be the end of February. The end of February came and no report, then she said it will be 2 weeks, 2 weeks went by with no report.

Well, it has arrived today, but then they're saying, "Well now we're going to wait to implement it for awhile longer." Well anyway, I didn't mean to release my frustrations, but I can identify with that, but I guess it's rather disconcerting that the medical community would have so little input, and that the normal procedures would not be followed. I guess I would say to you, especially with your national position that I hope you will encourage others in the medical community to speak up, because we are trying to speak up in Congress and we need some help, frankly. We'll help you if you help us.

Mr. AKHTER. Appreciate it very much. Certainly that is what we are doing.

Mr. TAUKE. Thank you, Mr. Chairman.

Mr. SKELTON. Thank you. Mr. Hyde, you said that there were four somethings that should of been published, what four somethings should of been published?

Mr. HYDE. Four pieces of regulations.

Mr. SKELTON. Four pieces of regulations should have been published. What kind of four pieces of regulation should of been published?

Mr. HYDE. One was on confidentiality, one was on the area of review, sanctions, what happens when there are violations, and reconsideration.

Mr. SKELTON. Why were they not published?

Mr. HYDE. My colleague tells me that they were published with 30-day comment period but they have never been published in final form.

Mr. SKELTON. They have been published for comment, is that correct?

Mr. HYDE. For proposed rulemaking with a 30-day comment period some time ago, in April and July of last year, and not published yet in final form.

Mr. SKELTON. In talking with you, Mr. Hyde, I assume this 65,328 figure is not necessary, is that correct?

Mr. HYDE. We point out again, sir, that it's talking about unnecessary admissions.

Mr. SKELTON. Is it necessary for that figure to be in this contract?

Mr. HYDE. I think that there has to be some number in the contract, and the number that is in there is 65,000, and if that is inappropriate, and the PRO wishes to renegotiate that, certainly we will talk to them about it.

Mr. SKELTON. You are willing to negotiate this, is that correct?

Mr. HYDE. Yes, yes. I think I should also emphasize that last July 31, I believe, Carolyne Davis, the Administrator of the Health Care Financing Administration, testified before Senator Durenberger's committee, and indicated essentially the same thing that I have today, that these numbers in these contracts are targets rather than quotas.

Mr. SKELTON. Then state that. Any first year law student knows of the proevidence rule. That you can talk all you want to, and say all you want to, but it's what's in writing that counts. It says reduce admissions statewide by 65,328. That is not almost, or approximately, or around, that's down to the patient, and I'd hate to see my State burdened with this. If you mean that it's an attempt to get toward that figure, you ought to state that, or whatever figure you're talking about. That really concerns me, and if you're doing it to the State of Missouri, you're doing it, what, some 10 other States, is that correct?

Mr. HYDE. Twelve other States.

Mr. SKELTON. Twelve other States.

Mr. TAUKE. Let me ask the doctors. Does the Missouri PRO wish to renegotiate the figure, or have you tried?

Dr. AKHTER. Let me answer this question very straightforwardly. I think we have had excellent cooperation with Mr. Hyde, the regional office. They've been willing to renegotiate on things that we had concerns about, about which we had hard evidence which we could just go out and show them that this is what's happening, and that we will renegotiate. I think that as time goes on, we still don't have exact information how much. You know right now it's about 3 percent. I mean that's where it's at, and it's a very short period of time. This is a new program, there is still far to go. And as we get the hard evidence in hand, we certainly would like to renegotiate. Of course we would like to clarify some of these things, so that we don't have any written obligation, and I appreciate also Mr. Hyde's comment to you, his public statement that he is interested and

willing to renegotiate as he has already told us before. So yes, we will be very interested in doing that renegotiation.

Mr. TAUKE. He also indicated that these four pieces of regulation have been published for comment. Were you aware of that, have you commented?

Dr. AKHTER. Again, Congressman Tauke, I've been aware of those things. They've been published, but the things under which we have to operate come in terms of a directive that have no relationship to some of those things. Just set-up something that somebody comes up and says, "Tomorrow you will do this."

Mr. TAUKE. Where do these directives come from?

Dr. AKHTER. From the central office in Washington. Sometimes Mr. Hyde and his staff are not even aware of those things. They come to us first, directly, because somebody over there wanted to do something.

Mr. SKELTON. Without him knowing?

Dr. AKHTER. Without him knowing, yes, of course. We call his office and ask are you aware of this thing?

Mr. TAUKE. You have perhaps a break with the chairman. You could submit for the record, a copy of those, maybe two, three, four directives, to give us some example of what we're talking about.

Dr. AKHTER. Absolutely. We could give you those examples, not only those, but we will certainly receive a directive No. 7, when we don't know what the directives 4, 5, and 6 are, what they are, where they are. We really don't know anything. Suddenly a seventh will appear on the horizon, and say you will do this and it is effective immediately, upon receipt.

Mr. TAUKE. I can see where this could be a problem. It is a little humorous, but I guess from a very practical perspective it's not the kind of thing with which we'd be familiar unless somebody tells us about it, and it would be probably quite helpful if you would give us some indication of what's coming because I am sure that I haven't seen it and I don't know if staff has, or the gentleman from Missouri. One more comment, Mr. Hyde, I do want to tell you as I open my folder this afternoon my staff had inserted a note that your office has been very cooperative with our office and we have no complaints about the breaches.

Mr. HYDE. Thank you, sir.

Mr. TAUKE. Although we have had some disputes with the folks at HHS, we have had good cooperation from your office. By the way, I think Carolyne Davis is a wonderful head of Health Care Financing Administration. I have great respect for her. We just have to get some of these things moving along a little quicker. I thank all the members of the panel for some excellent testimony.

Mr. SKELTON. I might add, Mr. Hyde, I've heard nice things about the way you operate your office, you're the messenger today. I hope you understand.

Mr. HYDE. I think you understand there is concern that I am being an old country lawyer. I know what the English language means, and I hate to see the State of Missouri put under the gun, because I think it brings about a diminution of confidence in this system when we see things like this in a contract.

Mr. SKELTON. You are listening for those times that have come to you in directives straight to you and I understand that even Mr.

Hyde didn't know about some of them, that he received without notice, without any opportunity to comment.

I would appreciate that we will leave the record open until we receive word from you on this.

Gentlemen, these are not easy questions that we have to ask. The bottom line is we want the Medicare system to work and work well, each in your own specific role. We want not for just Missourians but for all Americans who are qualified for Medicare to receive the best, and still we understand the serious problem of holding hospital costs down.

Thank you so much for participating today, we appreciate it. Your comments have been made for the record that will be part of the permanent record of the Committee on Aging, and we hope that from this, recommendations will be able to come forth from our subcommittee and to our committee, so that we can possibly correct some of these problems so that next time we see you, we won't have the opportunity to ask you these questions.

Thank you again, and have a good day.

[Whereupon, at 5:15 p.m., the hearing was adjourned.]

APPENDIX

MISSOURI PATIENT CARE REVIEW FOUNDATION,
Jefferson City, MO, April 9, 1985.

Hon. IKE SKELTON,
U.S. Congressman,
Washington, DC.

DEAR CONGRESSMAN SKELTON: This is a follow-up on our presentation at the hearing of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, United States House of Representatives, held on March 29, 1985, in Jefferson City, Missouri.

As you know, the Missouri Patient Care Review Foundation has contracted with the Health Care Financing Administration to perform review of the hospitilization of Medicare patients. This review was mandated by the Tax Equity and Fiscal Responsibility Act of 1982. The review is performed through the peers to determine that health care services provided to Medicare beneficiaries are medically necessary, are appropriate, and that care is complete and meets professionally recognized standards of quality. Since the implementation of this program in August of 1984, we have reviewed over 42,000 cases, almost one-third of the total Medicare cases during that period.

MEDICARE DENIALS

Approximately three percent of the cases reviewed have been denied during the past five months. Most of the denied cases are of elderly individuals who need diagnostic tests. Most of the tests, in themselves, are not indications for admission to an acute care hospital, but the patient's general condition is such that he/she cannot come to the hospital from his/her home to get these tests done. This is particularly true of our rural elderly population. Some of them live in remote rural areas—forty, fifty, or even one hundred miles away from the hospital. Some of them have no indoor bathroom facilities in their homes, live alone, and have no way of transportation to the hospital, and yet they need diagnostic procedures like barium x-rays, colonoscopy, and other diagnostic procedures.

By issuing a denial for admission to the hospital, under HCFA directives, we are making it very difficult for these individuals to get access to the needed health care. Some physicians in rural areas spend up to thirty percent of their time on Medicare patients, trying to figure out how they will take care of these patients on an outpatient basis (making arrangements for their living near the hospital and assuring that there will be someone with them to take care of them).

In some urban areas of the State of Missouri, the local hospitals are providing a motel-type arrangement. Expenses are paid either by the patient or the hospital. In the rural areas where the rural elderly are poor and the hospitals are barely breaking even, it is very difficult for the hospitals to provide such a service. Approval by HCFA of $25 to $30 for one night's motel expenses for such patients will go a long way in meeting the needs of the elderly for medical care, and we will remove a lot of worry from the hospitals and the physicians for the well-being and welfare of these patients.

The Board of the Missouri Patient Care Review Foundation would appreciate any action that you may take to convince HCFA to have such a regulation permitting these people to get needeed medical care without the added expense of in-hospital admission.

MALPRACTICE INSURANCE

While doing peer review, we come across cases where certain expensive procedures were performed primarily to protect the physician and/or the hospital from

potential litigation. The Board believes that something has to be done about malpractice insurance if we really are determined to reduce the cost of health care, particularly for Medicare patients.

It is the opinion of the Board of the Missouri Patient Care Review Foundation that Congress should look at providing similar coverage to the physicians and hospitals who take care of Medicare patients to what is available now to physicians working in the VA and other military hospitals. If, by legislation, we can provide the same kind of coverage to physicians who provide services to Medicare patients, we could reduce the cost of health care for Medicare patients. After all, Medicare is a federal program.

RURAL HOSPITALS

Small rural hospitals are having a particular problem. Because of their location and because of excessive Medicare population in the rural counties, most of the admissions to these hospitals are for Medicare patients. There is not much room for shifting the cost for Medicare patients to private insurance because there are relatively few admissions of private patients to these hospitals. There is also the problem of lower DRG payment for rural hospitals. The PRO's mechanism of denying payment for inappropriate admissions has a profound effect on the finances of these hospitals. I know some hospitals are already in trouble, and the others are barely breaking even. We suspect some of these rural hospitals may close. When a rural hospital closes, local physicians will have no place to admit their patients. As a result, the physicians will leave that rural community. This will lead to a community without a hospital and without physicians. Patients will need to travel 50, 60, or even 100 miles to get to the nearest hospital. It may be cost effective in the short run to do so, but looking at the conditions of the patients and the welfare of our population, closing the small rural hospital is not the answer.

We ask that you explore the possibility of asking HCFA to review the rate of payment under DRGs for rural hospitals. The Board of the Missouri Patient Care Review Foundation recommends that Congress look into other ways of supporting rural hospitals that provide care to our citizens in rural Missouri.

IMPLEMENTATION OF PRO PROGRAM BY HCFA

HCFA has implemented the PRO program very aggressively, and there are now PROs in every state. However, in the process of implementation of this program, the normal process of rulemaking was not followed. The program was implemented by using several directives, with little or no input from the public. HCFA lacks adequate medical support staff, and therefore some of these mandates have come down without adequate input from physicians, hospitals, and other professionals involved in the delivery of care to our Medicare population. Enclosed please find copies of several directives that have been issued during the implementation of this program.

Last, but no least, there are problems with the entire Prospective Payment System. Several of the DRGs do not actually match with the actual medical expenses for inpatient care. Enclosed is a letter from one of our physicians dealing with DRG 021 (viral meningitis). Fairly large hospitals have been designated as rural hospitals, and some of the very small rural hospitals have been designated as urban, thus creating a problem of inappropriate payments to these institutions.

Therefore, we recommend that Congress provide some oversight to assure that some of these inadequacies are corrected as soon as possible so that a fair system is put in place.

Any help you could provide us on the resolution of these problems will be greatly appreciated. If you need additional information, please do not hesitate to contact us. We appreciate the opportunity to testify before your committee and to provide this additional input.

Sincerely,

MOHAMMAD N. AKHTER, M.D., M.P.H.,
Executive Vice President and
Medical Director.