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QUALITY CARE FOR SENIORS

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

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QUALITY CARE FOR SENIORS

MONDAY, APRIL 10, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,
AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Fort Wayne, IN.

The subcommittee met, pursuant to notice, at 9 a.m., at the John F. Young Center, 2109 East State Street, Fort Wayne, IN, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica and Souder.

Staff present: Sharon Pinkerton, chief counsel; and Lisa Wandler, clerk.

Mr. MICA. Good morning. I'd like to call this meeting of the Subcommittee on Criminal Justice, Drug Policy, and Human Resources to order. Today's hearing is a congressional field hearing entitled, "Quality Care for Seniors. Are HCFA and its contractors managing health care efficiently and fairly?"

By way of introduction, I'm the chairman of the subcommittee, John Mica, and I'm pleased to be here this morning at the invitation of Congressman Souder, who has probably been one of the most active and effective members of the Government Reform Committee in the House of Representatives. I have enjoyed working with him, and we are conducting this investigation as an oversight hearing in Fort Wayne at his request this morning.

I'll open the hearing with an opening statement, and then yield to Mr. Souder. Without objection, the record will be left open for 2 weeks. That's so ordered. Anyone who would like to submit testimony for this hearing is welcome to do so contacting Mr. Souder for this subcommittee, and we will make your statement part of the official congressional record.

We'll then proceed today with two panels. We have witnesses in two panels. And there being no other business at this time, I will proceed with my opening statement.

Today, I'm pleased to convene this hearing to examine the impact of Health Care Financing Administration, which is also referred to as HCFA's regulations which they're having on health care providers and ultimately who needs good health care, and that is our senior citizens not only in Fort Wayne, IN, but throughout this country.

Medicare has become one of the most complicated programs run by the Federal Government. In fact, the Mayo Clinic, a well-respected medical group, has counted more than 130,000 pages of laws, rules, manuals, instructions, alert notices that govern the de-

livery and the payment for health care services. It's no wonder that senior citizens, health care professionals, vendors and others who care for our senior citizens and those in need of health care are tormented by the restrictions under which they are forced to function. Their hands are tied by what appear to them as sometimes meaningless and arbitrary red tape.

In 1997, Congress enacted landmark changes to the Medicare program, which were contained in the Balanced Budget Act. Many of these changes were designed to provide more beneficiary choices and to help guarantee the solvency of the Medicare program well into the 21st century. The good news is that many of the objectives of that legislation have been accomplished. Wasteful spending is down, the Medicare program itself is more secure, and many of our Nation's elderly have expanded preventative benefits and increased choices for accessing quality health care.

Also, the Department of Health and Human Services' Inspector General has reduced the amount of money lost to fraud as a result of having new tools available to tackle that problem. However, as we've learned during the past few years, the Balanced Budget Act has also had some unintended but nevertheless troubling consequences. In some cases, providers and hospitals were pressured for more savings than were originally anticipated under the law. In other cases, HCFA—again, our Health Care Financing Agency—has failed to act in the interest of seniors or in accordance with congressional intent and sometimes sent out confusing messages or response. Congress has learned about these problems from many communities, and I applaud Congressman Souder for bringing our subcommittee here to help evaluate the impact of Federal regulations on his community. I think he's also doing a service to the country, because what we see here in Fort Wayne, IN is no different than what we face in Florida or across our Nation.

As a result of some of the feedback that Congress has received, Congress passed legislation 4 months ago which we hope will address some of these problems. Our goal today is to gather more information and help ensure that your concerns here in Fort Wayne are considered both by HCFA, the Federal administering agency, and also by the U.S. Congress. We hope to do that as Congress decides how best to ensure that our Nation's citizens have access to quality, affordable health care.

Today, we'll hear from the entire range of those individuals and agencies involved in providing health care from our Federal Government, again HCFA, to the hospitals and other providers, right down to the patient who is really the major concern of our health care service system. I'm hopeful that HCFA will be sensitive to the concerns and issues put forward today by the providers and also by the patients. If these concerns can be resolved administratively, HCFA should take action now. If further refinements are needed to be made by law, then Congress should act to make them.

With health care of seniors at stake, we need to ensure that the Medicare Program is working as we intended it to work. This is certainly an issue which requires the attention and the oversight of the U.S. Congress and the House of Representatives and particularly our committee, which is an investigation and oversight subcommittee of the U.S. House of Representatives.

I wish to again personally thank Congressman Souder for his request, for his perseverance in getting to the bottom of this matter and also making one of the most important things we do in our Federal Government work, and that's make certain that our seniors and others who rely on health care can get that service and have access to that service, and those who are providing that service know that the rules are set up in a fashion to make certain that all that is done cost effectively and efficiently and for the benefit of the patients.

We'll yield at this time for the purpose of an opening statement from the gentleman from Indiana. Mr. Souder, you're recognized.

Mr. SOUDER. I thank Chairman Mica. It's a great sacrifice. He comes here from Daytona Beach and Orlando——

Mr. MICA. Yes.

Mr. SOUDER [continuing]. Where the combined——

Mr. MICA. Great sacrifice. It was almost 80 degrees this weekend and the sun shining.

Mr. SOUDER. It isn't——

Mr. MICA. Thank you again for the invitation.

Mr. SOUDER. It isn't always 30 degrees on April 10th, but it's enough that many of us this time of year visit Florida. This hearing today really arose out of a series of town meetings and could prove to be a series of hearings examining issues and problems related to the Health Care Financing Administration's Medicare guidance and reimbursement practices and the impact of those policies on the health care industry and health care beneficiaries, because I hear from many of my colleagues similar concerns around the country.

HCFA's responsibility for administering the Medicare Program is undoubtedly a large and complicated one. With 39.5 million beneficiaries and 870 million claims processed and paid annually, it is reasonably expected that errors will occur in processing payment. Additionally, the Balanced Budget Act of 1997 restructured the program immensely to ensure the program's solvency. As such, the program has certainly experienced numerous changes. While it is true that the Balanced Budget Act included provisions to ensure the solvency of the Medicare program into the 21st century, it is also true that the core mission of HCFA to assure health care security for beneficiaries was intended to remain intact. Congress is aware of the unintended consequences that resulted in the Balanced Budget Act and the effect it has had on the health care industry. Those issues are currently being addressed in Congress, and we passed several measures last year, and several bills have been introduced to further alleviate the pressures felt by the health care industry and its recipients as a result of those consequences because, in fact, when reimbursement or these questions arise, the hospitals and health care providers usually do one of two things: They either reduce benefits to the beneficiaries or shift costs to other families. And that's been one of the primary ways health costs have been rising in this country; it is because of the cost shifting that occurs when the Federal Government doesn't adequately reimburse for other costs.

We're not here today to contemplate the far-reaching effects spurred by the Balanced Budget Act; we are here to discuss the

perceived changes of the Medicare policies, including those that involve diagnostic screening, pre-surgical testing and reimbursement issues. In February 2000, I held 27 town meetings throughout northeast Indiana. During the course of those meetings, numerous Medicare patients expressed concerns about information they had received indicating Medicare would not cover certain pre-surgical tests. When asked what a patient should do when his or her doctor ordered a test for which Medicare ultimately denied payment, I could not answer. For example, one person said they had started the testing process. It was now being denied. They didn't have enough money to finish out the tests. "What am I supposed to do?" She said, "Mark, what am I supposed to do now?"

Both my mom and mother-in-law are on Medicare, and I feel the pressures in my own family, as well. When asked why Medicare would refuse payment for tests a doctor deemed a necessity, I simply didn't have an answer. I mean, I could guess, but I wanted to find out what at core was the problem. Appearances suggested that what a medical professional perceives as medically necessary does not always coincide with what HCFA, the Health Care Financing Administration, and its carriers define as medically necessary. It is my hope that such appearances will prove to be false.

We are here today to listen to information from a wide range of health care affiliates from one end of the spectrum to the other. Our goal is to begin to untangle the confusion surrounding the Medicare program in northeast Indiana and define for Medicare recipients the policy issues at hand. Nobody's assuming any malicious behavior on anybody's part. HCFA is trying to make very difficult budget decisions as are health care providers, and we want to make sure there is a fair process so that everybody is covered in as cost-effective way as possible.

I'd like to thank the subcommittee chairman, Mr. Mica, for his efforts in investigating this issue, and I'd also like to thank those who came and testified today for their valuable time. Also want to say a last word about my friend, Mr. Mica. He, like I, was a Senate staffer prior to getting elected to Congress. He was elected to the House before me, had a number of years in service there and has been leader in a number of issues, including health care. But, as our No. 1 leader on our drug task force in this country on anti-drug abuse, we have travelled to Columbia and Mexico together many times. We've been at hearings around this country, and we've worked with many other issues facing families and children, as well, and I very much appreciate his national leadership on that. And as we tackle these difficult health issues in addition to the drug abuse problems, I hope we can have a similar impact.

I yield back.

Mr. MICA. Thank you.

Now to proceed with our first panel. Our first panel consists of Ms. Lorraine Altenhof, and she is a Medicare recipient. She's accompanied by her daughter, Patty Altenhof. We also have Thomas D. Miller, who's president and chief executive officer of Lutheran Hospital of Indiana, Fort Wayne, IN, and Dennis L. Knapp, another witness. He is president and chief executive officer of Cameron Memorial Community Hospital from Angola, IN; and Kelly L. Borror, administrator of Lutheran Homes in Fort Wayne, IN.

I don't believe you've testified before our subcommittee or before our Government Reform Committee before, this is an investigations and oversight subcommittee of the House of Representatives. In that capacity, we do swear in our witnesses and in just a moment, I'll ask you to stand and be sworn.

Additionally, we try to limit your oral presentation before the subcommittee to, approximately, 5 minutes. We'll wind the clock on you here and ask you to try to summarize around 5 minutes. You can, upon request, submit an entire statement, which will be printed and part of the official record of this congressional hearing. At a simple request, we will grant that.

And, as I said, we're leaving the record open of this hearing for 2 weeks. We cannot possibly hear everyone who would like to speak in this hearing, but we do allow submission of testimony upon a request to the committee or Mr. Souder at this point to be made part of the record.

So those are some of the ground rules for our hearing today. We'll proceed first by having you stand and be sworn.

[Witnesses sworn.]

Mr. MICA. Since the answer is in the affirmative, we'll let the record reflect. I'm pleased this morning to welcome both Lorraine Altenhof and her daughter, Patty Altenhof. I understand we're going to have one of you provide testimony and the other available for questioning. You're recognized.

Ms. LORRAINE ALTENHOF. How should I——

Mr. MICA. However you'd like to proceed. Just recognize yourself for the record.

STATEMENT OF PATRICIA ALTENHOF, DAUGHTER

Ms. PATRICIA ALTENHOF. My name is Patricia Altenhof, and this is a letter my mother received from Parkview Hospital right before she was scheduled for surgery. The letter reads:

Dear Medicare Recipient: Changes to Medicare occur frequently and they can be confusing. This letter describes one of these changes. We hope this explanation helps.

Medicare has always had a regulation that it will only pay for what is medically necessary. Its definition of this term is "a service that is ordered by a physician for the diagnosis or treatment of an illness or disease." Medicare recently changed this interpretation on what tests they will cover, now disallowing any service that is considered a screening that is not specifically identified by Medicare as a screening for which it will pay. Among screenings that Medicare does allow are the mammogram and Pap test for women and PSA prostatic test for men.

Screenings considered not covered by Medicare include pre-surgical testing (the tests that hospitals or ambulatory surgery center does before your surgery). The anesthesiologist must have the pre-surgical test results to know how you will tolerate general anesthesia; many potential problems are identified as a result of this testing; however, Medicare does not define this testing as a covered service.

Medicare's decision is very narrow and does not take into account such issues as family history for a disease or exposure to certain elements that cause a disease. Therefore, even though Medicare deems that a test is not covered, that test may still be very necessary from your physician's point of view. Nonetheless, if the test is not covered under Medicare's definition, they will not pay, despite the fact that your doctor ordered the test.

When your physician orders a test for which Medicare will not pay, he or she has a sound medical reasoning for investigating a possible health hazard that could cause problems for you. If this is the case, you are still responsible for any charges resulting from such tests. At the time of service, you will be asked to sign a document which notes that this information has been explained to you and that you take financial responsibility for the service being provided for which Medicare does not

pay. In addition, Medicare will not allow hospital or health care facilities to provide these services free of charge.

Hospitals and laboratories work closely with your doctor to ensure that Medicare covers every test possible. However, there will be times when you will be required to pay for these services since Medicare does not cover them.

STATEMENT OF LORRAINE ALTENHOF, MEDICARE RECIPIENT

Ms. LORRAINE ALTENHOF. As soon as I received that letter——

Mr. MICA. Could you identify yourself again——

Ms. LORRAINE ALTENHOF. Alright, I'm Lorraine Altenhof.

Mr. MICA. Thank you.

Ms. LORRAINE ALTENHOF. And this letter came to me about 2 or 3 weeks before my surgery was scheduled. I was operated on March 1st, and I had subclavian bypass and carotid artery. And when I called Medicare, the girl there told me that the doctors and hospitals should not use the word "pre-op." She said if they would just use the word "diagnosis," Medicare will pay it. So I said OK.

So I called the Parkview Hospital, and I talked to a gal there. And she said, "We can't." I told her what the girl at Medicare told me, and she said, "Well, we can't do that. They'll get us on fraud." I told it to my doctor, Dr. Sanford, and he said the same thing. He said, "We can't do that" and "They would get us on fraud."

So at the Parkview, when I talked to this gal, she told me that, in the past, if Medicare didn't pay for something, the hospital would write it off and take the loss. But now she's telling me that Medicare's saying that the patient must pay it. And I said, "Well, how much money are we talking about?" And she said, "From $200 to $250 for those tests." And I said, "Well, what if you don't have the money to pay for it?" She said, "Well, I don't know what to tell you."

And I don't understand why Medicare has the right to tell a hospital whether or not they want to write something off for a Medicare patient. What right does Medicare tell them they can't do that? I don't understand that. And I was really very upset. And, so far, all I've received from my—I have supplement insurance with Medicare, and all I've received so far is one statement, and on it was an $11.07 charge that Medicare did not pay. So I called my supplement insurance company and asked them what that charge was for, and she said it was for a chest x-ray, which I had to have a chest x-ray, a blood test and an EKG.

Now, I don't want anybody operating on me without that test. And I don't understand why, if they're calling it a screening, why it should—why can't they change the word? Why use it as a screening? Those are necessary. You don't want a doctor operating on you without that. So, anyway, I just wanted to come here and say those things, because I don't understand. And then the girl at Medicare also told me that "Congress makes the rules," she told me, and "We have to do what Congress says." That's what I was told. And those are her exact words.

Mr. MICA. But——

Ms. LORRAINE ALTENHOF. And——

Mr. MICA. If you had something else to add, go right ahead.

Ms. LORRAINE ALTENHOF. No.

Mr. MICA. Well, we appreciate your testimony. We appreciate your also coming forward to our congressional subcommittee to pro-

vide us with your personal experience. What we're going to do is hear from these other individuals, and then we'll come back and we'll ask questions.

[The prepared statement of Ms. Lorraine Altenhof follows:]

Committee on Government Reform and Oversight
Subcommittee on Criminal Justice, Drug Policy and Human Resources

Congressional Field Hearing
Fourth Congressional District of Indiana

April 10, 2000

Testimony of:
Lorraine Altenhof
8 Turquoise Drive
Huntington, Indiana

Topic:

Concerns of Medicare Coverage for Pre-Operative Testing

I was scheduled for surgery on March 1, 2000. Approximately two weeks before my surgery I received a letter from Parkview Hospital telling me that Medicare was making some changes on pre-operative testing and would no longer pay for those tests. I immediately called the Medicare office for some answers.

I was told by the Medicare person that if the hospital used diagnostic codes instead of pre-op codes, then Medicare would pay for the tests (pre-operative tests usually consisting of blood test, EKG, and a chest X-ray).

I then called Parkview Hospital and spoke with Shana Jones. I told her what Medicare said about the diagnostic coding. Shana said if they did that, then Medicare could accuse them of fraud. My doctor told me the same thing. Shana at Parkview also told me that in the past whenever Medicare refused to pay for any test, the hospital could write it off and take the loss. Now, however, Medicare won't allow the hospitals to do that any longer. Medicare said the patients had to pay for these test, which cost approximately $200 to $250. I was very upset because Medicare said that Congress makes the rules and they had to follow them.

This doesn't make any sense to me at all. Why would Medicare make us seniors pay for all these test if the hospital is willing to write them off? There is no anesthesiologist or doctor of any credibility that will perform surgery without these tests, so what options do we seniors have?

I am very confused and upset about this and would appreciate it very much if you would look into this matter. Thank you.

My daughter Patty Altenhof has agreed to read the letter that I received concerning these changes in Medicare coverage.

Letter follows

PARKVIEW

Dear Medicare Recipient,

Changes to Medicare occur frequently and they can be confusing. This letter describes one of these changes. We hope this explanation helps. '

Medicare has always had a regulation that it will only pay for what is "medically necessary." Its definition of this term is "a service that is ordered by a physician for the diagnosis or treatment of an illness or disease." Medicare recently changed its interpretation on what tests they will cover, now disallowing any service that is considered a screening that is not specifically identified by Medicare as a screening for which it will pay. Among screenings that Medicare does allow are the mammogram and Pap test for

Screenings considered not covered by Medicare include pre-surgical testing (the tests that the hospital or ambulatory surgery center does before your surgery). The anesthesiologist must have the pre-surgical test results to know how you will tolerate general anesthesia; many potential problems are identified as a result of this testing.

Medicare's decision is very narrow and does not take into account such issues as family history for a disease or exposure to certain elements that cause a disease. Therefore, even though Medicare deems that a test is not covered, that test may still be very necessary from your physician's point of view. Nonetheless, if the test is not covered under Medicare's definition, they will not pay, despite the fact that your doctor ordered the test.

When your physician orders a test for which Medicare will not pay, he/she has sound medical reasoning for investigating a possible health hazard that could cause problems for you. If this is the case, you are still responsible for any charges resulting from such tests. At the time of service, you will be asked to sign a document, which notes that this information has been explained to you and that you take financial responsibility for the service being provided for which Medicare does not pay. In addition, Medicare will not

Hospitals and laboratories work closely with your doctor to insure that Medicare covers every test possible. However, there will be times when you will be required to pay for these services since Medicare does not cover them.

If you have any questions, please contact Parkview Health System at 219-482-9561 or toll free at 1-800-933-0590. We will be happy to explain these issues further or to provide you with a copy of the regulation.

Sincerely,

Shana Jones
Vice President
Patient Business Services, Parkview Health Systems

PARKVIEW

MEDICARE PRE-SURGICAL TESTING, MEDICAL NECESSITY CHANGES
AND
ADVANCED BENEFICARY NOTICES (ABN'S)

PRESURGICAL TESTING

- Medicare does not cover Pre-Surgical Testing because it is considered a "screening". Medicare only pays for a limited number of pre-identified screenings. This does not mean that screenings are not necessary, as in the case of pre-surgical testing.
- The only tests that Medicare will cover when ordered for screening or prevention are:

  Mammograms

  Pap Tests

  PSA testing

  Colorectal screenings

  Bone mass measurements

- Any service considered a screening by Medicare will be the financial responsibility of the patient. Medicare will not allow us to write this off.
- Any service found to be a screening under Medicare's regulations will require the patient to sign an Advance Beneficiary Notice indicating that they have been informed of this issue and are accepting financial responsibility.
- If the patient chooses not to have Pre-Surgical testing, we will ask the patient to contact you to discuss this.

  We have provided letters that you may use in your offices to notify your patients of this issue. More will be supplied if you need them.

- We will always explain to the patient that it is not the physician who is practicing inappropriate medicine but that Medicare has made a policy decision not to cover screenings

MEDICAL NECESSITY

- Any test can be considered Medically Unnecessary if it is not for the:

  Diagnosis or

  Treatment of a specific illness or disease

- Any service considered Medically Unnecessary by Medicare will be the financial responsibility of the patient. Medicare will not allow us to write this off.
- Parkview Health System has the same software as Medicare to edit any procedure and diagnosis for medical necessity.
- The editing will be done at the point of scheduling or service for the patient.
- Any service found to be medically unnecessary under Medicare's regulations will require the patient to sign an Advance Beneficiary Notice indicating that they have been informed of this issue and are accepting financial responsibility.
- Upon the request of the patient, we will be calling your offices to ask for your assistance in providing additional diagnoses, if appropriate, to alleviate the patient's financial burden.

  The patient may be waiting to have the service when we contact you. Please try to accommodate your patient quickly when there is an additional diagnosis.

- If you contact Care Medic at 1-800-653-6153, they can provide you with software similar to that used by Medicare. There may be other vendors who also provide this software.
- We have provided letters you may use in your offices to notify your patients of this issue. More will be supplied if you need them.

  We will always explain to the patient that it is not the physician who is practicing inappropriate medicine but that Medicare has different medical criteria for covering the tests.

  For more information contact the Patient Accounting Departments at:

  PARKVIEW HEALTH SYSTEM

  (219) 482-

  (800) 933-

Mr. MICA. At this time, I'm going to Thomas D. Miller, president and chief executive officer of Lutheran Hospital of Indiana. You're recognized, Mr. Miller.

STATEMENT OF THOMAS D. MILLER, PRESIDENT AND EXECUTIVE OFFICER, LUTHERAN HOSPITAL OF INDIANA, FORT WAYNE, IN

Mr. MILLER. Thank you, Chairman Mica and Congressman Souder, for taking time out. Chairman Mica, if it's 80 degrees in Florida, I would suggest that it's minus 10 degrees in health care today in hospitals. And let me tell you that I appreciate you folks doing quality care for seniors, but let me give you an overview of what hospitals see from Medicare.

Medicare spending for the last 3 years has been flat while Medicare senior population has grown by 3½ percent a year and inflation has grown by 2.6 percent. Part A, which is the Hospital Trust Fund, spending fell by 4.4 percent last year and 4.5 percent in the first quarter of fiscal year 2000. Congress intended on saving $103 billion for 1998 through 2000 through the Balanced Budget Act, but, due to dramatic cuts and regulation changes, has determined that they now saved $227 billion, twice as much as what was intended.

Since November 22nd, the day Congress recessed, Medicare spending projections have dropped by another $62 billion for fiscal year 2000 to 2004. The additional cuts in the program have been done without a single vote. Hospitals are faced today with an unprecedented struggle to stay viable.

For background purposes, Medicare represents the single largest payer for hospitals throughout the country. In Indiana, 46 percent of the patients discharged are Medicare patients, and when you look at the illnesses of those Medicare patients, roughly 60 percent of the revenues that go through hospitals. This is according to the Indiana Hospital Association. Also, according to that, Medicare only reimburses hospitals in Indiana 82.1 percent of our costs. Not of our charges; of our costs. When combined with the additional cuts that were not included into these numbers, you can understand that a crisis has developed. Medicare is our largest payer, but has become our most unreliable. Policy and regulation changes are ongoing without concern for a hospital's ability to implement changes or without regard to the quality of care for our seniors. The concern only appears to be money. The current regulations have shown a unique ability to be successful in this practice.

Two recent changes that occurred involving Outpatient Perspective Payment System, which I'll refer to as APC, and the encouraged use of Advanced Beneficiary Notification that Mrs. Altenhof has mentioned. APCs are a new and unique way to reimburse hospitals for outpatient services. HCFA's indicated for years that these changes were coming and that they would be in effect July of this year. Unfortunately, until this past week, they didn't publish the guidelines that they've been working on for over 10 years. It appears that HCFA is interested in meeting a deadline here of July 1st more than whether hospitals can adjust to the new payment methodology. It is interesting that HCFA is implementing these changes when the intermediaries have indicated that they cannot

pay the hospital under this system due to lack of time. If the interest is to further place hospitals in a position where incorrect bills are sent so that the term "fraud" can be used, the current practice with APC will be successful. I would suggest a focus should be placed upon making the infrastructure changes that need to take place before regulations are changed.

One hears regularly that there is rampant fraud in health care and it's costing the government billions of dollars. Using the APCs as an example, the problem is not as much a problem of hospitals billing accurately, as it is a problem of changing regulations and processes that the hospital can't adjust to. It is merely impossible to accurately implement a total outpatient reimbursement methodology within 90 days of last week when the total information systems have to be installed at our hospital that haven't even been written yet because the guidelines were just established.

In regard to the Advanced Beneficiary Notifications, this change has taken place over the last few months, and it involves outpatient tests that HCFA determines to be not medically necessary or screening and as such are not covered under Medicare. Just so that you understand the regulations, Medicare holds the provider liable for non-coverage of services if it is determined that the provider either, one, had the actual knowledge of the non-covered services of a particular case or, two, could reasonably have expected to have such knowledge. In general, providers should have known a policy or rule if the policy or rule is in a Federal Regulation, Medicare manual or in other publications.

This statement is being used to hold providers accountable for all regulations and a reasonable interpretation of the regulations by HCFA before they bill. One can already see how easy it is for HCFA to make a policy for which compliance is so difficult, specifically APCs where 1,000 pages in the initial regulations of which hospitals have to communicate to physicians and all of our billing staff the accuracy of all aspects of 1,000 pages.

Regarding ABNs, the local Medical Review Policy provided guidance on whether or not it is covered and under what clinical circumstances considered reasonable, necessary and appropriate for the diagnosis and treatment of illness or injury. Providers who knowingly bill services as covered that are—I'm using the word that is in the manual—clearly not covered are, according to the local Medical Review Policy, considered to be knowingly submitting a false claim. They may be subject to civil monetary penalties of $10,000 per claim.

The word that is more disturbing in the regulations is the use of the word "clearly." I personally find very little in regulations that are clear. With this as a basis, the following was issued in December 1999, Part A news,

> Providers are encouraged to provide their patients with an Advanced Beneficiary Notification or Hospital-Issued Notice of Non-Coverage when the services rendered may be reduced or denied as part of a reasonable—or, as denied as not reasonable or necessary. Providing an ABN or Hospital-Issued Notice of Non-Coverage protects you from liability.

To understand the ramifications of the above, one must understand how tests are ordered. First, the problems are generally outpatient tests. HCFA and intermediaries are holding hospitals re-

sponsible for determining the medical necessity of tests. However, 100 percent of the time, hospital is only completing a test ordered by a physician. In the case of most hospital outpatient tests, we receive blood samples, urine or other specimens with an order for the test to be performed and a stated diagnosis or symptom from the physician's office. We do not see the patient or generally interpret or enter the physician—or, excuse me—interrupt the physician at his office to question his written order. We perform over 600,000 lab tests a year.

Based on the information above, if the test ordered does not meet the medical necessity as defined by HCFA for the specific tests and the hospital bills, this is considered a fraudulent claim. Because of the magnitude of the volume and the reality that hospitals are not in a position to question doctors' orders for tests that they believe are important, we perform the tests and send the results to the patient. It is this practice that is coming under specific focus by the intermediary under the umbrella of medical necessity. Recent software changes at Lutheran now match the symptom and diagnosis for the tests ordered; however, the ability to do errant claims is prevalent throughout the system.

The hospitals are in a no-win situation. The physician writes an order but doesn't have the knowledge or time to know what tests were ordered or approved for a specific diagnosis. The hospital has no computer systems to determine medical necessity before the tests are performed, and not doing a test that a physician orders could be harmful to the patient. Local hospitals are working hard to overcome these issues, but HCFA is holding them accountable today for a system that is not manageable. If we don't do the tests and we send the results to the physician before billing determines that it may not be medically necessary, so we don't bill them to avoid a fraud charge, then we are found guilty of an anti-kickback statute. A New Jersey hospital which offers free care to patients is coming under significant pressure because they provide free care to patients because they might be inducing referrals from physicians. This is truly a catch 22.

To understand the scope of the situation we're dealing with, we believe that 30 to 40 percent of our lab tests may fall into this category that don't meet the medical necessity, and that's 30 to 40 percent of 600,000 tests. The problems don't relate just to laboratory tests but to pre-admission testing and diagnoses. The only safeguards that a hospital has according to the guidelines were published in the Part A news providing "An ABN protects you from liability."

Today, Medicare is viewed by many as nothing but bad insurance. It is every hospitals most unreliable payer. Hospitals face threats of civil penalties and anti-kickback statues. The HCFA appears accountable to no one and are only interested in cutting cost. I learned today that 70 percent of the budget surplus is due to reductions in Medicare and Medicaid spending. Also, 1999 was the first time that the actual dollars paid for health care went down as compared to the prior year even though the population has increased by 3.4 percent for the elderly.

HCFA's approach has not been to improve the system or to help hospitals, seniors or doctors comply. They say nothing has changed.

Perhaps that's the problem. Health care is changing dramatically, and if we're living under regulations that have not been updated, simplified or computerized, then we're bound for failure. I believe HCFA has made compliance difficult. Based on current regulations, providing ABNs to Medicare patients is our only remedy available to us. Many procedures that have been paid for by Medicare in the past will now be paid for by those who don't have the resources—our seniors.

HCFA may use the term that these procedures are not medically necessary, but, in reality, hospitals are not in a position to know because they don't see the patient and they don't practice medicine. We have, in the past, relied on the knowledge of physicians to determine the best course of patient care. It appears that in the future, we must be only concerned about meeting a regulation that has not changed for decades. There is no doubt that the system is broken.

I hope that you will be able to fix this problem. I hate implying that everything is related to antiquated rules and money, but in the case where 80 percent of the hospitals in the country can't even cover the cost on a Medicare patient and rules are written in a way that they cannot be administered, then it is the only conclusion that can be reached.

I appreciate the opportunity to testify and your interest in solving——

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Miller follows:]

Lutheran Hospital

Lutheran Hospital

Phone:
FAX:
email:

Thursday, April 6, 2000

John L. Mica, Chairman
Subcommittee on Criminal Justice,
Drug Policy, and Human Resources
Congress of the United States
House of Representatives

Dear Sir

I appreciate the opportunity to testify in front of you on the current issues affecting Hoosiers who rely on Medicare for their health care needs _Quality Care For Seniors._ I believe that the US health system provides the best health care in the world, although current changes may compromise the ability to provide this same level of care going forward. The current state of affairs of the health system is best characterized by the following issues:

*** Medicare spending for the last three years has been flat (1.5%, -1.0%, 1.0% growth) while the Medicare senior population has grown by 3.5% a year and inflation grew by 2.6%. Part A (the Hospital Trust Fund) spending fell by 4.4% last year and 4.5% in the first quarter of FY 2000.** *1*

*** Congress intended on saving $103 Billion from 1998-2002 through the Balanced Budget Act, but due to drastic cuts and regulation changes has determined that they have saved $227 Billion.** *1*

*** Medicare spending is $27 Billion less this year (-12%) than Congress intended when it passed the 1997 Balanced Budget Act.** 2

*** Since November 22, the day Congress recessed, Medicare Spending projections have dropped by another $62 Billion (FY2000-2004).** 2

These additional cuts in program funding have all been done without a single vote. These policies cannot be sustained. Hospitals are faced today with a unprecedented struggle to stay afloat.

1 Federation of American Health Systems, March 2000 Hospitals Outlook

2. American Hospital Association, March 30, _Did you Know_

For background purposes, Medicare represents the single largest payor for most hospitals throughout the country. In Indiana 46% of the patients discharged from gospitals are Medicare and due to the severity of illnesses Medicare represents 60% of the revenues to hospitals. Unfortunately, according to the Indiana Hospital and Health Association, Medicare only reimburses Hospitals in Indiana 82.1% of our costs. When combined with the additional cuts outlined above it is easy to understand that a crisis has developed. Medicare is our largest payor but has become the most unreliable. Policy and regulation changes are ongoing without concern for a hospital_s ability to implement changes or without regard to how the quality of care changes. The concern appears only to save money, the current regulations have shown a unique ability to be successful at this practice!

Two specific recent changes involve Outpatient Prospective Payment System (APC) and the encouraged use of Advanced Beneficiary Notification (ABN) by the intermediaries. The Ambulatory Patient Groupings (APC_s) are a new and unique way to reimburse hospital for outpatient services. HCFA as indicated for a year that these new changes were coming and that they would be in effect by July 2000. Unfortunately, until this past week they did not publish the guidelines on this payment system. It appears HCFA is more interested in meeting a deadline than whether the hospital could actually adjust to this new payment methodology. It is interesting that HCFA is implementing this change when the Intermediaries have indicated that they cannot pay the hospital under this system due to lack of time. If the interest is to further place hospitals in a position where incorrect bills are sent so that the term Fraud can be used the current process with APC has been successful. I would suggest a focus should be placed on making sure an infrastructure is in place before regulations are changed.

One hears regularly that there is fraud rampant in health care costing the government billions of dollars. Perhaps using APC_s as an example, the problem is not as much an issue of hospital not billing accurately as it is a policy of changing regulations and processes that hospital cannot adjust too or manage concurrently. The implementation of a total outpatient reimbursement methodology with a 90 day notice when total information systems will have to be installed (that have not been written since the regulations have only just been published) is impossible to do accurately.

Advanced Beneficiary Notifications:

A second major change involves the encouraged use by the HCFA through the intermediaries of Advanced Beneficiary Notifications as a process to inform the patient

of those test performed that HCFA has determined to be _Not Medically Necessary or Screening_ and as such are not covered under Medicare.

First, HCFA and our local intermediary will tell you that nothing has changed, and in fact, the _regulations_ have not been rewritten. However, health care changes daily with the advent of new testing modalities, the change of many surgeries to outpatients and in general much shorter length of stay. If hospitals used the same policies today as were written 15 years ago some might consider this malpractice. HCFA, however, through the intermediaries (in our case Administar) continually issues interpretation, advisories, alerts and local medical review policies (LMRP) that guide hospitals even if the regulations do not change. It is this guidance that has caused hospital to focus on a more extensive use of ABN. If you find a clear written policy from HCFA concerning ABN_s and their use and what has changed you would be quite a detective because the regulations are extensive. You must cross reference continually and clear determination does not exist. Yet the word Hospital fraud in billing errors is being used as a gun over the health care field. The paragraph below comes directly from existing HCFA policies.

> _Providers are responsible for knowing the rules and regulations that apply to all services they are billing to the Medicare program. According to the Medicare Intermediary Manual, Section 3432.2, _Hold the provider liable for non-coverage of services if it is determined that the provider: (1) had actual knowledge of the non-coverage of services in a particular case, or (2) could reasonably have been expected to have such knowledge._ In general, provider should have known a policy or rule if the policy or rule is in the Federal Regulation, Medicare Manual governing the provider type, or is made through publication from the Intermediary which includes, but are not limited to, the Part A news and mailings sent periodically to all or individual providers._

This statement is being used to hold providers accountable for all regulations and the reasonable interpretation of the regulations by HCFA before they bill. I hope you can already see how easy it is for HCFA to make such a policy but how difficult it is to comply with specifically as in APC with little notice and no computerized systems to help.

In looking at ABN_s, the local Medical Review policy _provides guidance on whether

an item/service(s) is covered and under what clinical circumstances it is considered reasonable, necessary and appropriate for the diagnosis or treatment of illness or injury..._
Providers who knowingly bill services as covered, that are clearly not covered, are according to published LMRP, (published national guidelines) considered to be knowingly submitting false claims. They may be subjected to penalties outlined in the False Claims Act.

The word that is most disturbing in these regulations is the use of the word **_clearly_**. I personally find very little in the regulations that are clear. With this as a basis the following was issued in a December, 1999, Part A News.

> _Providers are encouraged to provide their patients with an _ABN/HINN when the services rendered may be reduced or denied as not reasonable or necessary. Providing an ABN/HINN protects you from liability._

To understand the ramification of this you must understand how tests are ordered. First, the problems that we are having are outpatient tests. HCFA and the intermediary are holding hospitals responsible for determining the medical necessity of tests. However, 100% of the time the hospital is only completing a test ordered by a physician. In the case of most outpatient lab tests, we receive a sample of blood/urine or other specimen with an order for the test to be performed and a diagnosis or symptom. We never see the patient or talk to the physician. We perform over 600,000 lab tests a year. Based on the information above, if the test ordered does not meet the medical necessity as defined by HCFA for that specific test and the hospital bills it, this is considered to be a fraudulent claim. Because of the magnitude of the volume and the reality that the hospitals are not in a position to question a doctor_s reason for ordering a test when we have never seen the patient and don_t know the history, we do the test and send the result to the patient. It is this practice that is coming under a specific focus by the Intermediary under the umbrella of _Medical Necessity._ Recent changes of the Intermediary systems now match the symptom or diagnosis with the test ordered. If there is not a match then the claim is not paid. If, however, it is paid by the Intermediary and subsequently determined to be medically unnecessary then the claim is fraudulent with a $10,000 fine per occurrence.

The Hospital is in a no-win situation. The physician writes orders but doesn_t have the knowledge or time to know what tests are approved for a specific diagnosis. The hospital has no computer system to determine medical necessity before the test is performed, and not doing a test ordered by a physician could be malpractice or public relations nightmare in the community. Local Hospitals are installing a system to help determine the medical necessity through the Florida Intermediary (actually the only one with a computer networking capability) but until then, we are held accountable by HCFA for a process that is not manageable, and where we are dependent on the individual physicians medical judgment. An interesting *Catch 22* in this process is, if we do the test, send the result to the physician, but before billing determine that it may be medically unnecessary so we don_t bill to avoid a fraud charge, then we can also be found guilty of anti-kickback statute. A New Jersey hospital who offers free care to all patients is coming under significant pressure because of providing free care to the patient they might be inducing referrals. This is truly a _Catch 22._

So that you get an idea of the scope that we are dealing with, we believe 30-40% of our lab tests may fall in this category. This problem does not relate to just lab but Pre-Admission Testing and all other diagnostic procedures. The only safeguard that a hospital has according to Part A News, December, 1999:

Providing an **ABN**/HINN Protects You from Liability

Let me give you another example. This is related to Part A News, January 2000, Pre-Operating Testing. In advance of a surgery a physician may order a series of tests that he believes to be necessary. HCFA may not agree, or the documentation in the order from the physician is not thorough enough, and although paid by Medicare is determined a year later to be a screening test and as such is not allowed to be paid. In the past, screening tests that may have been related to wellness issues are now being applied to pre-operative testing that does not meet a specific guideline as identified by HCFA. These guidelines are not generally known by the physicians. HCFA has placed the burden on the hospital to

educate them under the threat of fraudulent claims. Unfortunately they have also said we cannot identify on the order forms what diagnoses go with specific tests because that encourages inappropriate documentation by the doctor. We do our best but with 800 physicians in the community it is impossible. Hospitals should not be put in the position of policemen by HCFA, they should take it on their own to educate the medical community to the changes in their interpretation.

Today, Medicare is viewed by many as nothing but bad insurance. It is every hospital_s most unreliable payor. They are bullying hospitals with the threat of civil penalty or anti-kickback statutes. They appear accountable to no one and are only interested in cutting cost. I learned today that 70% of the budget surplus is to due to reductions in Medicare and Medicaid spending. Also, 1999 was the first time the actual dollars paid out for health care went down as compared to the prior year even though the population over 65 is growing significantly and people are living longer.

HCFA_s approach has not been to improve the system or to help hospitals and doctors comply with their regulations. As they will say, nothing has changed. Perhaps that_s the problem. Health care is changing dramatically and if we are living under regulations that have not been updated/simplified/or computerized, then we are bound for failure. I believe we provide the best health care in the world but every hospital is running scared and trying to protect themselves from a system that does not work and one where I believe HCFA has made it impossible to comply. Based on the current regulations providing ABN to Medicare patients is the only remedy available to hospital by regulation. Many procedures that have been paid by Medicare in the past will be born by those who don_t have the resources to pay. HCFA may use the terms that these procedures are not Medically Necessary, but in reality hospitals are not in a position to know because they don_t see the patient and don_t practice medicine. We have in the past relied on the knowledge of the physician. In the future will only be concerned about meeting a guideline that has not been changed in a decade. There is no doubt that the system is broken and the only motivation for change is to save money but to improve it or provide good health care.

I hope that you will be able to fix this problem. I hate implying that everything is related to antiquated rules and money but in this case when 80% of the hospital in the country cannot even get their cost back on Medicare patients and rules are written in a way that they cannot be administered, than this is the only conclusion I can find. I appreciate the opportunity to testify and your interest in enhancing the quality of the health care system in this country.

Mr. MICA. We'll now hear from Dennis L. Knapp, who's president and chief executive officer of Cameron Memorial Community Hospital in Angola, IN. You're recognized, sir.

STATEMENT OF DENNIS L. KNAPP, PRESIDENT AND EXECUTIVE OFFICER, CAMERON MEMORIAL COMMUNITY HOSPITAL, ANGOLA, IN

Mr. KNAPP. Thank you, Chairman Mica. I'll try not to cover some of the same ground that Mr. Miller covered, although we all deal with the same problems. As a preface to my statement, we are a small, 61-bed hospital located about an hour overland trip to any large tertiary facility. So ours is an issue of providing services to about 40,000 people in a rural county.

We deal a lot with allocation of resources and the most efficient use of those resources, and Medicare has made this very complex for us to do. Since we do sit in the northeast corner of Indiana, we also get patients from Ohio and Michigan, and the local Medical Review Policies vary from fiscal intermediary to fiscal intermediary. So we deal with not only fiscal intermediaries from Indiana but fiscal intermediaries from Ohio and from Michigan. And if you would think that it would be very easy to come up with a software program that could look at a patient's requested examination and determine whether it was appropriate for payment under the Medicare system, however, these policies are made at the local level through the local fiscal intermediaries. Thus, something that may be covered in Michigan may not be covered in Indiana and vice versa, making it very complex for us.

Included in my testimony is 13 pages of codes for a chest x-ray. Each one of those codes is for a different condition, and, of course, to code any x-ray that was coming through our institution erroneously through those 13 pages of code would be considered a fraudulent charge. And with the stepped-up enforcement of the fraudulent-going system, I think we're all concerned about that.

We also deal a lot with program conflicts. Right now, our small institution has 794 laboratory tests, 781 radiology tests that we have to determine whether an Advanced Beneficiary Notice is needed each time that patient comes through for one of those tests prior to us doing the test. And, again, remember this has to be done on a manual basis since no software exists at this time due to lack of standardization of the policies to perform this. That totals 1,575 procedures, which then have to be looked through and compared with about 74,000 diagnoses to determine whether the billing is appropriate for that particular patient.

Other areas we deal with in program conflicts is that, again, we are encouraged to secure an ABN up front if that's necessary. When a patient comes through our emergency services, we always opt on the safe side and perform the emergency care first, as required by the Emergency Medical Treatment And Labor Act [EMTALA]. And, so, the emergency service is always performed first at the risk possibly of not getting any reimbursement for the procedures that you're performing on the patient or lacking the protection of an ABN. So, in that area, the program is actually conflictual with itself.

Mr. Miller discussed patient concern over pre-operative screenings. That, too, has come to us. Quite recently in the face of this, I reviewed a chart where a lady was in for a surgical procedure, and had she not had the pre-surgical screenings, most notably the chest x-ray, we would not have seen that she had a partially collapsed lung, an enlarged heart and a broken rib, and she would have went to surgery, anyway, or chose not to have the procedure.

The many Medicare recipients come to us to ask, "What do I do?" And, right now, we have no good answer for them. We have to say that, "Yes, you should, for your patient—for your safety and your good health, have these screening procedures performed prior to your procedures; however, we also have to notify you that they'll be at your cost." And patients are very confused by this. The HCFA has not communicated this well to patients, and a lot of the seniors just plain don't have the resources to cover these pre-testing procedures.

And, also, as Mr. Miller said, with the new APCs that are coming across——

Mr. MILLER. APC.

Mr. KNAPP. APCs that are coming into implementation July 1st, we are going to lack the ability to efficiently bill those procedures. The implementation time is just not enough. In the last year, we've purchased almost $1 million worth of computer equipment to upgrade our computer systems only to be faced with purchasing more software when and if it becomes available to provide these services. We realize that being in a rural hospital setting, we are allowed up to 2 years leniency, I guess, from being impacted by APCs, but, at the same time, we have to go ahead and bill as if they were in effect.

We are hoping for clarification from HCFA in the future regarding these areas, and we are most certainly asking for clarification as far as to do pre-operative screening for patients. Thank you.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Knapp follows:]

April 4, 2000

Congressman John L. Mica
Subcommittee on Criminal Justice,
Drug Policy & Human Resources
B-373 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Mica & Members of the Committee on Government Reform:

Thank you for the opportunity to offer testimony on Medicare and the Health Care Financing Administration's effect on rural health access. It is our understanding that the hearing on April 10 will examine reimbursement practices and the impact those policies have on hospitals ability to provide access to needed services for Medicare and Medicaid beneficiaries.

Our story is a simple one of providing resources and the ability to use these resources to improve the health of people that come to us for care and at the same time maintain a viable facility for future generations. The recently passed BBA legislation implemented an estimated $44.1 billion dollars in reimbursement cuts to hospitals across the country. While we were prepared for those decreases and the anticipated reduction in purchased resources that would be necessary, we were not prepared for the escalation of BBA cuts that would ultimately total $76.6 billion dollars.

We are grateful for the Balanced Budget Refinement Act of 1999, which although it restored a portion of lost reimbursement, even though these dollars still will not prevent possible reductions in services to our rural Steuben county population.

Hospitals have received a 1.6% update factor from Medicare over the last three years combined, while medical inflation equaled 7% over that same period. In addition to the reimbursement cuts, the complexity has increased geometrically. To remain a healthcare provider in the Medicare program has meant increasing investment in computer systems and additional personnel (Nearly $ 1,000,000 in the last year). Now with the upcoming implementation of APG's and the need to determine at admission if a diagnostic test is program qualified or if a notice of non-coverage (ABN) must be obtained from the patient will require further purchases of edit software at additional costs.

The staff and physicians of Cameron Hospital view it as our duty to provide care to all who come to our doors. Our ability to fulfill our duty in supplying this care in a meaningful fashion will be severely impacted unless we can truly reform Medicare to simplify the administration of the program and reduce its cost and complexity. We feel that government cost reductions could be better utilized if allocated to healthcare facilities to at least offset the cost outlay of providing

care to program recipients, the elderly of our county. To emphasize the complexity of the program I would like to offer exhibits for your review.

1. **Program Complexity**
Medicare complexity is extreme and compounded by the implication that a billing error is deemed by the OIG as a fraudulent act. Exhibit 1 lists 13 pages of codes for payment of one chest X-ray. To choose the wrong code could be a fraudulent billing act. Normally you would think a software coder would be able to provide the correct code with little problem. However, coding decisions are established by fiscal intermediaries in the form of Local Medical Review Policies (LMRP). There can be as many as 3 fiscal intermediaries per state with no federal standardization of their policies. Therefore, there is little hope that relief in the form of software development is in the future without federal standardization of payment policies. I realize for data analysis categorization by 13 pages of codes may be desirable, but how much data can be managed for a simple Chest X-ray. The Health Insurance Portability and Accountability Act (HIPAA), which Congress had intended to reduce the administrative costs and burdens associated with healthcare has been of great assistance but many more practices need to come under review.

2. **Program Conflicts**
Exhibit 2 relates to the advanced beneficiary notice. We perform 794 laboratory procedures and 781 radiology procedures all that could require obtaining an advance beneficiary notice (ABN) depending on LMRP. In this process we must notify a Medicare recipient in advance that the service is not covered by Medicare and they may be responsible for payment. However, before a hospital or healthcare provider can determine whether or not an ABN is required, we need to match these 1575 different procedures with approximately 74,000 different diagnoses. Certain procedures, with certain diagnoses, require an ABN. The same procedures, with different diagnoses, will not require an ABN.

The ABN requirement also applies to services received through the emergency room, yet the Emergency Medical Treatment and Active Labor Act (EMTALA) states that healthcare providers cannot delay treatment to obtain financial information from patients. The dilemma is how to proceed with treatment – we always provide emergency treatment first with financial information becoming a secondary issue. We're still left with a conflict, while one law requires us to obtain an ABN before providing treatment, another law requires us to provide treatment before obtaining an ABN. As a community hospital, we will always choose to provide emergency care first, yet we will be faced with the situation of not complying with the ABN requirement and then risk the loss of reimbursement for the care provided and the subsequent impact on the future of the institution.

The fact that healthcare providers get any Medicare claims approved is a testament to the tenacity with which we must pursue service dollars in order to continue our mission, yet we believe it's just as big of a problem s for the Health Care Finance Administration to work and implement these same regulations. The need to capture data and watchdog the providers of healthcare have overwhelmed the system that provides the care. The high speed, high tech CAT Scanners today can produce 90 cross-sectional images of the body in 90 seconds. Generating the necessary forms, filing of claims and following up with Medicare can take 90 minutes for a single patient. If the CAT scan is deemed medically necessary payment will be received in approximately 30 days. If further follow up is needed payment expectations change to greater than 90 days.

3. **Clear Concise Education By HCFA**
Healthcare Providers equipped with computers, seminars, provider manuals and consultants often are stretched to keep up with the pace of regulatory change. Senior citizens do not have much hope of understanding their coverage let alone managing it. As a result, many seniors turn to healthcare providers for answers. It's a frustrating process for both seniors and healthcare providers because there are too many gray areas in interpretation which only Medicare can clarify. The most recent area where clear, concise, pre-implementation education would have been valuable would have been in the area of pre-operative screening. This change in regulation interpretation placed many preoperative diagnostic testing services in the area of screening procedures not reimbursable under Medicare and thus the responsibility of the Medicare patient. As you can imagine Anesthesiologists and Surgeons were concerned that patients would be sedated or have surgical procedures without acceptable preoperative screening for lack of financial resources of the patient to pay for the screening. Patients were concerned that because of an unknown recently acquired problem their life could be at risk during a procedure. This created considerable confusion for the Medicare patient. HCFA says, we are not telling you that you shouldn't have the screening however, it will be your financial responsibility. The provider physician says, for your safety you need this screening. The patient comes to the hospital and ask, what do I do? More Education is needed for program recipients. Everyone would benefit – seniors, hospitals and the Medicare program itself – if Medicare would proactively communicate the changes it makes.

4. **Adequate Time to Implement**
Healthcare providers are rarely given enough time to implement changes enacted in Medicare. We often have to use very expensive manual methods to comply with new regulations. Often there is no computer software solution to help hospitals comply with new Medicare billing requirements.

The new outpatient prospective payment system is scheduled to become effective July 1, 2000. The final rules are not scheduled to be released in their final form until April 10th, the date of this Congressional hearing. The time needed to evaluate and absorb the massive 700 plus pages of final regulations, develop an implementation plan, create the systems to assure that we are able to accurately determine the Ambulatory Payment Classifications (APC's) and determine the financial impact of the APC system upon our hospital is less than 90 days. Even with pre-planning based of preliminary regulations the chances of being 99% accurate is slim. This means that the chances of committing fraud in the OIG's eyes is inversely so.

5. **Clear Concise Simplified Documentation To Enable Efficient Resource Utilization**
The Equation.
As with any business hospitals operate in a simple realm of supply and demand. If the cost for the cardiac blood clot buster TPA is $ 4,953 per vial (actual) and the typical heart attack requires two vials and 30% of your volume is Medicare that will pay $ .41 on the dollar for the drug, how much TPA do you keep on the shelf?

Decision Factors:
We can get drug delivery in 24 hours.
We are an hours travel time to another supply.
We can increase shelf stock and compensate for losses by increasing services not utilized by Medicare to keep the facility open and still provide care for these patients.
We can adopt the policy of not stocking the medication and transfer every heart attack one hour overland to another facility after stabilization and create considerably more cardiac risk.

Although HCFA is very clear that they do not practice medicine they're every decision causes restructuring of the administration of every facet of healthcare on almost a daily basis. Until HCFA can produce clear concise documentation that doesn't waver in the short term there isn't much hope that efficient resource utilization planning can take place in any meaningful fashion.

By the way, the answer to how much TPA we keep on the shelf in today's environment is **: Enough, Hopefully Enough.**

> We believe that healthcare providers and HCFA are both facing incredible challenges. While we are not experts on the funding of government agencies, we believe that the Health Care Financing Administration is under-funded. We are sure that it would probably take additional resources for HCFA to play a role in improving and simplifying the administration of the program, communicating more proactively with seniors and providing more formal interpretation for providers who need clarification on finalized rules.

We don't think it's too naïve to suggest that healthcare providers and the Medicare program can become better partners, where we cooperate on goals, such as administrative simplification and smooth billing practices. The current environment is one of skepticism and mistrust on both sides. Senior citizens will best be served only when Medicare and healthcare providers work together to help provide benefits to our nation's older adults.

The Board of Directors, staff, physicians and myself of Cameron Memorial Community Hospital wish to thank Congressman Mark Souder, the House of Representatives and the Committee on Government Reform for the opportunity to provide feedback on this very important program and its associated issues.

Sincerely,

Dennis L. Knapp
President and CEO
Cameron Memorial Community Hospital

Mr. MICA. Our last witness on this panel is Kelly L. Borror, and she is the administrator of Lutheran Homes in Fort Wayne, IN. Welcome, and you're recognized.

STATEMENT OF KELLY L. BORROR, ADMINISTRATOR, LUTHERAN HOMES, INC., FORT WAYNE, IN

Ms. BORROR. Thank you, Mr. Chairman and Congressman Souder, for inviting me to participate in this panel. I am honored to be selected to give testimony today.

In the current system of Federal oversight for nursing facilities, the State survey agency has been given the authority by HCFA to evaluate facility adherence to the law, cite deficiencies and even impose sanctions. The State agency is responsible for informal dispute resolution and also the appeals process. In short, under the current system, the State survey agency acts as the judge, the jury and the enforcer. We are concerned about the deficiencies that are considered actual harm. Minor isolated incidents are resulting in severe enforcement penalties. If facilities are cited for actual harm on consecutive surveys, they are subject to immediate fines up to $10,000. There is survey team subjectivity regarding interpretation of the regulations. Some teams evaluate compliance based on outcome, others base it on potential outcome, and still others focus almost entirely on the process itself. Survey inconsistency is viewed as the largest problem for providers in long-term care in northeast Indiana.

HCFA conducted an extensive training campaign for nursing home inspectors to help States enforce Federal requirements more effectively and consistently; however, by not conducting training sessions that included both the inspector and the provider, discrepancies in interpretation continue. An annual survey cycle may extend as long as 6 months before a facility is found to be in full compliance. New deficiencies or followup surveys extend the survey and create the possibility for additional sanctions.

It is our desire to have HCFA require States to contract with outside entities to review the cited deficiencies, scope and severity, recommended sanctions and to independently conduct informal dispute resolution. It is, furthermore, our desire for HCFA to train inspectors and providers at the same time; to utilize sanctions to assist providers; to encourage a team approach during survey; and to expedite a survey process.

Providers are currently struggling with the Prospective Payment System known as PPS to survive; there are many, many hidden costs. We are accountable for all expenses which are incurred within the resident's plan of care. Cost constraints and containment are affecting quality services, such as transportation and mobile x-ray to name two. The decreases in available ancillary service results in increased outpatient admissions to hospitals, increased transportation costs and increased expenses to providers. It is greatly appreciated that the Balanced Budget Refinement Act of 1999 was passed; however, it is felt the revision did not go far enough, specifically with the non-therapy ancillary costs that are involved.

In a Prospective Payment System based strictly on average payments, some residents will have costs that far exceed the average. These are known as outliners. HCFA has created other outliner

provisions for hospital, home health and hospital outpatient services for expensive cases. It is time that long-term care providers have an outliner provision. It is our desire to meet individual care needs, whether known or unknown at the time of an admission to a nursing facility; for HCFA to provide PPS billing training to ancillary vendors; for HCFA to re-evaluate ancillary reimbursement; and, finally, to require HCFA to develop an outliner provision for skilled nursing facilities.

Staffing issues in nursing facilities remain the priority from everyone's viewpoint. Currently, with the reimbursement restrictions, facilities are tied to low-end salaries due to the PPS system. This is especially true in reference to reimbursement for our cognitively impaired residents, such as Alzheimers. Facilities across the country are experiencing a nursing staff crisis. In view of the shortage, it becomes imperative that facilities have the option of training individuals who are not certified or not licensed. Permitting individuals to be trained to perform certain tasks can offer partial relief to the shortage and additional individual attention to residents.

Currently, the area where training non-nursing assistance is most needed is assistance with eating. It is our desire for HCFA to revise cognitively impaired payment classifications specifically related to Alzheimer/dementia population. It is further a desire to request the additional language submitted in my prepared statement to be added to the Medicare and Medicaid statutes to give the facilities flexibility to use non-nursing staff to assist residents with eating.

Mr. Chairman, please note, due to the time restraint, I did not cover Full Federal Rate Reimbursement Option or Consolidated Part B Implementation this is currently posing, although there are many complex issues associated with long-term care, as well as acute care, and I request you admit my full written statement and encourage the committee to review that.

Mr. MICA. Without objection, your entire statement will be made part of the record.

Ms. BORROR. Again, thank you for the opportunity to provide information. Facilities are struggling with survey process, reimbursement issues and a lack of available staff, and it is time for HCFA, State regulators and providers to work together toward quality care for seniors. Thank you.

[The prepared statement of Ms. Borror follows:]

TESTIMONY PRESENTED

TO THE

U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON
CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES

"QUALITY CARE FOR SENIORS"
LONG TERM CARE ISSUES

PRESENTED BY

KELLY BORROR, ADMINISTRATOR
LUTHERAN HOMES, INC.

APRIL 10, 2000

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Thank you, Mr. Chairman and members of the Committee, for inviting me to participate in this panel dealing with "Quality Care for Seniors" issues. I am Kelly Borror, Administrator of Lutheran Homes, Inc., Fort Wayne, Indiana. Lutheran Homes is a not-for-profit nursing facility that offers a full continuum of care from 178 independent living apartments to 396 licensed beds

consisting of assisted living, intermediate care, Alzheimer's care, behavior care, hospice care and medicare/skilled care.

I am in my second year as Chairperson for the Fort Wayne Long Term Care Task Force; therefore, I am here today to not only represent Lutheran Homes, Inc. but also to represent the area Long Term Care Providers regarding issues of importance to the industry which impacts the quality care for seniors. I am a member of Indiana Association of Homes & Services for the Aging, Inc. (IAHSA), as well as the American Association of Homes and Services for the Aging (AAHSA).

Together, we are committed to providing quality care to the people we serve and to meeting the needs of these individuals in a manner that enhances their sense of self-worth and dignity, and that allows them to function at their highest levels of independence. I am honored to give testimony before the Subcommittee on Criminal Justice, Drug Policy, and Human Resources..

INDIANA RANKS 3RD IN THE NATION REGARDING SUB-STANDARD CARE

In the current system of federal oversight for nursing facilities, the state survey agency has been given the authority, by the Health Care Financing Administration (HCFA), to evaluate facility adherence to the law, cite deficiencies, and impose sanctions. The state agency is also responsible for informal dispute resolution and the appeals process. In short, the state survey agency acts as judge, jury and enforcer, with little recourse, and limited due process, for the provider who disagrees with survey findings. Based on the third quarter 1999 OSCAR Summary for Non-Profit Providers, Indiana ranks 3rd in the Nation regarding sub-standard care. (Exhibit A)

The imposition of sanctions (remedies) is based on the surveyor's assessment of the scope (the number of residents affected) and the severity (the potential for harm or actual occurrence of harm to residents) of the finding. Sanctions range from civil money penalties and denial of payment for new admissions, to de-certification.

The surveyor's role in finding deficiencies, and assessing the scope and severity is critically important, and is based in large part on subjective judgement and personal preference, not on objective criteria with a focus on the outcomes of care. From my discussions with other long term care providers in the Fort Wayne area, there remains a great deal of survey team subjectivity regarding interpretation of the regulations. Policies and procedures are surveyed differently in each building. Some survey teams evaluate compliance with the regulation based on observable outcome; other teams survey based on "potential" outcome, while some focus almost entirely on process. The approach will vary from area-to-area depending on the survey team assigned. The outcome approach will often times result in more positive survey findings, as concerns are verbally expressed by the survey team at the time of exit, resulting in fewer, and less severe deficiencies cited. These inconsistencies in survey methodology and focus, as well as the limited ability to dispute findings, is viewed as the largest problem for Long Term Care Providers in Northeast Indiana.

Providers are concerned about the kinds of instances that are considered "actual harm". The State Survey Agency may impose an immediate fine any time a nursing home is found to cause harm that is not immediate jeopardy (a level "G" deficiency) to one resident on consecutive surveys. (Exhibit B) The descriptions of "actual harm" deficiencies vary widely from survey team-to-team, and area-to-area. There is a strong likelihood that a facility may receive a level "G" or higher on consecutive surveys. (Exhibit C) Minor, isolated incidents are resulting in severe enforcement penalties. A few examples from Fort Wayne facilities include the following:

> "...facial hair on chin and upper lip which was not removed in accordance with the plan of care....Level G"
>
> "...an assistant refused to comb a resident's hair...Level G"
>
> "...a family member posted a sign regarding resident care issues...Level G"
>
> "...a finger nail cut in the palm of a contracted hand...Level G"

The above are examples of level "G" citations of actual harm. (Exhibit D) If these facilities are cited again this year with a level "G" or higher, they are subject to immediate fines up to $10,000.

Under the new rules, any facility that receives a deficiency cited at level "G" or above on two consecutive surveys will no longer have an opportunity to make corrections before sanctions are imposed. Although HCFA has eliminated the "poor performer" designation, the imposition of immediate sanctions now includes back-to-back "G" level deficiencies. The providers in the Fort Wayne area work diligently to avoid any harm to any resident but question that instances such as those mentioned previously constitute harm punishable by fines. This expansion of enforcement is expected to increase the number of homes given immediate sanctions from 1% to 15%. Although HCFA has stated that the intent is to improve the quality of care in nursing homes; for non-profit providers, it directly decreases the amount of money available to facilities for resident care and services.

Along with the authority to impose immediate sanctions, the state is authorized to encourage speedier action to stop payment for new admissions. (Exhibit B) Should a minor, isolated incident of actual harm (as determined by the state) constitute loss of payment for new admissions?

In Indiana, the survey agency has the authority to impose State fines when federal civil monetary penalties are not imposed, or for findings against facilities that are state licensed only and do not participate in the Medicare or Medicaid programs. Currently, the revenue from state fines is placed in the Indiana General Fund. The funds collected are not utilized to improve quality care of residents. A bill was passed this year by the Indiana General Assembly that would have established the "Quality Improvement & Education Fund" by requiring that 50% of the state fines collected be deposited in this fund. The bill was subsequently vetoed by Governor Frank O'Bannon. As of September 3, 1999, the Indiana State Department of Health (ISDH) reported

that fines totaling $451,250 were imposed against Indiana nursing facilities, compared with a total of $322,500 for all of 1998. In 1997, the total sanctions imposed were $77,500. (Exhibit E)

HCFA conducted an extensive training campaign for nursing-home inspectors to help states enforce federal requirements more effectively and consistently. HCFA has directly trained more that 600 federal and state survey managers, who have conducted training for their staffs. (Exhibit B) The training has been done in an attempt to strengthen the state inspection and enforcement process.

Unfortunately, HCFA trains nursing home inspectors separately from providers. By not conducting training sessions that include both the inspector and the provider, discrepancies in interpretation of the regulations and inconsistent expectations on the part of surveyors adds to the hostile atmosphere and negates any hope of a collaborative approach in providing quality care to seniors entrusted to our care. One constant remains: inspectors are pitted against providers or vice versa.

During 1999, it was not uncommon for an annual survey cycle to extend as long as six (6) months before a facility was found to be in full compliance with all regulations. This generally includes two additional follow-up surveys. When a survey team returns to complete a follow-up survey, they no longer only review the corrected deficiencies from the previous visit. There are many providers who are being cited with new deficiencies which extends the annual survey process and creates the possibility for additional sanctions, including denial for new admissions. Our joint goal should be to collaboratively work toward the provision of superior care to our elderly, instead of spending inordinate amounts of time and money *attempting* to pass a survey.

It is the desire of the Long Term Care Providers in the Fort Wayne, Indiana, area to have HCFA require state survey agencies to contract with outside entities to review cited deficiencies, the scope & severity assigned to deficiencies, the recommended sanctions, and to independently conduct informal dispute resolution. Independent outside review of survey findings will result in more appropriate citations by surveyors. It is, furthermore, the desire of Long Term Care Providers in the Fort Wayne, Indiana, area for HCFA to train inspectors and providers at the same time; to utilize sanctions to assist providers; to encourage a team approach in providing quality care in meeting regulations and to expedite the annual survey process.

PROSPECTIVE PAYMENT SYSTEM (PPS) REIMBURSEMENT– A NEED FOR OUTLIER PROVISION

Long Term Care Providers are struggling with the Prospective Payment System (PPS) to survive--there are many hidden costs. Providers are accountable for all expenses which are incurred within the resident's plan of care. The plan of care expenses are an unknown at the time of a hospital assessment.

If there were previous appointments scheduled not related to the hospitalization, these appointments and/or treatments become the responsibility and expense of the admitting nursing

facility. Examples of items which have become a part of the plan of care include dental extractions, cataract surgery, skin graphs, ECT treatments, wound care, respiratory care, medication outliers, pharmacy items, lab fees, specific equipment requirements, etc... It is difficult for Long Term Care Providers to bear the burden of the plan of care expenses without an Outlier Provision.

Due to the changes in the reimbursement structure through the implementation of PPS, the long term care industry has been forced to become a managed care entity. The pre-admission assessment has become an extremely detailed process involving complete chart reviews, medication outliers (medications which are in excess of the daily reimbursable amount), determining current/future medical needs, and cost reimbursement decisions. There is a need for an Outlier Provision in order for providers to be able to meet resident care needs.

Duplicate billing remains a problem under PPS regarding non-therapy ancillary costs. As a long term care provider we notify outside vendors when a resident is a PPS Medicare Patient and that we should be billed for services performed unless an exempt service as outlined. However, frequently, we do not receive an invoice. HCFA must ensure all out source entities are educated regarding PPS billing processes.

The cost constraints and containment are affecting quality ancillary services which are available to long term care providers in an attempt to manage costs. Currently, there are very few mobile x-ray services; the current vendor in the Fort Wayne area has filed Chapter 11. If they are not able to reorganize, we will be left without a mobile service; this will result in increased outpatient admissions, increased transportation costs, and increased expense to the providers to meet the plan of care requirements. We have approached an acute facility to negotiate a mobile x-ray service; however, with pending Ambulatory Patient Classifications (APC) the potential reimbursement prohibits this as a viable option. It is imperative for providers to perform as many services in-house as possible in order to manage the total care costs.

It is greatly appreciated that HCFA passed the Balanced Budget Refinement Act of 1999 which revised fifteen (15) RUG-III classifications regarding reimbursement; revised certain ambulance services, revised how chemotherapy and prosthetic devices are viewed; as well as, delete the requirement for rehab caps. However, it is felt the increases in RUG-III classifications didn't go far enough–specifically regarding non-therapy ancillary costs. It is now time to further change the Balanced Budget Act to reflect an Outlier Provision.

The PPS for skilled nursing facilities bases reimbursement on the average cost of providing care within resource utilization groups (RUGs-III). In a prospective payment system based on average payments, some residents will have costs that far exceed the average. The exclusions identified in the Balanced Budget Refinement Act of 1999 will help alleviate some of the disparities associated with extremely expensive services. However, there will always be a small number of cases, generally known as outliers, whose costs greatly exceed the average payment.

In other prospective payment systems that HCFA has created (hospitals, home health and hospital outpatients), an outlier provision was included for the excessively expensive cases. The

Balanced Budget Act did not specifically allow for such a provision for skilled nursing facilities, and HCFA maintains that it cannot create an outlier without statutory authority.

It is the Long Term Care Provider's desire to meet individual care needs whether known or unknown at the time of admission, it is our desire to have HCFA provide PPS training to ancillary vendors for outpatient services which are billable to the provider, it is our desire for HCFA to re-evaluate ancillary reimbursement schedules to afford services to Long Term Care Providers in-house, and finally it is our desire to require HCFA to develop an outlier or exceptions policy within the skilled nursing facility PPS to pay adequately for RUG-III episodes with costs that far exceed the prospective payment. The outlier provision would kick in after the cost to provide services is more than the outlier threshold and would help the long term care provider recuperate some of the cost of extremely expensive cases.

CONSOLIDATED BILLING PART B IMPLEMENTATION

The Balance Budget Act changed nursing homes' Medicare billing procedures, requiring nursing facilities to bill Medicare for all Part B services provided to residents. Because of the complexity of this change, HCFA delayed its implementation, with the exception of billing for outpatient rehabilitation therapies. HCFA now is developing the process for full implementation of Part B consolidated billing.

The new policy was designed to reduce the opportunity for multiple service providers to submit fraudulent, duplicate bills by holding nursing facilities liable for any errors in billing, whether or not they are intentional. Although the concept of consolidated billing is laudable, it places added administrative burdens and fiscal risks on nursing facilities that could prove catastrophic.

Billing for many Part B services requires specially trained staff and claims processors to meet complex billing procedures. For example, claims for orthotic and prosthetic equipment require not only detailed codes, but also extensive modifiers to indicate how the device is constructed. Currently, specially trained coders employed by the orthotic and prosthetic vendors prepare the bill. Skilled nursing facility staff do not have the expertise in all the intricacies of billing each of these services to produce consistently, accurate claims. If skilled nursing facilities rely on vendors to produce the claims, the nursing facilities will be liable for fraud if the claims contain any errors.

It is the desire of Long Term Care Providers to request HCFA to exempt from consolidated billing ancillary services that are extremely complex and that already have safeguards established to eliminate fraud such as specialized claims processors and fee schedules. The exemptions would not increase the budget; it would clarify who bills–the long term care provider or the supplier.

FULL FEDERAL RATE REIMBURSEMENT OPTION

Over the three-year implementation of the skilled nursing facility prospective payment system, reimbursements are made according to a formula that combines a facility-specific rate with a federal rate, which is given increasing weight each year. Facility-specific rates are based on cost reports that skilled nursing facilities filed in 1995. Since that time, many facilities have significantly changed their operations, often by accepting patients who need a higher level of care than a facility previously provided. For these facilities, the facility-specific rate is inadequate, and the federal rate more appropriately reimburses the kind of care residents are now provided.

The Medicare Balanced Budget Refinement Act allowed facilities to opt for the full federal rate at the beginning of their next cost reporting year, effective January 1, 2000. Facilities have only 30 days into the cost reporting period to notify the fiscal intermediary of the desired change. Facilities whose cost-reporting years began this January received significant relief under this provision. Facilities whose cost reporting periods do not begin until July or October will benefit to a much lesser extent since they already are farther into the transition period.

It is the desire of Long Term Care Providers for HCFA to allow skilled nursing facilities the option to opt for the full federal rate on or after January 1, 2000, retroactive to the start of their second year in the prospective payment system. Long Term Care Providers that suffered through the start-up implementation of PPS do not have the opportunity to move to full federal rates until their third year on PPS while others are allowed to move at the start of their second year.

STAFFING ISSUES A PRIORITY

Staffing issues in nursing facilities remain a priority from everyone's view point--consumers, providers and inspectors. Higher acuity levels as well as projected aging demographics support the continued need for Certified Nursing Assistants (CNAs) as well as licensed staff. Increased funding must be made available to enable facilities to recruit and retain quality staff. Currently, with the reimbursement restrictions under the prospective payment system, nursing facilities are tied to low-end salary ranges in attempts to maintain the non-therapy ancillary service expenditures within RUG-III classifications. This is especially true in reference to the reimbursement for cognitively impaired residents where greater staff time is required to meet resident needs.

Nursing facilities across the country are experiencing a staffing crisis. Insufficient numbers of staff--licensed practical nurses (LPNs) and registered nurses (RNs)--can endanger quality care for residents. However, one of the greatest challenges currently faced by nursing facilities in assuring quality of life and care outcomes to residents is the ongoing shortage of nurse aides. Cornell University's Applied Gerontology Research reports that some 600,000 new nursing assistants will be needed within the next ten (10) years.

In view of the shortage for CNAs it becomes imperative that nursing facilities have the option of training individuals who are not certified and/or licensed to perform certain tasks. Current law defines a nurse aide as "any individual providing nursing or nursing-related services to residents in a skilled nursing facility or a nursing facility." The statute requires that nurse aides

successfully complete a training and competency evaluation program. However, in the nursing home environment, many employees who are neither nurse aides nor licensed health professionals also have frequent and regular contact with residents. Permitting these individuals to be trained to perform certain tasks determined to present little or no risk to a resident and can offer partial relief to the CNA shortage as well as offer additional individual attention to the residents.

Currently, the area where trained non-nursing assistance is most needed is assistance with eating. In addition to providing assistance at regular mealtimes, examples include a dietary aide who might be permitted to help residents eat birthday cake at a party, or office personnel and activity assistants who might assist with eating during a special event or outing. The ability to provide assistance would be based on a comprehensive assessment of the needs and potential risks to the residents. The individuals performing the task would be required to complete in-service training in dining skills and assistance with eating, and demonstrate competence in the duties assigned.

It is the desire of Long Term Care Providers to request HCFA to revise cognitively impaired RUG-III classifications specifically related to the Alzheimer/dementia group, and it is further a desire to request the addition of the language below to the Medicare and Medicaid statutes to give nursing facilities flexibility to use non-nursing staff to assist residents with eating under certain conditions:

> "Amend Sections 1819(b)(5) and 1919(b)(5) of the Act to include:
>
> (H) Non-Nursing Personnel Performing Limited Duties
>
> (i) Nursing facilities may permit personnel other than nurse aides to provide assistance with eating without completing the NATCEP or CEP if they have acquired the necessary knowledge and skills through an in-service training program established by a professional organization, such as the American Dietetic Association, that includes

dining skills and assistance with eating; and that has been reviewed and approved by
the regulatory authority; and they have been found competent to perform their duties.

(ii) The determination of ability to provide assistance with eating and dining skills will
be made by an interdisciplinary team, to include at minimum, licensed nursing, dietary,
speech therapy, and occupational therapy staff responsible for the care of the resident.
The determination will be based on the needs and potential risks to the resident as observed and documented in the comprehensive assessment and care plan.

(iii) The facility will document that the interdisciplinary team has assessed the resident to determine that his or her health status does not require this particular task to be performed by nursing personnel.

(iv) Non-nursing personnel providing assistance with eating and dining skills may augment, but not replace existing staff, and cannot be counted toward meeting or complying with requirements for nursing care staff and functions."

Mr. MICA. Thank you for your testimony. I thank all of our witnesses. I'd like to proceed with a few questions. First of all, Mrs. Altenhof, did you get your medical procedure?

Ms. LORRAINE ALTENHOF. [Nods head.]

Mr. MICA. You did.

Ms. LORRAINE ALTENHOF. Yeah. You mean the testing?

Mr. MICA. Well, the whole works.

Ms. LORRAINE ALTENHOF. Oh, yeah. They operated on me on March 1st.

Mr. MICA. OK.

Ms. LORRAINE ALTENHOF. And I have——

Mr. MICA. What about payment?

Ms. LORRAINE ALTENHOF. So far, I've just received one statement, and it came from my supplement insurance, stating that Medicare did not pay a charge of $11.07. So I called the insurance company, and they told me it was for a chest x-ray, which amazed me, because I'm sure a chest x-ray costs more than that. So is it possible that the hospital could be writing it off?

Mr. MICA. Well, we can ask that question, but that's the only charge that you've——

Ms. LORRAINE ALTENHOF. So far.

Mr. MICA [continuing]. Incurred? And that would be covered by your supplemental?

Ms. LORRAINE ALTENHOF. Only if Medicare pays my supplemental insurance pays.

Mr. MICA. All right. OK.

Ms. LORRAINE ALTENHOF. If Medicare——

Mr. MICA. It would not——

Ms. LORRAINE ALTENHOF [continuing]. Doesn't pay, neither will my insurance.

Mr. MICA. All right. Obviously, you had a difficult experience, and I'm sure it caused you additional pain and suffering in addition to your medical procedure.

Ms. LORRAINE ALTENHOF. Yeah. They were two major surgeries.

Mr. MICA. Yes, ma'am.

Ms. LORRAINE ALTENHOF. But again, I was only in 2 days, and they asked me if I wanted to go home.

Mr. MILLER. Yeah.

Mr. MICA. Thank you. Mr. Miller, it's almost getting to the point where this is so frustrating dealing with trying to straighten out a program that produces 140,000 pages of regulations and compliances. It becomes almost impossible, and one of the things Congress has tried to do since we've attempted to reform the Medicare Payment System is to cut down on some of the fraudulent billing, some of the extra procedures, sometimes medically unnecessary procedures, that were not done often by legitimate operators, but trying to sort through this and create a system. Congress really sets the general parameters, and then we let the agencies set the rules.

Is there any way you can see us ever correcting this, other than just coming back time and again and trying to do this patchwork approach to fixing?

Mr. MILLER. Well, just to note, first of all, that Medicare is one of the unique insurers that doesn't actually communicate to the

beneficiaries what services are covered or not covered. All other insurers that hospitals deal with, it's the insurance company's responsibility to determine whether a test is medically necessary or not, and, if not, they then allow for the hospital to bill the individual for that care.

Medicare requires the hospitals to determine in advance without communicating to the seniors what is medically necessary or not. Medicare has not taken the responsibility to educate physicians; they hold the hospitals responsible for educating physicians. The hospitals are caught in a catch 22. Perhaps, the first suggestion would have to be to take the same approach as every other insurer in the country and begin communicating to physicians and patients what is or what is not covered and allow for those items that are not covered to be billed by the providers as opposed to sending Advanced Beneficiary Notifications, making patients then choose maybe not to have a procedure that is medically necessary. And in Mrs. Altenhof's standpoint, she might have chose not to have that procedure because of the $300 or $500. That is a very difficult situation.

The other thing is that Medicare and HCFA would indicate that the standards, the guidelines, the rules have not changed since 1960. My suggestion, it's time for a total overhaul. Wish I could give you what the right answer is, and I don't profess to be the best policymaker in health care, but I know 1,000 pages of additional regulations last week on outpatient payment is not the way to go, and a 90-day implementation process. Interpretations of new policies like the Advanced Beneficiary Notification, where the only intent is to reduce the payment to providers at a time when providers are already receiving less than their cost just causes conflicts between hospitals and the patients.

I think it's a very difficult situation. I wish I had an easy answer.

Mr. MICA. Mr. Knapp, you described 13 pages of coding for a chest x-ray, and how can a hospital comply with those kinds of regulations? Is it becoming impossible or difficult to make certain that you're in compliance?

Mr. KNAPP. It's very difficult. Over the last——

Mr. MICA. If you'd like to pull that up——

Mr. KNAPP. Oh. I'm sorry.

Mr. MICA. We can catch you.

Mr. KNAPP. Over the last 2 years, most hospitals have had to develop a complete corporate compliance program to avoid HCFA implementing much of the—they come in and find a deficiency. In a full corporate compliance program, their responsibility is to develop policies and procedures to make sure that things are appropriate.

In our institution, we've had to bring in our audit team and do a complete review of our charge master to make sure all codes, all edits—all the procedures that, through their audit, we would lessen the probability of any kind of fraudulent billing occurring. And, of course, that all costs a lot of money and pushes up our health care cost overall.

Mr. MICA. So you're sort of caught in a difficult position between being charged with fraud or not covering yourself as far as liability, if something happens with a patient.

Mr. KNAPP. That's very true.

Mr. MICA. In surgery and if a test is not done or some procedure is not done; then you face, I think, liability problems.

Mr. KNAPP. Yes.

Mr. MICA. And I think that the pressure has been, from Congress, to try to eliminate fraud and eliminate unnecessary tests or diagnoses, but by the same token, you must cover yourself as far as liability, and that becomes a big cost and also a big factor in health care today; is that correct?

Mr. KNAPP. That's true.

Mr. MICA. Ms. Borror, you talked about a system of possible independent evaluations and trying to get someone to independently make a determination, I guess, where there's a conflict either in payment or services. Is that correct?

Ms. BORROR. I think you're referring to the survey process——

Mr. MICA. Right.

Ms. BORROR. With independent review. Basically, what we go through right now is the survey—the survey agency is empowered by HCFA, comes out and surveys the facility. They determine what citations need to be or found as far as deficiencies, and then they also determine what sanction is going to be implied or imposed.

Mr. MICA. But you were recommending a system that changed that?

Ms. BORROR. Correct.

Mr. MICA. Can you elaborate a little bit?

Ms. BORROR. Right now, they are doing the appeals process, as well. If we could have an outside entity that would oversee what the survey results were and——

Mr. MICA. Who would appoint that—also HCFA, or——

Ms. BORROR. I do not know who would end up appointing that. And it would be nice for HCFA to state that that is required by the State survey agencies to have outside review rather than to be appointed by HCFA or not, but——

Mr. MICA. All right. But, again, you're calling for some type of a change in the evaluation system?

Ms. BORROR. Correct.

Mr. MICA. All right. You're also having problems complying with HCFA regulations, and if they impose some of these additional APC, I guess, rules——

Ms. BORROR. Uh-huh.

Mr. MICA [continuing]. By July, that gives you 90 days to comply. Would you have difficulties?

Ms. BORROR. The way APC affects us is with outpatient services that we need to use for ancillary services under the Prospective Payment System. And when we try to utilize services in-house—we've attempted to work out something with an acute care facility here in town, trying to bring services in-house which they would need to bill out patient wise. And, at this point in time, their reimbursement fees are not such they can even offer the service to us, which then results in us sending the patient into the hospital for maybe a service that could have been done at the nursing facility.

And under the Prospective Payment System, we are accountable for our—all charges. We are given one set lump sum of money and whatever that individual needs, rather it was a part of their plan of care at the hospital or rather it was something that developed

beforehand or afterward becomes a part of that person's plan of care under Medicare, then the nursing facility has no other alternative but to provide that to meet the resident's needs, and that is at our expense. So the Payment System itself does not cover generally an individual's needs at that point in time.

Mr. MICA. Thank you. I yield at this time to the gentleman from Indiana, Mr. Souder.

Mr. SOUDER. One thing, just in general, which is true for the second panel, as well, but we may have additional written questions in this 2-week period, and if any of you have additional things you'd like to get into the record that we can ask HCFA either in Chicago or Washington to respond to, or answer in future hearings. This is just scratching the surface, as you well know, particularly because we've combined so many different things in this hearing.

Before we restructured the committee system after Congressman Hastert became Speaker, he was the chair of the committee that had the drug policy. We restructured, moved Human Services from a different subcommittee into the one that Mr. Mica now chairs. We had seven hearings that I attended on Medicare and Medicaid fraud before we passed the Balanced Budget Act, and in each one, we'd go through just a little subsection of this. So I know it's a massive subject.

There are a couple of things I wanted to get on the record and see where we might follow through: one, with Mr. Knapp. You referred to the difference in Michigan and with patients from different areas. Is it because of State clearances that there are differences? Is it because they go through a different HCFA regional office?

Mr. KNAPP. The payment usually comes from a fiscal intermediary, which is—in Michigan, it can be Travellers, it can be Blue Cross. There's a couple fiscal intermediaries up there. But the local Medical Review Policies for payment are made at the fiscal intermediary level; therefore, there's no Federal standardization of those. Standardization across the United States would certainly help.

Mr. SOUDER. One of the things we found earlier on is that even in trying to track "fraud," the regional system computers couldn't even talk to each other in the Federal Government.

Mr. KNAPP. That's true.

Mr. SOUDER. And I was trying to see whether we had much of that in the Midwest or where exactly the lines were. What percentage of the patients that come through are from Indiana in your case?

Mr. KNAPP. Of the Medicare patients, probably 60 percent.

Mr. SOUDER. So 40 percent.

Mr. KNAPP. Yeah. We're located in the very northeastern corner of the State, so we get people from both Ohio and Michigan.

Mr. SOUDER. Now, in the Lutheran system, with your other hospitals outside of Allen County, as well, do you know what your percentage runs?

Mr. MILLER. Just to quote a number, I would guess for Medicare patients, probably 80 to 85 percent are local and 15 percent may be outside.

Mr. SOUDER. What other unique questions would apply to your situation? I saw in your written testimony, Mr. Knapp, you referred to even what kind of medications you'd have in supply in a rural hospital an hour away from any major city—South Bend or Fort Wayne or Lansing. You would have to supply questions on urgent needs. Does that mean you would have different types or have to do substitutions that wouldn't necessarily be under the guidelines?

Mr. KNAPP. Yes. In my testimony, I used the example of a drug that dissolves blood clots, and I use it because it's a very expensive drug, first of all.

Mr. SOUDER. Uh-huh.

Mr. KNAPP. I think hospitals are put in the position many times of having to have these resources on hand and a quantity of these resources and have a lot of capital, so to speak, sitting on the shelf and not knowing if they're ever going to get at least their cost back out of them.

Again, because of our position in the county being an hour away from a major tertiary facility, we're forced sometimes to keep many things available that normally we wouldn't use on a frequent basis. And so, we have to tie up a lot of our money that way. Overall, I think right now we're getting about 41 cents on the $1 reimbursement for Medicare. So, again, we have to tie up resources for use on Medicare patients, and——

Mr. SOUDER. Could you——

Mr. KNAPP [continuing]. And we're glad to do that.

Mr. SOUDER. Forty-one cents on the dollar; could you explain that?

Mr. KNAPP. On the $1 of charge. And, again, it's an overall number for Medicare.

Mr. SOUDER. And how do you make up the gap difference?

Mr. KNAPP. You mentioned earlier the process of cost shifting, and that, of course, has led to a—I think one of our major problems in health care expenses in that hospitals are forced to keep their rates at what the market will bear. There may be other insurance companies out there willing, obviously, to pay more than Medicare is willing to pay. And, so, you have to keep raising your charges and consider the Medicare shortfall as a contractual deficit for the hospital in order to make up for that shortfall through other insurers.

Mr. SOUDER. Mrs. Altenhof referred to another thing that's a byproduct. That is that you can squeeze services to some degree, for example, the length of time somebody's in the hospital, because if you're losing money on that individual, there's no incentive to keep them there any longer than is the absolute minimum. You are certainly not going to put somebody out who's at health risk——

Mr. KNAPP. Oh, no.

Mr. SOUDER [continuing]. But that's the kind of things that are occurring.

Mr. KNAPP. In the early 1980's, we made the conscious effort to induct the outpatient technology to take care of as much outpatient work as we could in the inpatient setting. And we've reduced our average length of stay to about 2 days. Again, that was a small

general hospital. And then, last year, we saw 77,000 outpatients through a 60-bed hospital.

Mr. SOUDER. Ms. Borror, I wanted to put a couple of things in the record as to the home health care area and then the long-term care nursing home area. And, again, we're just scratching the surface a little bit today. I wanted to clarify a couple of things.

My understanding—and Mr. Mica asked a variation of this question—is that, based on what you chose to stress here, you felt that the clearance process was a bigger problem than a lot of other things currently, taking 6 months and then constantly re-evaluating, that you're taking so much time filling out forms that you weren't able to provide care.

Ms. BORROR. Correct.

Mr. SOUDER. Is that——

Ms. BORROR. This is correct. It wasn't that way until about 1½ years or so ago with a lot of the changes in regulation and the imposition of fines and sanctions. In 1997, Indiana imposed $77,000. In the third quarter, by 1999, there was over $400,000 in fines imposed. So there's a drastic difference, and this money goes to the Indiana General Fund. And that comes as a result of the survey process. And the longer a survey takes in a building, the greater the possibility for sanctions to be enforced and applied on a facility.

Mr. SOUDER. In the small church I grew up in out in the Grabill area, once a month, we would go up and have a church service at the nursing homes up in Butler. Much of my life, I went to Butler on Sunday. In addition, we have large homes in Warren, Avilla and Swiss Village, in Berne—all over this district. I've also been in the Golden Years Homestead, where my grandma was and at Cedars, where my father-in-law was before they both passed away over the last few years. Clearly, everybody here is concerned about the quality of nursing care. Nobody's arguing that there aren't problems. I've also heard from the nursing home providers that one of the big difficulties is staffing questions and how to adequately meet the staffing needs.

Do you have anything you'd like to put into the record today related to that and how we might look at addressing that and what pressures you're facing?

Ms. BORROR. I think right now, the staffing issue, there's a tremendous shortage, not only for long-term care, but also with acute care, and I'm sure these gentlemen can attest to that.

When we look at staffing, unfortunately, we cannot pay the same salary rates as a hospital or an acute care system. Our rates that we receive from Medicare are quite a bit lower than even a hospital transitional care unit, specifically with the full Federal transition into reimbursement right now. The certain task-performed training would be a great assistance to individuals, specifically when we're looking at nutrition and we can only have a certified or a licensed person do any feeding or assistance with feeding at mealtime. To be able to train other individuals who are not licensed or certified would assist us in meeting some additional staffing needs and quality care needs for residents and having availability of individuals.

Mr. SOUDER. Thank you. Mr. Miller, I wanted to thank you personally, as well as Dr. Schroeder and others and Jim Tobalski and

the many from Parkview that have come in and tried to overall clarify. I'd like to put this into the record, because it's a frustration with the administration on the unfairness of the fraud question.

Clearly, we have to track the fraud, and we've made some attempts to say in Congress you're innocent until proven guilty. There's an assumption that there is a maliciousness which the word "fraud" implies as opposed to the lack of clarity. And, with all due respect, we'll get into this in the second panel. It's difficult with the cost pressures for HCFA to make lots of different changes and to do all those. But, that said, we ought to acknowledge that difficulty, and this whole question of fraud has been disturbing.

Here in Fort Wayne, we've seen newspaper headlines where, in fact, hospitals here have been accused of fraud where, in the end, most of even the things that were in question were resolved in the hospital's favor. And, at the same time, the only things that weren't were marginal decisions, but because of the headlining in the Fort Wayne newspapers, the implication was that there was fraud practiced, or at least alleged, by the Federal Government inside our district when, in the end, there was none. There wasn't a single case. There were a couple of cases that were these questionable judgments. And I appreciate you're bringing those kind of things out, because too many times, people say, "Oh, the Federal Government is having all this fraud" or "Hospitals are practicing fraud" when, in fact, we can see these are very difficult decisions by you all and by the doctors, and the number of classifications are just amazing. So I thank you for that.

I wanted to ask a technical followup on Ms. Altenhof's situation. How long in her case where she comes in, how long until you get a clear definitive decision from Medicare as to whether it's covered or not covered?

Mr. MILLER. I don't know her individual situation, but——

Mr. SOUDER. Right.

Mr. MILLER [continuing]. Generally for Medicare—and the reason why she probably hasn't received a bill is just because of the timing. For someone who had surgery in March, which is less than 30 days, she looks great, so the health care system is working. But I would guess that 60 days is a reasonable timeframe. Generally between 60 and 90 days, we should know exactly what was paid or what wasn't. But Medicare's unique. Medicare's the only insurer who pays first and then questions later. Sometimes——

Ms. LORRAINE ALTENHOF. Yes.

Mr. MILLER [continuing]. A year later, sometimes 3 years later. Most insurers make the determination and then you appeal. They pay and then, if they determine 2 years later they shouldn't have, they charge you with fraud and ask for, you know, $10,000 per incident over and over and over again multiple denominators of that number. So it's a unique situation that, in her case, I'm sure they're going to pay first and then—they don't even have the systems in place—you mentioned the differences between different intermediaries to look through it, and they'll be doing that over the next few years, and we'll come back, I suspect, in this case maybe to indicate that that was a fraudulent billing.

Mr. SOUDER. One of the things that, after you hear the full testimony today—and if you have additional questions you'd like us to

submit or additional comments—I appreciate you clarifying that, because one of the undoubted difficulties is that I can see how unintended consequences occur. For example, one of the things we heard in our oversight hearing 5 years ago was that Medicare was the slowest payer. So most likely what we did or I assume we'll hear, was that we forced them to pay first and question later, because we were hearing from providers that they weren't getting paid fast enough.

The problem here, to me, appears that at the crux of what you said is the lack of clarity at the beginning that every other provider does. Now, I'm sure—and I do want to acknowledge this for the record—that part of this is that Congress makes some of these rules and the biggest thing we've done here is we haven't actually made the rules; for the most part, what we've done is restricted the budget. And then there's an interpretation, as Mr. Miller said and others, and this is our dilemma that we're working through. I remember traveling throughout northeast Indiana saying we were going to reduce the Medicare growth from 10 to 7 percent. And, in fact, it has only grown by about 2.5 percent. Now, I and other Members of Congress are going all around the country talking about surpluses. Well, as we heard, a big chunk of that surplus is because we've saved costs in Medicare because HCFA has made difficult rulings, not Congress making the rulings, and that way, all the politicians can talk about a surplus, but we're the bad guys that made the rulings. So what we've done last year, we came in with about 8 or 10 billion at the tail end to try to relieve some of the pressure.

And, clearly, some of these things are cost-driven, but even if they're cost-driven and what we're—what we need to sort through is how much of this is cost pressure, how much of this is just not good business practices? If other insurance companies can do it and give the guidelines in advance, can the government do that? How do we have to put into that kind of infrastructure? How much of these were arbitrary decisions that need to be relooked at? How much of this is, in fact, cost? And we're all going to have to share in part of that, whether it's hospitals, whether it's in patient preplanning, whether it's in the Federal Government trying to put more dollars in if, in fact, we don't have enough knowledge.

Any other comments any of you want to make? You can make written requests, too.

Ms. LORRAINE ALTENHOF. I just wanted to tell you that my daughter, Patty, is a nurse at Marcell Nursing Home, and they have the same problem the lady down here was talking about with the shortage of nurses there, right?

Ms. PATRICIA ALTENHOF. Uh-huh.

Ms. LORRAINE ALTENHOF. Terrible.

Mr. SOUDER. And we have a strong nursing training program in this market, yet I still hear it everywhere——

Ms. PATRICIA ALTENHOF. Yes.

Mr. SOUDER [continuing]. That there is this tremendous shortage, and we're going to have to look for creative ways to address it.

Mr. MILLER. Just one other thing. You mentioned what can be done. Let me offer one suggestion. The determination of medical

necessity shouldn't be different for seniors as it is for non-seniors, and the billing process shouldn't require within hospitals 10 or 11 or 12 different processes to bill. Perhaps, within 5 years, the determination of what's medically necessary can be consistent among outpayers and perhaps one billing system could be put in place that would allow us to bill consistently between all providers.

Mr. MICA. Thank you. Well, I think we're going to recess here for about 7 minutes. We'll reconvene at 10:20, and then, at that time, I'll call forward our second panel. This hearing is in recess.

[Recess.]

Mr. MICA. I would like to stay on schedule today, and I just checked. There will be votes scheduled on time today, but let me call the subcommittee back to order in this hearing on the quality care question for seniors.

I'm pleased at this time to welcome our second panel. Our second panel consists of Dr. Barbara Schroeder. She is the president of the Fort Wayne Medical Society here in Fort Wayne, IN. We also have Dorothy Burk Collins, and she is the Regional Administrator for the Health Care Financing Administration, Department of Health and Human Services from Region Five located in Chicago. We also have Jim Tobalski, and he is the senior vice president of Community Relations for Parkview Health Systems and Parkview Health Hospital here in Fort Wayne, IN.

Again, let me inform our witnesses this is an investigations and oversight subcommittee of the U.S. House of Representatives. In that regard, we do swear in our witnesses, which I'll do in just a moment. Also, if you have a lengthy statement or documentation you'd like to be made part of the record, upon request, that will be submitted and part of the complete record of this hearing.

At this time, if you'd please stand and be sworn. Raise your right hand.

[Witnesses sworn.]

Mr. MICA. Witnesses have answered in the affirmative.

Mr. SOUDER. Mr. Chairman.

Mr. MICA. Yes.

Mr. SOUDER. I think I should have said this in the first panel, too. You now join all the—everybody from Craig Livingstone, Nussbaum, and John Podesta, and all of this is the same committee that's done all the investigations on all the White House investigations and so on. And, actually, some people who got sworn in later found out that they should have stuck with what they said.

Mr. MICA. Yes. We have one of the more difficult tasks in Congress, particularly in the House. We're the investigative panel, and it is an important responsibility, and it does provide an opportunity to help us make our system of government work and be responsive. It's an important task.

Mr. SOUDER. That is unless you lost your e-mails. We're having Charles Ruff this week.

Mr. MICA. We do have a vast array of witnesses, but we're pleased to welcome these three witnesses from this local community and Chicago to testify before us today. In that regard, I'll recognize Dr. Barbara M. Schroeder, president of the Fort Wayne Medical Society. Welcome, Dr. Schroeder, and you're recognized.

STATEMENT OF DR. BARBARA M. SCHROEDER, PRESIDENT, FORT WAYNE MEDICAL SOCIETY, FORT WAYNE, IN

Dr. SCHROEDER. Thank you. I'd like to begin just by saying thanks for giving us the opportunity to speak. I'm very much a neophyte in terms of the government. And seeing this process gives me a little bit more faith that legislators really do want to hear all sides of the issue.

The core issue that I'm going to address is pre-operative tests as being screening tests. And it's my view that pre-operative tests are not in the same category as general screening tests. In my mind, a screening test is one that's done on a large segment of the population, looking randomly for a disease whereas pre-operative testing is done specifically to see if there's a reason that the person shouldn't have surgery or if they should be somehow investigated further to see when an abnormal test has come forward.

As you know, Congress has excluded from coverage examinations that are performed for a purpose other than the treatment or diagnosis of a specific illness, symptom, complaint or injury, except for certain approved screening tests, and these are published in the code of Federal Regulations. In the February and March 1999 issue of our Regional Medicare Update, a clarification regarding pre-operative testing was published, and it stated that screening services other than those named by law as exceptions are not covered and will be denied in accordance with Section 1826 of the Social Security Act. And this clarification superseded all prior policy publications regarding screening procedures, such as pre-operative tests, chest x-rays, etc.

A further word on this was published in January 2000, and this stated that pre-operative tests ordered routinely are considered screening services and are not reimbursable by the Medicare program. And, again, I would argue that certain routine tests are necessary for the treatment of an illness, and I'm certain that many physicians, anesthesiologists in particular, might have varying opinions on what is actually necessary for the surgery and what is not. And that, I think, is partly the problem; it's not totally clear all the time what's necessary to safely do a surgery.

I've attached with my testimony some guidelines that were circulated to Parkview staff physicians as a guideline for all certifications as to what pre-operative tests would be necessary for anyone undergoing surgery independent of whether or not they have a sign or a symptom related to that particular test. For example, an electrocardiogram within a year is recommended by the Parkview anesthesiologists for anyone over 65 who's undergoing any kind of a surgery, even a local, and this is recommended even if the person doesn't have chest pain, doesn't have a heart history, no high blood pressure. Why is that? Because the stress of surgery on a 65-year-old heart is significant, and the likelihood of heart problems even in the absence of symptom is high enough that the most basic of good medical care would warrant that an EKG be done. And this allows the physician to check for any heart disease and also for knowing a baseline when you do put the person through surgery in case they have any chest pain or problems during the surgery.

Another example is the ordering of a hemoglobin within 30 days of a surgery if significant blood loss is anticipated. The person doesn't have any signs or symptoms that would otherwise qualify the ordering of a hemoglobin under the Medicare testing guideline, and, yet, to do a surgery where you anticipate major blood loss without a hemoglobin is something that no prudent surgeon would do, and that's kind of the basis of my argument that it's not a screening test; it's a test to prepare the person for surgery.

The challenge, of course, is to determine which tests are necessary to surgically treat a disease and which are not. And, as I stated earlier, physicians will differ on what they feel is medically necessary to get a person ready for surgery. Few people would argue, for example, that you need a cholesterol for a cataract surgery. I mean, there are some things which are clear. So I believe that simple guidelines could be developed, such as those included in this testimony that I've submitted, which would allow for the coverage of necessary pre-operative testing.

In summary, then, I think that the HCFA and Congress have three options: One is to continue to designate all tests done prior to surgery that do not have associated signs and symptoms as screening, and to deny coverage as thus. And the fact that seniors have and will continue to object to this is the source of this hearing. The result of continuing this practice is that some seniors will refuse to have the testing based on their lack of ability to pay for it and morbidity and perhaps mortality will result.

The second option would be to leave the pre-operative testing up to physicians and let us decide what's medically necessary. This might require some further legislative clarification that specifically excludes pre-operative testing from screening testing. The third option would be to develop some specific guidelines such as those that I've attached which would protect Medicare from indiscriminate pre-operative testing and help guide physicians as to what is truly medically necessary to perform the surgery. Another option within this category would be to state legislatively that certain tests ordered pre-operatively do not require signs and symptoms to be covered, such as EKGs, hemoglobins, electrolytes or a serum glucose.

Thank you again for the opportunity to speak.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Dr. Schroeder follows:]

Testimony of Barbara M. Schroeder, M.D.
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Prepared for a public hearing on "Quality Care for Seniors", April 10, 2000

Thank you for giving us all the opportunity to speak. I am a neophyte in terms of how our government works and proceedings like this give me some faith that there are legislators who really want to hear all sides of an issue, and who want to do the best things for Americans.

The core issue, in my view, is whether preoperative tests are truly a screening, or whether they are a part of the treatment of an illness or disease. As you know, congress has excluded from coverage "examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptom, complaint, or injury", except for certain approved screening tests. This is published in the Code of Federal Regulations (42CFR411.15)

In the February-March 1999 issue of our regional Medicare update a "clarification" was published regarding the issue of coverage for preoperative services. It stated "Screening services other than those named by law as exceptions are not covered, and will be denied in accordance with Section 1826 (a)(1)(A) of the Social Security Act. This clarification supercedes all prior policy publications regarding screening procedures (e.g. pre-operative chest x-rays, EKGs, laboratory studies, etc.)

A final word was published in the January 2000 issue of Part A News. This stated that "pre-operative tests ordered routinely are considered screening services, and are not reimbursable by the Medicare program."

I argue that certain routine tests ARE necessary for the treatment of illness or disease. I am certain that many physicians, anesthesiologists in particular, might have varying opinions of what those routine tests might be. Attached please find the guidelines that were circulated to Parkview medical staff surgeons regarding which preoperative tests are felt necessary for ANYONE undergoing surgery, independent of signs or symptoms.

For example, an EKG within one year is recommended for anyone over 65 undergoing any type of surgery, even local. This is recommended even if the patient has no chest pain, no heart history, etc. Why? Because the stress of surgery on a 65 year old heart is significant. The likelihood of heart problems even in the absence of symptoms is high enough that it is the most basic of good medical care to have a baseline EKG available. This allows the physician to check for heart disease before putting the patient through the stress of surgery, and to have a baseline available should the patient develop problems intraoperatively

Another example is the ordering of hemoglobin within 30 days of a surgery if significant blood loss is anticipated. The patient has no signs or symptoms of problems. Yet to proceed with surgery not knowing the patient's bloodcount is something no prudent surgeon would feel comfortable with. Is obtaining a blood count a "screening test"? Or is it necessary for the surgical treatment of the illness or disease? I would argue that tests such as these ARE necessary for the treatment of the disease.

The challenge of course is to determine which tests are necessary to surgically treat a disease and which are not. As I stated earlier, physicians will differ on what they feel is medically necessary. Yet few would argue that a cholesterol level is necessary to do cataract surgery. I believe that simple guidelines could be developed, such as those included in my written testimony, which would allow for the coverage of necessary preoperative tests.

In summary then, HCFA and congress have three options:

1. Continue to designate all tests done prior to surgery that do not have associated signs and symptoms as screening and deny coverage. The fact that seniors have and will continue to object to this option is

the source of this hearing. The result of continuing this practice is that some seniors will refuse to have the testing based on their lack of ability to pay for it and morbidity and perhaps mortality will result.

2. Leave the preoperative testing up to physicians and let us decide what is medically necessary. This might require some further legislative clarification that specifically excludes preoperative testing from the designation of "screening".
3. Develop specific guidelines such as those attached, which protect Medicare from indiscriminate preoperative testing and help guide physicians as to what is truly medically necessary to perform the surgery. The other option within this category would be to state legislatively that certain tests ordered preoperatively do not require signs and symptoms to be covered, such as EKGs, Hemoglobins, electrolytes, and serum glucose.

Thank you again for the opportunity to speak on behalf of the local medical community.

Mr. MICA. I'm going to call on Jim Tobalski next. He is a senior vice president of community relations for Parkview Health System and Parkview Hospital. You are recognized, sir.

STATEMENT OF JIM TOBALSKI, SENIOR VICE PRESIDENT COMMUNITY RELATIONS, PARKVIEW HEALTH SYSTEM AND PARKVIEW HOSPITAL, FORT WAYNE, IN

Mr. TOBALSKI. Thank you, and thanks to Chairman Mica and Congressman Souder for this opportunity. A lot has been said today about the Balanced Budget Act and its impact on hospitals across the Nation and a lot of the unintentional impact. I did want at least to try to provide something much more personal and specific about the Balanced Budget Act. For the Parkview Health System, which is Parkview Hospital, Whitley Hospital and Huntington Hospital, the Balanced Budget Act will reduce our reimbursement over a 5-year period by $47.7 million. That at least provides, I think, an example at a much more local level. Even with the Balanced Budget Refinement Act, that reduction will still be about $40 million over 5 years. So at least you have some context as to the change.

While we're concerned about the reimbursement cuts, we're equally concerned about how increasingly complicated it is to be a health care provider in the Medicare Program. Each one of our health care staff is proud to provide health care to our community seniors. It is becoming increasingly more difficult, though, and we believe that our mission to care for seniors in the future will be jeopardized unless we can truly reform Medicare and improve and simplify the program, and we've got several suggestions.

Quite simply, Medicare is just too complex, and there doesn't seem to be any relief in sight, even with the passing of the Health Insurance Portability and Accountability Act, which Congress had intended to reduce the administrative costs and burdens associated with health care. I'd like to go over one example, because I think it's at the heart of administrative simplification.

There are, approximately, 300 different medical procedures that Medicare might require health care providers to obtain an Advanced Beneficiary Notice [ABN] which was mentioned earlier, where we must notify a Medicare recipient in advance that the service is not covered by Medicare and they may be responsible for payment. However, before a hospital or health care provider can determine whether or not an ABN is required, we need to match those 300 different procedures with, approximately, 14,000 different diagnoses. Certain procedures, with certain diagnoses, require an ABN. The same procedures with different diagnoses will not require an ABN.

To compound that, there are Federal regulations often that conflict with one another. The ABN requirement also applies to services received through the emergency room, yet the Emergency Medical Treatment and Active Labor Act [EMTALA] states that health care providers cannot delay treatment to get financial information from patients. The dilemma for Parkview and other hospitals is not how to proceed with treatment. We're going to do what's best for the patient; we're going to treat first and worry about finances later. We're still left with a conflict, though, where one law re-

quires us to obtain an ABN before providing treatment while another law requires us to provide treatment before obtaining an ABN. Now, as a community hospital, we will always choose to provide emergency care first, yet we will be faced with the situation of not complying with the ABN requirement and then risk the loss of reimbursement for the care provided.

Earlier, there was discussion also about education for senior citizens, and I think it's important, so I'd like to repeat this in my testimony. Senior citizens just do not receive enough information from Medicare to help guide them through the system. It's a very complex process for health care providers and I think equally, if not more, complex for older adults. Many seniors turn to health care providers for answers and clarifications, but that's a very frustrating process for both seniors and health care providers, because there are often far too many gray areas in interpretation which only Medicare can truly clarify, not health care providers and not seniors.

We recently attempted to proactively inform senior citizens about a change in pre-surgical testing covered by Medicare. I won't go over that in detail. We sent out 30,000 letters to current and past Medicare patients. I have made a mental note, if we're going to do that again, to hand-deliver a copy of one of those letters to Congressman Souder, especially if he plans on holding town hall meetings in his district before we do that.

While this topic is very, very complex, we still wanted to attempt to provide education to recipients, like Mrs. Altenhof, who you've heard from earlier. We feel it's better for Medicare recipients to learn about changes in advance of them arriving at the hospital, where it's a more frustrating a time to learn about changes or new interpretations of rules and regulations. Everybody would benefit from more education—seniors, hospitals and the Medicare program itself.

Another key area is just having an adequate enough time to implement changes from new laws and new legislations and new regulations. Mr. Miller covered earlier the whole Ambulatory Payment Classification. I know it's probably not possible to enter a prop into my testimony, but these are the new regulations, explanations and addendums. I think it comes out to, with the addendums, approximately, 1,300 pages just for the new Ambulatory Payment Classification, and we have until July 1st to have this system in place if we are going to comply with all the new rules and regulations.

One other key area is written verification. We often ask Medicare to verify if we're interpreting the rules correctly; it seems like a very reasonable thing to do. Medicare is typically hesitant to provide answers in writing when we try to clarify them. A written response to providers would help with consistency, it would help with compliance and it would, to me, even more importantly help with overall trust and relationship-building, which really needs to take place within the entire system.

Last, while Parkview and I are not experts in the funding of government agencies, we believe that the Health Care Financing Administration is underfunded. We are sure that it would probably take additional resources for HCFA to play a role in improving and

simplifying the administration of the program, and Ms. Collins has not asked me to present this testimony today.

A recent report indicated that in the past 20 years, the number of Medicare beneficiaries has gone up 50 percent. Of course, the complexity of new policy directives and rules are even more mind-boggling, yet HCFA's work force—in this study, it was indicated it is now smaller than it was two decades ago. If Congress wants this program to be effective, they should at least consider the resources that HCFA may need to meet the tremendous challenges of simplifying the program.

I don't think it's too naive to suggest that health care providers and the Medicare program can become better partners, which we really are not right now with all the skepticism that's involved. We could accomplish a lot on administrative simplification and making billing practice smoother if there was more of a partnership relationship. Right now, the current environment is one of skepticism and mistrust really on both sides. That's really the only way senior citizens will best be served is when Medicare and health care providers work together to provide benefits to our Nation's older adults.

Again, thanks for this opportunity to provide you with this feedback today.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Tobalski follows:]

PARKVIEW
HOSPITAL

April 3, 2000

The Honorable John L. Mica
Chairman, Subcommittee on Criminal Justice,
Drug Policy & Human Resources
B-373 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Mica and Members of the Committee:

Thank you for the opportunity to provide input on Medicare and the Health Care Financing Administration. It is our understanding that the hearing on April 10 will examine reimbursement practices and the impact those policies have on hospitals, healthcare providers and beneficiaries.

The first area that the Parkview Health System (PHS) would like to comment on is the Balanced Budget Act of 1997 and its financial impact on our three hospitals (Parkview Hospital, Huntington Memorial Hospital, and Whitley Memorial Hospital). When this legislation was passed, it implemented an estimated $44.1 billion dollars in reimbursement cuts to hospitals across the country. While our hospitals have prepared for the decreases, we were not prepared for the news we received several months ago that the cuts will most likely total $76.6 billion dollars – approximately $32 billion more than intended when Congress voted for the BBA. Listed below are the five year projections that demonstrate the reimbursement cuts we experienced in the BBA's first two years and what we will continue to deal with in the next three years.

1998	$5,000,000
1999	$6,900,000
2000	$9,300,000
2001	$12,200,000
2002	$14,300,000
Total	$47.7 million in reductions for PHS

We are grateful for the Balanced Budget Refinement Act of 1999, which restored $7.9 million dollars in reimbursement for Parkview Health System hospitals. While this amount is helpful, it still only represents about 16% of the total decrease in our Medicare reimbursement ($47.7 million dollars).

Hospitals have received a 1.6% update factor from Medicare over the last three years combined, while medical inflation equaled 8% over that same period. I've enclosed a one page summary of the BBA and BBRA impact at the national level that was prepared by the Lewin Group for the American Hospital Association. In addition to the reimbursement cuts, we are equally concerned about how increasingly complicated it has become to be a healthcare provider in the Medicare program. Each one of our healthcare staff is proud to provide healthcare to our communities'

a member of
PARKVIEW
HEALTH SYSTEM
2200 Randallia Drive • Ft. Wayne, IN 46805 • (219) 484-6636 • http://www.parkview.com

senior citizens. Our mission is to "provide quality health services to all who entrust their care to us and to work to improve the health of our communities." This mission, though, will be jeopardized in the future unless we can truly reform Medicare and improve and simplify the administration of the program. We would like to offer some suggestions.

1. Administrative Simplification

Quite simply, Medicare is too complex and there is no relief in sight, even with the passing of the Health Insurance Portability and Accountability Act (HIPAA), which Congress had intended to reduce the administrative costs and burdens associated with healthcare.

One example might be helpful. There are approximately 300 different medical procedures that Medicare might require healthcare providers to obtain an advance beneficiary notice (ABN), where we must notify a Medicare recipient in advance that the service is not covered by Medicare and they may be responsible for payment. However, before a hospital or healthcare provider can determine whether or not an ABN is required, we need to match those 300 different procedures with approximately 14,000 different diagnoses. Certain procedures, with certain diagnoses, require an ABN. The same procedures, with different diagnoses, will not require an ABN.

In addition, federal regulations often conflict with one another. The ABN requirement also applies to services received through the emergency room, yet the Emergency Medical Treatment and Active Labor Act (EMTALA) states that healthcare providers cannot delay treatment to get financial information from patients. The dilemma for Parkview Hospital is not how to proceed with treatment – we always provide emergency treatment first and worry about financial information second. We're still left with a conflict, though, where one law requires us to obtain an ABN before providing treatment, while another law requires us to provide treatment before obtaining an ABN. As a community hospital, we will always choose to provide emergency care first, yet we will be faced with the situation of not complying with the ABN requirement and then risk the loss of reimbursement for the care provided.

To state that the volumes of regulations are problematic for healthcare providers is an understatement, yet we believe it's just as big of a problem for the Health Care Finance Administration to work and implement these same regulations. It's unmanageable.

2. Education for Senior Citizens

Senior citizens do not receive enough education from Medicare to help guide them through the process, which is just as complex for older adults as it is for healthcare providers. As a result, many seniors turn to healthcare providers for answers. It's a frustrating process for both seniors and healthcare providers because there are too many gray areas in interpretation which only Medicare can clarify.

We recently attempted to proactively inform senior citizens about a change in pre-surgical testing coverage by Medicare. These tests are often done before surgery so that anesthesiologists and surgeons know how patients will tolerate general anesthesia and to identify potential problems. In 1999, our Medicare fiscal intermediary published a bulletin stating they had interpreted an existing policy and that pre-surgical testing would be considered a "screening" that would not be covered by Medicare. Since this was a new interpretation of policy, we decided that we needed to try to explain this to Medicare recipients. We mailed a letter to approximately 30,000 of our current and past Medicare patients to explain this change to them. While this topic is very complex, we still wanted to attempt to provide education. We feel it's better for Medicare recipients to learn about this change in advance of them arriving at the hospital for pre-surgical testing. Responses received from our letter were mixed; some individuals were grateful that we informed them in advance, others were also grateful but still confused, and some individuals were upset that a change had taken place and their anger was directed at both Medicare and the hospital. We've enclosed a copy of the letter.

Everyone would benefit – seniors, hospitals and the Medicare program itself – if Medicare would proactively communicate the changes it makes.

3. Adequate Time to Implement

Healthcare providers are rarely given enough time to implement changes enacted in Medicare. We often have to use very expensive manual methods to comply with new regulations. Often there is no computer software solution to help hospitals comply with new Medicare billing requirements.

The new outpatient prospective payment system is scheduled to become effective July 1, 2000. The rules are not scheduled to be released in their final form until April 7. Parkview and hospitals across the nation are concerned about our ability to implement this massive change in such a short period of time, and we have a lot for which to prepare: evaluate and absorb the massive 750 pages of final regulations; make sure that we are able to glean all needed information from our billing and computer information systems to accurately determine the Ambulatory Payment Classifications (APC's); purchase "grouper" software (once it is complaint with the final regulations) that will correctly group our procedure codes into APC's; process our data through the grouper software and follow up on all inconsistencies; determine the financial impact of the APC system upon our hospitals; and other tasks.

4. Written Verification

Hospitals often ask questions of Medicare to verify if we're interpreting the rules correctly. Medicare is typically hesitant to provide answers in writing. A written response to providers would help with consistency, with compliance, and with overall trust and relationship building. Currently, we document in writing our phone call conversations with Medicare. Sometimes we also send our written summaries of those

phone conversations back to Medicare indicating our interpretation of their verbal responses.

We believe that healthcare providers and HCFA are both facing incredible challenges. While we are not experts on the funding of government agencies, we believe that the Health Care Financing Administration is under-funded. We are sure that it would probably take additional resources for HCFA to play a role in improving and simplifying the administration of the program, communicating more proactively with seniors and providing more formal interpretation for providers who need clarification on rules. A recent report indicated that in the past 20 years Medicare spending has increased ten-fold, the number of beneficiaries has gone up 50%, the complexity of new policy directives and rules are even more mind-boggling, yet HCFA's workforce is now smaller than two decades ago. If Congress wants this program to be effective, then they should consider additional funding for HCFA, to enable it to meet those challenges.

We don't think it's too naïve to suggest that healthcare providers and the Medicare program can become better partners, where we cooperate on goals, such as administrative simplification and smooth billing practices. The current environment is one of skepticism and mistrust on both sides. Senior citizens will best be served only when Medicare and healthcare providers work together to help provide benefits to our nation's older adults.

In closing, the Parkview Health System would like to thank Congressman Mark Souder, the House of Representatives and the Committee on Government Reform for the opportunity to provide information today.

Sincerely,

Jim Tobalski
Senior Vice President Community Relations
Parkview Health System

Mr. MICA. We'll now hear from Dorothy Burk Collins. She's the Regional Administrator for HCFA, the Health Care Financing Administration, with HHS for Region 5 located in Chicago.

Welcome, and you're recognized.

STATEMENT OF DOROTHY BURK COLLINS, REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REGION V, CHICAGO, IL

Ms. COLLINS. Chairman Mica, Congressman Souder, thank you for inviting me to be here today with you and your constituents to discuss our efforts to improve Medicare guidance to hospitals and other providers. I appreciate this opportunity to hear firsthand from you and from others here about your needs and concerns.

Assuring and enhancing access to quality care is a high priority for us. We want to help hospitals and physicians provide all the care their patients need that we, by law, can cover, and we are taking a number of steps to help providers understand Medicare policy and procedures. We're also working to increase our oversight of the private insurance companies that, by law, process Medicare claims. We want our guidance to be clear so providers and contractors understand and can follow the rules. This isn't always easy since the laws governing Medicare are complex and extensive. We have, therefore, initiated a wide range of educational activities targeted specifically to hospitals and other providers.

For example, we are airing satellite broadcasts to hundreds of sites across the country on topics of interest to providers, such as resident training, as well as other health initiatives. We are developing computer-based training modules for providers on topics such as proper claim submission and Medicare Secondary Payer rules. And we maintain the Health Care Financing Administration Web site, www.hcfa.gov to provide up-to-date, easily accessible material for hospitals on a wide variety of issues, including interactive courses on proper filing and documentation of claims. And we are enhancing our toll-free customer service lines at all Medicare intermediaries to provide answers to questions hospitals and other providers may have. Also, for our contractors, we are developing report cards that will rate and rank their performance. We are requiring them to report regularly to us on payment and coding policy changes. We are evaluating local coverage policies that contractors, by law, can establish in areas where there is no national policy so that we can better determine where national policy is needed and where there are issues or concerns about contractors' local policies.

We want to work together with all parties, including beneficiaries, providers and contractors. Only by working together can we develop effective solutions so patients can get the care they need and providers can get the fair treatment they deserve to the greatest extent the law will allow. Medicare is a complex program; we've heard a lot about that here today. As you know, medicine itself is complex, and on any given day, someone will disagree with a decision or feel we were not responsive enough. We have been working hard to improve our service to beneficiaries and providers. We want to continue working to improve. We will continue to closely monitor how laws and regulations governing our programs affect

beneficiaries and providers. We want to hear from you about problems that Medicare providers and beneficiaries may be having. We will continue to examine our own regulations and policies to make adjustments where we can under law to ensure that beneficiaries continue to have access to the quality care that they deserve.

I thank you again for inviting me. I look forward to hearing from you, working with you, and I am happy to answer any questions.

[The prepared statement of Ms. Collins follows:]

Statement of
DOROTHY BURK COLLINS

REGIONAL ADMINISTRATOR, REGION V

HEALTH CARE FINANCING ADMINISTRATION

Before the

HOUSE COMMITTEE ON GOVERNMENT REFORM

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,

AND HUMAN RESOURCES

on

MEDICARE REIMBURSEMENT

April 10, 2000

TESTIMONY OF
DOROTHY BURK COLLINS,
REGIONAL ADMINISTRATOR, REGION V
HEALTH CARE FINANCING ADMINISTRATION
on
MEDICARE REIMBURSEMENT
before the
HOUSE GOVERNMENT REFORM SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES
in
FORT WAYNE, INDIANA
April 10, 2000

Chairman Mica, Congressman Souder, thank you for inviting me to be here today with you to discuss the Health Care Financing Administration's (HCFA) efforts to improve Medicare guidance to hospitals and other providers, as well as recent changes in Medicare hospital payment policies. I am grateful for this opportunity to hear from you firsthand about your needs, concerns, and ideas.

HCFA is responsible for administering the Medicare program, which provides health insurance coverage to about 39 million Americans. The Medicare program provides coverage for hospital services in accordance with Medicare law, which is very prescriptive. HCFA issues regulations governing the program based on the law. And, also by law, HCFA contracts with private insurance companies, referred to as intermediaries or carriers. These companies are directly responsible for processing and paying claims to hospitals and other providers, in accordance with the regulations we have established and their own local medical review policies.

Assuring and enhancing access to quality health care for beneficiaries is a priority for HCFA. We are taking a number of pro-active steps to educate providers about Medicare payment policy and procedures, and to increase our oversight of the private insurance companies that process Medicare claims. We want to ensure that our guidance is clear, and that providers and our contractors understand Medicare rules and follow them appropriately. We also are increasing our efforts to identify fraud, waste, and abuse.

In addition, we already have implemented over the majority of provisions in the Balanced Budget Act of 1997 (BBA). We are also implementing additional changes included in the Balanced Budget Refinement Act (BBRA), which became law late last year. The BBRA makes substantial investments to meet the needs of our nation's hospitals and their patients. The BBA changes, combined with efforts to fight fraud, waste, and abuse in the Medicare program, have helped extend the solvency of the Medicare Trust Fund until 2023.

Improving our Guidance and Education

The laws governing Medicare are complex and extensive. We recognize this and are increasing our efforts to reach out to all providers to ensure that our guidance on Medicare policies, and that issued by our contractors, is clear and understandable. As part of this education effort, we have initiated a wide range of provider educational activities targeted specifically to hospitals. For example, we are:

- airing satellite broadcasts to hundreds of sites across the country on topics of interest to providers such as resident training, as well as women's health and adult immunization initiatives;

- surveying health care providers nationwide and analyzing data collected to develop new education strategies for reaching out to Medicare providers;

- developing computer-based training modules for providers on topics such as proper claims submission, Medicare Secondary Payer rules, and Medicare fraud and abuse efforts;

- writing articles on timely topics for fiscal intermediary bulletins and other publications targeted toward hospitals;

- maintaining the HCFA web site, www.hcfa.gov, to provide up-to-date, easily accessible material for hospitals on a wide variety of issues, including interactive courses on the proper filing and documentation of claims;

- communicating on a regular basis through conference calls with national and state hospital associations and mailings to hospitals nationwide on issues of interest;

- sharing feedback with providers, both on an individual and community level, about how to correct and prevent the types of errors identified in medical review of claims so we can reduce the number of improper claims among the vast majority of providers who make only honest errors; and,

- enhancing our toll-free customer service lines at all Medicare intermediaries to provide answers to questions hospitals and other providers may have or to discuss problems they encounter in dealing with Medicare.

As part of our enhanced provider education efforts, we are launching a multi-faceted education program to ensure that hospitals and their billing vendors have both the information and training needed to implement systems changes for the outpatient prospective payment system (PPS), which becomes operational July 1. As part of this effort, this May we will conduct "train-the-trainer" sessions for our Medicare fiscal intermediaries. Our intermediaries will, in turn, provide training to hospitals and their vendors. We will provide intermediaries with a comprehensive guide and two days of intensive in-person training. We are instructing all intermediaries to take steps to disseminate program information to providers as soon as possible. Intermediaries will post these instructions on their Internet websites as well as publish articles in provider bulletins and conduct other outreach efforts to get the message out to providers. In addition, we have invited representatives from national and state-level hospital associations to attend the training sessions in order to facilitate the timely exchange of information. We are also hosting a national satellite broadcast on June 1 so that all interested parties can learn about the new regulation.

Improving Oversight of Our Contractors

We are also taking steps to substantially strengthen oversight of the private insurance companies that process and pay Medicare claims. The FY 2001 President's Budget invests $48 million in a contractor oversight initiative to improve internal controls and financial management. We have also consolidated responsibility for contractor management by establishing the new position of Deputy Director for Medicare Contractor Management. And we have created a Medicare Contractor Oversight Board to set policy regarding contractor-related activities. As part of this effort, we also are working with the Inspector General's office to create individual report cards on each contractor's performance against specific goals and criteria. Contractors that perform poorly and fail to improve risk losing their Medicare business.

In addition, we are hiring additional physicians as claims processing contractor Medical Directors to improve the effectiveness of medical review and foster better understanding of program integrity issues with the provider community. We are making more efficient use of prepayment review with claims processing computer "edits" that automatically deny improper claims before payment is made. We are also evaluating local review policies to determine where national policy may be needed, and measuring how well individual contractors perform medical review activities.

We also have implemented a change management process to manage and coordinate changes to the Medicare fee-for-service program in a more timely and effective manner. This process is designed to allow our central and regional office staff, as well as our contractors, to participate cooperatively in each phase of the development and review process on Medicare Contractor manual issuances and program memoranda. It also ensures that we provide a single, consistent voice to our contractors.

In addition, we are requiring contractors to report to our regional offices quarterly on the implementation of Medicare instructions that directly impact providers, such as payment and coding changes. Our regional offices will work in consultation with the contractor to

ensure that any implementation problems are quickly resolved. The regions also will track the timeliness of the contractors in addressing any needed changes on an ongoing basis, and will incorporate these findings into the annual contractor performance evaluation process.

Ensuring Program Integrity

We also are redoubling our efforts to identify fraud, waste, and abuse in all of our programs. Today, our efforts are more effective than ever before. From April-September, 1998, we stopped about $5.3 billion from being paid to providers for inappropriate claims. Our anti-fraud efforts returned nearly $500 million to the federal government, a 65 percent increase over the previous year. And we have reduced the Medicare error rate by almost half since 1996, and maintained that progress in 1999. The annual Medicare financial audit helps us to identify areas where we can be better stewards of the Medicare program. Each year it has led us, working in cooperation with Congress, providers, and contractors, to improve the integrity of our program, including our claims processing and payments.

We realize that our efforts to reduce fraud, waste, and abuse may have generated concern among some providers. Let me be clear. We have no intention of prosecuting anyone for honest mistakes. If providers do make billing errors, we want to find those errors, preferably before we make payment. If we find errors after we make payment, make no mistake about it--we do want the money back.

However, we are not looking to put anyone in jail for honest mistakes, and we are not going to refer providers to law enforcement for occasional errors. We know that the majority of providers are honest and conscientious. Let me also be clear, however, that we have zero tolerance for fraud, waste, and abuse. Our goal is to receive accurate and properly documented claims from providers and to pay those claims correctly. That way beneficiaries, taxpayers, and providers can all be confident that our program is effectively managed, our tax dollars are appropriately spent, and our beneficiaries receive the quality, affordable care on which they depend.

Balanced Budget Refinement Act

Working together, Congress and the Administration, enacted the BBRA last year, which includes a number of payment reforms and other changes to address some of the BBA's unintended consequences. A number of these refinements will be particularly helpful to America's hospitals. These include:

- modifying the hospital outpatient prospective payment system (PPS);
- increasing indirect medical education payments to teaching hospitals;
- reducing the geographic disparity in direct medical education payments to teaching hospitals;
- increasing disproportionate share hospital payments;
- increasing payments for PPS-exempt hospitals; and
- improving rural hospital programs.

We also have taken a number of our own administrative actions to moderate the impact of the BBA. These steps complement the legislative changes included in the BBRA and will help hospitals and other providers in meeting the needs of the patients they serve. For example, we are postponing expansion of the BBA's "transfer policy" for all hospitals for a period of two years, through 2002. As a result, the transfer payment limits will apply only to the current 10 Diagnosis Related Group (DRG) categories, as prescribed by the BBA. We are carefully considering whether further postponement of this policy is warranted.

The BBA created a new PPS for hospital outpatient care that pays set amounts for services that are similar clinically and in their use of resources. Responding to the concerns expressed by providers, the BBRA modifies the outpatient PPS in several important ways. It smoothes the transition to the new system, during the first three and a half years, by creating payment floors, holding small rural hospitals with fewer than 100 beds harmless for three and one-half years and cancer hospitals permanently harmless. During the transition period, we are protecting hospitals by paying a part of any reduced payments they might incur, under the new system, for outpatient services. In addition,

this new system makes additional payments to hospitals for certain new medical devices and drugs, and it establishes an outlier payment policy for high-cost cases.

The BBRA makes important investments in our nation's graduate medical education (GME) programs by increasing Indirect Medical Education payments and reforming Direct Medical Education. It reduces the geographic disparity in payments to teaching hospitals; raises the minimum payment for hospitals to 70 percent of the national, geographically adjusted average; and limits growth in payments for hospitals being paid more than 140 percent of the geographically adjusted average.

The BBRA also increases Medicare disproportionate share hospital payments, makes adjustments to the PPS system for inpatient rehabilitation hospitals, and requires the development of PPS systems for long-term care and psychiatric hospitals. And it enhances a series of Medicare policies designed to support rural hospitals. For example, it allows certain rural hospitals to reclassify as Critical Access Hospitals, Sole Community Hospitals, or Rural Referral Centers; extends the Medicare dependent hospital program for five years; provides exceptions to the residency caps for rural GME; and rebases targets for Sole Community Hospitals and provides them with a full increase for inflation in 2001.

Using our administrative authority, we are building on the BBRA changes to further assist rural hospitals. For example, we are making it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. This change will be included in the inpatient PPS regulation that will be published shortly. As a consequence of this change, these rural hospitals will receive higher reimbursement. Similarly, we are helping rural hospitals adjust to the new outpatient PPS by using the same wage index for determining a facility's outpatient payment rates that is used to calculate its inpatient rates.

We will continue to closely monitor how laws and regulations governing our programs affect beneficiaries and providers. We want to hear from you about problems that Medicare providers and beneficiaries may be having. And we will continue to examine our own regulations and policies to make adjustments where we can under the law to ensure that beneficiaries continue to have access to the quality care they deserve.

Conclusion

Ensuring that beneficiaries have access to quality health care is a priority for our Agency. We are increasing our efforts to educate hospitals and other providers about Medicare policies. And we are working closely with our fiscal intermediaries to ensure they have the information, tools, and training they need to process and pay claims appropriately and that their guidance to providers is clear. Together, we can minimize honest errors, and prevent fraud, waste, and abuse in the Medicare program. Through administrative actions, we have been working to moderate the impact of the BBA where we can. We are implementing the numerous changes contained in the BBRA that directly impact hospitals and other providers. We welcome your input and assistance as these efforts move forward, and we appreciate your continued interest. I am happy to answer your questions.

# # #

Mr. MICA. Well, thank you. You've heard, Ms. Collins, some of the problems that have surrounded trying to comply with HCFA regulations. Part of the problem is that Congress, of course, has altered some of the laws relating to operation of HCFA, and I think with good intent. But the agency is responsible for trying to put into place the regulations that make the system work.

We heard concerns about new guidelines coming out, I guess in July, in 90 days and then the problems of compliance. We heard a previous witness testify they had to spend $1 million, I think, on software and computer equipment for compliance reasons. And it appears that we have some problems in trying to define what's eligible for payment.

How do we best resolve that?

Ms. COLLINS. I think we share a goal that all hospitals and providers under Medicare be fully informed about Medicare rules and regulations. Meeting that goal is a challenge because of the breadth and scope of the program. We are taking steps to improve our efforts here. Increasing our educational outreach efforts to providers and beneficiaries is definitely a focus of our organization. I think communication and providing good information goes a long way to meeting that objective.

Mr. MICA. Well, one of the complaints we heard, too, we had someone who has been through the system, so to speak—a Medicare recipient—and then we had others testify that Medicare does not provide seniors even basic information about their benefits and what's covered. Is that correct?

Ms. COLLINS. I think we can always improve the information that we provide to the Medicare beneficiaries. As you may be aware, most recently, the Medicare handbook used to be given when beneficiaries first joined Medicare and then they were lucky if they got an update every so often. Now, the Medicare handbook is provided to beneficiaries on an annual basis as a basic step in making sure that beneficiaries understand their Medicare program.

Also, there are a variety of options available to Medicare beneficiaries now and there are choices for how they receive their Medicare benefits through managed care organizations, or other choices. So, there is an increased effort on the part of HCFA to provide information to Medicare beneficiaries at the local level, and, again, we are working very hard to increase that effort—use of our toll-free telephone lines and other services to try to inform Medicare beneficiaries.

Mr. MICA. What about on-line computer access?

Ms. COLLINS. Medicare maintains a Website www.Medicare.gov. The Website is specifically focused on providing Medicare information to Medicare beneficiaries and their representatives. The site is kept up-to-date with a full range of information about coverage and benefits to Medicare beneficiaries. Although use of the Internet by seniors and everyone else is increasing, there is nothing like that personal contact. So there is a 1–800 number for beneficiaries and also increased effort with local organizations to provide information on a personal level.

Mr. MICA. One of the questions and topics of conversation in this hearing has been the question of coverage for pre-surgical testing.

Has HCFA changed or reinterpreted its policies regarding coverage of these services? And, if so, why and where are we in this matter?

Ms. COLLINS. Health Care Financing Administration has not issued anything specific regarding a national policy on this particular issue. Pre-operative testing is paid for, is part of the diagnosis-related group for an inpatient surgery, and pre-operative testing for outpatient surgery is covered when it is medically necessary, meaning that there are signs and symptoms that justify the tests.

I think there's been some confusion about this, and I've heard a great deal about this here today and will seek to followup on this to make sure there is a clear understanding of this, because I think that there has been some confusion regarding outpatient billing. The rules require outpatient billing to be based on the final diagnosis. Sometimes the initial screening may not actually match up with that final diagnosis and it may appear that there isn't a reason for that initial test. Providers can put on the claim codes for symptoms that could justify that initial test.

Again, we would be happy to facilitate discussions here in Fort Wayne and throughout the State to try to make sure that there is a good understanding of the requirements and to clear up this issue.

Mr. MICA. Well, one of the questions that's arisen, too, is is HCFA redefining what's medically necessary, and if they're doing so on an overall basis or as it may refer to individual health problems. What's the status of the definition of "medically necessary" and how do health care providers and patients and others find out what "medically necessary," is defined as today by HCFA? And then is there a process—is this something that is changing, and then how do we get that word out so that both the providers and the beneficiaries know what's acceptable under the term "medically necessary?"

Ms. COLLINS. Health Care Financing has not recently issued any changes to the definition of "medical necessity," but that does not mean that there isn't active discussion going on about that and that there are differences of opinion about that across the country. In fact, I became aware that the American Medical Association, at one of their meetings just last week that the definition of "medical necessity" and "screening" was a topic of great discussion, and they issued proposals related to that.

I think that this is something that is under discussion, but no changes have been made nationally. Where there is no national policy, local medical review policy can be developed by the local intermediary, and after it is discussed with groups in the State, medical societies and others, to make decisions on medical necessity for certain procedures.

Mr. MICA. There's also concern today about the absence of a formal appeals process for coverage decisions. What can we do to improve that process? And maybe you've heard some of the suggestions that were put forward.

Ms. COLLINS. Are you referring to Ms. Borror's testimony?

Mr. MICA. Right.

Ms. COLLINS. I think her concern was the appeal of survey findings from a State survey while an enforcement action is still being determined and still under the control of the agency that did that

survey in the first place. There's a process called an "Informal Dispute Resolution Process," and how that is conducted by each State survey agency is at the option of the State under our requirements.

Some States do use independent entities to conduct that review. I believe here in Indiana the State agency itself conducts that review. There also is an independent body, through an administrative law judge process, through hearings and appeals, that would provide a fully independent process for review of any survey citations that led to enforcement actions that the nursing home would want to appeal.

Mr. MICA. Thank you. Mr. Souder.

Mr. SOUDER. The light that keeps going on and off above your head is a new thing that the Department of Justice has put in for our hearings. It's kind of to test your heart rate to see if you're answering——

Let me start with Ms. Collins, and I want to come back to Dr. Schroeder and Mr. Tobalski.

Parkview Hospital received two newsletters via your carrier, Administar, one dated March 1999 and another January 2000 that refers to "Coverage Policy Clarification Screening and Pre-operative Services and Pre-operative Testing, a Reminder."

Can you clarify or are you familiar with those two newsletters? And that certainly gives the impression that there were changes.

Ms. COLLINS. I would like to discuss those. I became aware of them late last week and I would like to discuss this in more detail with Parkview Hospital, with the intermediary and others to clear this up. I'm not a technical expert in this area, but I think there is confusion about routine screening—say like a cholesterol screening pre-operatively versus pre-op testing that may be entirely appropriate for a particular surgery I believe that that was the intent of the clarification that our intermediary issued. And I want to be sure that there's a good understanding about pre-operative testing that it's appropriate to assure safe and effective treatment for the beneficiary. That is, indeed, covered. But, as you know, routine screenings are specifically excluded by law from Medicare coverage, except certain preventive tests have recently been added for coverage.

Mr. SOUDER. Well, first let me say that I appreciate your commitment to work with Parkview directly in clarifying, and I'm looking forward to that and hearing the resolution. I do want to pursue this a little bit further, because just a few minutes ago in response to Mr. Mica, you said that certain tests could be justified if they were directly related. And I have a followup that related to something Dr. Schroeder said earlier.

But one of the concerns that was also expressed this morning and that I've had to deal with as a Congressman is a fact that "could justify" means if, in fact, they submitted them under what we heard earlier was a "Oh. Well, this should go as part of the operation and not as a diagnostic test" and could justify means that if it's put in under diagnostic but found to be inappropriate, then they get cited for fraud.

And Parkview and other hospitals in this region have had that very thing happen, because, in fact, in your testimony—and this is something we've tried to address—you talk about your anti-fraud

efforts, and we certainly have put a lot of pressure on it to try to address fraud, and we realize our efforts to reduce fraud, wastes and abuse have brought some of this on. But I think it would be fair to say that while you have discovered fraud, much of what usually gets mulched down—what we found is fraud, waste, abuse and lots of confusion. And that, in fact, the danger here is that it could be justified. If you were a hospital administrator, wouldn't you be erring on the side of not submitting rather than being cited for fraud and having a whole legal process develop with that? And have we not put the burden of proof, in fact, where it leads to denial of services as opposed to being responsive to the patient?

Ms. COLLINS. Let me respond to that by saying that I think that if I were a hospital administrator and coming from my perspective as an administrator of the program benefit, that the needs and the concerns of the beneficiary are always first, and, certainly, you want to operate within the parameters of the law. But providing good quality care to that patient is the priority.

Mr. SOUDER. It's the priority, but you go broke. And we've had a number of hospitals in this region financially not be able to make it, look at consolidations, and, in fact, Parkview and Lutheran have absorbed the administration of those hospitals, because a lot of the smaller hospitals have, in fact, tried to meet the medical needs of their people and can't. And, now, what we have are our remaining large hospital systems in this district coming to me and saying, "We can't, long-term, meet this unless we can figure this out—there's only so much cost shifting we can do."

Now, Dr. Schroeder raised another point, and that was is that she said, as I understood it—and correct me if I'm wrong—that some tests may not be necessary? As I understood Ms. Collins' testimony, that if there was a direct reason related to this test to have the pre-screening diagnostic tests, it would or could be justified. Doesn't necessarily mean it would, but it possibly could be justified. And, most likely, if it were directly related, it would be a medical necessity.

But, as I understood you to say in your testimony, there are some things with the heart that people at a certain age, particularly if they've had any pattern of heart problems, that you would do that test even if you normally wouldn't do it as a diagnostic test or have any indication; is that correct?

Dr. SCHROEDER. That's exactly it. That, pre-operatively, there may be situations where you want the results of a test even though they have no signs or symptoms. For an outpatient surgery, you want to know that that's OK before you do the surgery. That's the prudent thing to do.

Mr. SOUDER. And, Ms. Collins, are you saying that, either because of something that Congress has done or that HCFA has interpreted or a carrier has interpreted, that a test on somebody of an age who is at risk of a heart problem wouldn't be allowed testing?

Ms. COLLINS. There is no national policy saying that EKGs are or are not required pre-operatively across the board for any patient 65 years or older. The local fiscal intermediary here in Indiana, Administar Federal, has issued local Medical Review Policies related to the coverage of EKGs pre-operatively, and that policy was de-

veloped after a full review and comment here in the State, but, obviously, there is still concern regarding that.

And I would like to followup on that and see if we can have further discussions to try to reach a better consensus about what is appropriate pre-operatively.

Mr. SOUDER. So what I understand is that—I'm not sure I fully understood this before is that when we heard several times today that other insurers have to clearly say what is covered, and Medicare does not as much, although certainly there's a large attempt, but are you telling me that a decision like a question I just asked will depend by State?

Ms. COLLINS. Where there is no national policy regarding certain medical review decisions on determination of medical necessity, yes, the local intermediary, based on a local practice by physicians and providers in that State can make local policy.

Mr. SOUDER. So in Cameron Hospital in Angola where 40 percent of the people coming in are from other States and they're in the corner of northeast Indiana, or Parkview which gets a lot of Ohio traffic in through here, or even Lutheran and their system that gets, Mr. Miller estimated, 15 percent—how do they function?

Ms. COLLINS. The local Medical Review Policy applies within the State where the service is provided. If the intermediary in Ohio has a different policy in this area, it would not apply here in Indiana.

Mr. SOUDER. Mr. Tobalski, could you explain a little bit—I alluded to a few things there. Could you explain a little bit how what you've heard now from Ms. Collins and some clarification and willingness to work through it and how you came to your decision and what might have precipitated some of that?

Mr. TOBALSKI. Sure. We received the bulletins that you referred to earlier from Medicare, from HCFA and their fiscal intermediary that indicated that pre-operative testing would be considered a routine screening unless appropriate signs and symptoms were documented in the medical record. We asked for a clarification of that, and the clarification we were given is that a patient, for instance, with heart disease and/or diabetes would be a patient that a surgeon typically would have a concern over before operating, before putting them under general anesthesia.

And, of course, I'm reciting this from conversations that I've had with clinical people, and I, myself, am not a care provider. But that those people would have to have symptoms present for us to be able to do pre-surgical testing for that to be covered. Minus symptoms, the tests would not be covered. Yet I think most surgeons would tell you that pre-surgical screening is very important for patients with chronic conditions and/or other diseases whether or not symptoms are present at a given time in a person's medical history.

We felt there really was only one thing to do with that new interpretation. That was to change the way we were communicating policies and to proactively educate Medicare recipients on a very complicated topic. These are difficult enough topics for health care providers to sift through let alone Medicare recipients and/or seniors. And, so, we proactively sent out information to a large group of seniors in advance to try to get them more familiar with the new interpretation, because we felt they had a right to know.

Mr. SOUDER. Dr. Schroeder, do you want to add anything at this point?

Dr. SCHROEDER. Well, again, I think that the issue is best clarified, perhaps, by an example, and since I'm an ophthalmologist, most of my surgeries don't involve a huge amount of blood loss, but let's say a dacryocystorhinotomy, which is a surgery to open up a canal into the nose when the tears don't drain. And, usually, there's not a lot of blood loss, but there certainly can be. It's an outpatient procedure, and especially if you were going to do it on someone who's 70, you'd want to know in advance if they were anemic. They may not be dizzy; they may not be pale; they may not have any symptoms or signs of anemia. And if you'd link the diagnosis of a nasal lacrimal duct obstruction, or tears that don't drain, with obtaining a CBC, then it would be kicked out as being not medically necessary.

But my point is that no prudent surgeon would do some surgeries without—now, you people might argue about what is or isn't medically necessary. Maybe someone would say, "I'm so good, I never have blood loss. I don't need to check the CBC." But you see the point is that it's not linked as medically necessary by the diagnosis, and, yet, it's certainly not a screening test in the sense of screening massively for anemia, and that, I think, is the problem.

Mr. SOUDER. I would appreciate it, Ms. Collins, if you can look at the list that Dr. Schroeder gave, and if we can—I mean, this type of stuff isn't going to go away. We're likely to continue to have these kinds of discussions as long as there's a Medicare program, but to the degree that we can refine.

I also had a few other questions. One of the things also that came up is that hospitals can no longer write off as a loss outstanding bills. Could you explain that?

Ms. COLLINS. I took that as a note, and I just don't feel prepared to answer that question. I'd be happy to followup with a written response to that.

[The information referred to follows:]

As an incentive to hospitals to collect cost sharing and not cost-shift onto private pay patients, Medicare shares bad debts with hospitals. The Balanced Budget Act phased in a reduction in the amount of bad debt shared by Medicare. Currently, Medicare pays 55 percent of hospitals' bad debts attributable to unpaid Medicare beneficiary deductibles and coinsurance.

Mr. SOUDER. OK. We'll keep the record open, because we heard it several times. Do you have an additional comment with that, Mr. Tobalski?

Mr. TOBALSKI. No. The interpretation for us is very clear. We cannot write off charges to Medicare patients, because it is viewed as an inducement to get Medicare patients to come to our institution or to our providers, and that is clearly illegal to do.

Mr. SOUDER. Is that a relatively new regulation?

Mr. TOBALSKI. No. I think that's been in place. I think that regulation's been in place for a while. I'm not an expert on this as far as how long that has been in place, but it does exist.

Mr. SOUDER. Could you explain a little bit, Ms. Collins, why hospitals would be held responsible for determining the medical necessity, and is it possible to clarify this more? If other insurance com-

panies can clarify their guidelines, why is it, then, so difficult for Medicare to do this?

Ms. COLLINS. I don't know that it's more difficult for us than other insurance companies, but I think we have an obligation to try to make our rules and instructions more clear, so providers can better understand what is and is not covered. I don't have a new answer for that, other than our efforts to provide better information, to have discussions about this, to be sure that there's an understanding so that there is consensus about these issues and to keep the conflicts or legitimate differences of opinion to a minimum.

Mr. SOUDER. Mr. Tobalski, this stack of—well, first of all, let me ask Ms. Collins. We heard several times about the new regulations that just came out last week. Is HCFA going to ask Congress to delay the implementation? I don't think it seems reasonable that they're going to be able to get their systems.

Ms. COLLINS. The information I have is that we will meet the July 1st date for implementation of outpatient Prospective Payment System. The initial implementation of this had been delayed. There was a previous implementation date, but our efforts to ensure our Y2K compliance delayed implementation. The information I have is we are standing firm on this July 1st date.

Mr. SOUDER. The July 1st implementation date—is that when you're going to be ready or when you expect the hospitals to be ready?

Ms. COLLINS. That is when billing will begin under the new system.

Mr. SOUDER. Mr. Tobalski, how are you—how is Parkview and your system going to try to prepare and figure out how not to, A; get caught in fraud? B; make sure that patients know what they're going to have to cover and what you're going to cover by July 1st?

Mr. TOBALSKI. Well, we're going to work very, very hard. Our two biggest concerns are that almost all health care providers are going to have to find a software solution for this and find vendors who can provide the software solution. We have to implement that software solution, train staff, and, basically, our biggest concern is we will not have a software system in place that will produce a bill that the intermediary will accept and then pay.

That's not going to change the health care that we provide the patients, of course, but the amount of time that we have to adapt is extremely short and we are extremely skeptical of how ready we will be. If our only alternative is to be as ready as we can be, then that's obviously what we're proceeding on.

We had staff reviewing these documents this weekend, since they are now available. And that will be the very large task of some of our finance and patient accounting staff over the next 2 months.

Mr. SOUDER. Ms. Collins, given the fact that Mr. Tobalski raised for you the concern about HCFA's staff and the ability to respond and to work with these things—and, undoubtedly, we are under tremendous cost pressures, because we were told by the Medicare Commission multiple times that it's going broke initially by 2002, which is why everybody has been pushing so hard on this to try to preserve and save Medicare, but one of the things that's hard for me to understand with my business background is why, when

something like this was going, it wouldn't be built into the lead time in a plan that there would be software to help providers reach the ability to cope with something like this, particularly if you're facing lawsuits afterwards?

A natural business reaction would be to put up a protective shield that in effect, tells people, "We're not going to cover you. We'll cover you if we can." Then if, indeed, they can't write off the bad errors as a loss, we kind of caught them every which direction.

Was there any discussion inside HCFA about making sure there was software before you had a lead time?

Ms. COLLINS. I'm unaware of anything related to software development related to this, so I can't answer your question specifically.

Mr. SOUDER. OK. Well, we'll pursue these things at the Washington level, too, I'm sure. Are there any other comments or questions that anyone on the panel has?

Mr. TOBALSKI. I'd like to make one short comment.

Mr. SOUDER. Uh-huh.

Mr. TOBALSKI. Earlier, on the other panel, there was mention of hospitals and corporate compliance programs. I wanted to make sure that each of you understood that hospitals and health care providers developing comprehensive corporate compliance programs are a good thing. We should be doing that. You should expect us to do that. The difference is, I've worked in hospitals now for about 25 years—four different hospitals—and I don't think I've ever really looked across the desk or across the nurses' station at a nurse, at a physician, at an accountant, at an administrator who had fraud in their eyes. And corporate compliance programs really should be built on the assumption that we're doing things proactively, we're doing them right, we want to comply and with some level of cooperation between Medicare, the government and providers in developing these programs.

I think the current environment is not like that, like I mentioned earlier. Providers are really viewed as people who are abusing the system, and there just are way too many health care providers and physicians and hospitals that are trying to comply to the best of their ability, and the implication that somehow we're trying to get something out of the system that we're not entitled to is really insulting, to people who have worked in the profession for a long time or for just a short period of time.

So I do just want to again reinforce the commitment that health care providers and that Parkview Hospital have toward corporate compliance. It is important.

Mr. SOUDER. I do want to say, for the record, and in defense of the administration that we've had some whoppers in front of our committee. We had a firm out West with $1 billion in long-term health care, and, yet, they were still in the system because nobody else would provide some of that health care, and they had taken advantage of that. I saw on 20/20 or 60 Minutes where they had this lab in Los Angeles.

But, to me, as a business person, part of what I don't understand is why they had millions of dollars going through a little office where they didn't see any patients and just one walk-through and why there would be an assumption that a long-serving hospital or a doctor who had been doing this for a career would be in the cat-

egory of the exceptional. Is what you're trying to address there, that when you look for fraud, you assume past precedents might lead to the word "fraud" here? Most of what we've been dealing with is confusion, and that's really what's upsetting.

Also, I would like to thank Mr. Mica again. I know we're running really tight on time, but I thank him for coming in, for Sharon and Lisa for their work, for Elizabeth Rogers on my staff and Mary Honegger with working on the hearing. State Representative Gloria Goeglein has been here the whole time. She's been a crusader for seniors' rights in the legislature and making sure that all health care, including mental health, is well-covered in our district, and I appreciate her very much.

I'd also ask, for the record, that the charge that Mr. Miller presented and the other statements that weren't in the record in full be put into the record.

Mr. MICA. Without objection, so ordered. Also, Mr. Tobalski, you had presented 1,300 pages. Would you identify that again? What is it?

Mr. TOBALSKI. These are the regulations, explanations and addendums for the Ambulatory Patient Classification.

Mr. MICA. And you're——

Mr. TOBALSKI. Payment Classification.

Mr. MICA. And you're providing them to the subcommittee?

Mr. TOBALSKI. Well, I bought them as a prop. If you would like them.

Mr. MICA. Well, they're——

Mr. TOBALSKI. I had not brought them with the intent you would take them back. And one of your staffers, I think, is encouraging me to keep them.

Mr. MICA. OK.

Mr. TOBALSKI. And to not submit these into the record.

Mr. MICA. All right. Well, that is a request, but we will refer to those in the record, and they are available, I'm sure, as public record.

Mr. SOUDER. I'd also like to thank Ms. Collins for doing a schedule shift to be here with us today. Because of the tightness of the congressional schedule, we don't have the option of the other days during the week. And I appreciate very much your accompanying.

Mr. MICA. Thank you. As I announced at the beginning of the hearing and with the consent of Mr. Souder and the minority, we will leave the record open for a period of 2 weeks. Additional questions may be submitted to all of the witnesses who appeared before us today. We'd ask their compliance with providing that information, material and responses in a prompt fashion to the subcommittee.

Mr. Souder, anything further at this point? Again, I'd like to thank Mr. Souder for requesting this hearing. We try, at least under the period in which Mr. Souder and I've been in the majority, to not conduct all of the congressional business in Washington but to take it out into the country and hear from the people who are directly affected by our Federal programs. We do have a responsibility to make certain that taxpayer dollars are properly expended and also programs that are authorized and funded by Congress operate efficiently and with the full intent of Congress. So

this hearing will go a long way toward trying to make a very important program work and function as intended by Congress.

There being no further business come before the Criminal Justice, Drug Policy, and Human Resources Subcommittee of the House of Representatives, this meeting is adjourned. Thank you.

[Whereupon, at 11:20 a.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

QUESTIONS FOR THE RECORD
COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES
APRIL 10, 2000
FORT WAYNE, INDIANA

1Q. During the hearing, one of the witnesses stated that the fiscal intermediary published a clarification of HCFA rules which stated that screening services, other than those specifically named, would not be covered. In addition, the hearing highlighted confusion about coverage of pre-operative testing done on an outpatient basis. Please clarify HCFA's position on coverage of these services. Part of the problem is that it's not always clear what is medically necessary for the surgery. One witness gave the example of the need for an EKG for anyone over 65 before surgery since the stress of surgery on a 65 year old heart can be dangerous, even though their might not be any "signs and symptoms" indicating a need for this test. What is HCFA's guidance in this case? What will HCFA do to eliminate the confusion in this area?

1A: Medicare is committed to ensuring that beneficiaries receive all medically necessary services, including preoperative medical evaluations. We are aware that coverage and payment for preoperative medical evaluations is not consistent among all carriers and intermediaries and we are attempting to remedy the situation. Currently, Medicare covers preoperative medical evaluations in hospital outpatient departments when the evaluation is medically necessary, meaning the symptoms justify the test. The existing medical literature surrounding preoperative evaluations is limited and raises important questions about whether patients benefit from these evaluations. We are in the process of developing a national policy on this issue. This policy will be developed based on numerous factors, including review of the pertinent medical literature and will be made available for public review and comment as appropriate.

In the absence of a national policy, however, Medicare law makes clear that carriers and fiscal intermediaries have the authority to set their own local policy, so long as it is consistent with national coverage policy. The carrier or intermediary is required to follow certain procedures when issuing any local policy, including seeking guidance from medical professionals and providing the opportunity for public review and comment.

2Q: Testimony was also submitted indicating that the American Medical Association is actively discussing the definition of what is medically necessary screening. What are HCFA's plans to address this issue?

2A: We are carefully reviewing the available medical literature and will monitor developments in this area to determine whether the scientific evidence warrants a national coverage policy concerning preoperative medical evaluations in the outpatient setting.

3Q. Please provide the Subcommittee with an update on HCFA's interaction with Parkview and the fiscal intermediary to clarify HCFA's position on pre-operative screening.

3A: Our Chicago Regional Office requested documentation from the fiscal intermediary, AdminaStar Federal, explaining the procedures used to implement their local policy regarding coverage of preoperative medical evaluations. Our review found that AdminaStar followed proper procedures in the development of the policies. In addition, the Regional Office facilitated a discussion and review of the relevant policies with Parkview Health Systems' Medical Director and Compliance Officer; and the Regional Office will continue to work with Parkview should further clarification of these policies be necessary.

4Q. Testimony was presented at the hearing expressing concern that HCFA had issued the rules for the prospective payment system for hospital outpatient services with a nearly impossible date for compliance. Did HCFA consider or plan for software needs for hospitals to be able to implement the new system? What were those plans or considerations?

4A. We carefully considered the software needs of hospitals for implementation of the new hospital outpatient prospective payment system (PPS) and are working cooperatively with the hospital industry to ensure a smooth transition for beneficiaries and providers. We initiated a comprehensive outreach and education plan on the PPS last year. These education initiatives are unprecedented in their scope and second in size only to our successful Year 2000 provider outreach efforts.

For example, we held nationwide train-the-trainer sessions for fiscal intermediaries (FIs) this month. The FIs, in turn, will provide training for local hospitals and vendors in their area. We plan to hold additional training sessions for FIs, representatives from national and state hospital associations, and software vendors. We also will make training materials available on our website: www.hcfa.gov. And we are sponsoring a national satellite conference on the PPS this summer. At the same time, we are instructing all FIs to take immediate steps to disseminate final program information to the providers in their communities as soon as we release it, and to post these instructions on their websites. We also are encouraging FIs to publish articles in their provider bulletins and conduct outreach to get detailed information to providers.

We wanted to give the hospital industry and others the maximum amount of time to prepare for the proposed changes in payment methodology and make comments that would assist us in the design of the system. We published a Notice of Proposed Rulemaking on September 8, 1998 that discussed our plans for the PPS. We subsequently published four separate notices extending the comment period, giving the industry and others more than 10 months to comment. To assist hospitals in preparing for the transition to the PPS, we posted the preamble and regulation text, including the final rates and coinsurance amounts, on our web site.

It is important to note that hospitals have been using the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes, a key element in the new PPS, for many years to bill for some outpatient services, such as surgical, radiology, and other diagnostic services. However, we still need to ensure that hospital billing systems and software are ready for PPS. And we have been working closely with the industry to move forward on critical computer systems changes, such as developing the necessary software, as well as modifying the Outpatient Code Editor (OCE), an editing software, that groups services into (APC) categories; expanding the number of lines on the claim form; and creating a PRICER program that will calculate the wage adjusted ambulatory payment classification (APC) rate, including beneficiary coinsurance and deductible amounts.

In September 1999 and again in February 2000, we issued instructions regarding the use of billing code modifier that hospitals will be required to use with certain HCPCS codes when they submit bills under the PPS. In December 1999, we issued instructions to Medicare fiscal intermediaries (FIs) and hospitals about the expanded billing form, which allows for the additional line items needed under the PPS. In addition, hospitals will soon be able to use the OCE to see how it will group services into ambulatory payment classification (APC) groups. And in May, we began giving hospitals the option of filing the expanded billing form to verify they are submitting line items correctly.

We have endeavored to make the PPS effective on July 1, 2000, and we have achieved several important milestones toward this goal. However, there are others that we have missed and our informal surveys of the hospital community indicate that a significant number of hospitals may not be prepared to implement the PPS on July 1. Therefore, after careful consideration of the status of systems changes at our contractors and in hospitals, we have decided to postpone the effective date of the new PPS for one month from July 1 to August 1. This one-month postponement is critical to ensure that the hospital industry and we are ready for this significant change; and, by working together, we are confident that we will overcome the challenges posed by the implementation of this new system.

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