This memo is to inform you of a recent U.S. Senate Special Committee on Aging hearing on Medicare DRGs and supply you with the resultant information.

Attached please find the witness list for the hearing, the opening statement presented by Senator Heinz, Chairman of the Committee, and the Special Committee's staff report on DRGs.

Questions concerning any of this information should be addressed to:

Honorable John Heinz, Chairman
U.S. Senate Special Committee on Aging
SR-277 Russell Senate Office Building
Washington, D.C. 20510

Att.
WITNESS LIST
for a hearing on
MEDICARE DRGs: THE GOVERNMENT'S ROLE IN ENSURING QUALITY
before the
U. S. SENATE SPECIAL COMMITTEE ON AGING
THE HONORABLE JOHN HEINZ, CHAIRMAN

9:30 a.m. Room SD-628  Tuesday, November 12, 1985 Dirksen Building

PANEL I:
Eleanor Chemlinsky Director, Program Evaluation and Methodology Division, General Accounting Office, Washington, D.C.

PANEL II:
C. McClain Haddow Acting Administrator Health Care Finance Administration Washington, D.C.

PANEL III:
Bruce Vladek, Ph.D. United Hospital Fund New York, New York
Leon Malmud, M.D. Temple University Hospital Philadelphia, Pennsylvania
Susan Horn, Ph.D. The Johns Hopkins Medical Institutions Baltimore, Maryland
Vita Ostrander American Association of Retired Persons Washington, D.C.
Judy Waxman National Health Law Program Washington, D.C.
Catherine Hawes, Ph.D. Research Triangle Institute Triangle Park, North Carolina
Gerald Eggert, Ph.D. Monroe County Long Term Care Program, Inc. Rochester, New York
Good morning. Today this Committee convenes for the third time to hear testimony on the impact of the Administration's new Medicare cost containment program--Diagnostic Related Groups, or DRGs--on the quality of health care afforded 30 million older Americans.

It is a sad state of affairs indeed when the United States Congress has to resort to a subpoena to obtain information due it under law from an agency of the Executive branch. Unfortunately, this morning's exchange reflects an established pattern of withholding and misrepresentation of information by the Health Care Financing Administration. When asked to respond to reports of substandard care under the DRGs, agency representatives spoon feed us their "truths" in dribs and drabs. We're expected to buy these truths on faith alone, without the documentation behind them.

Well I for one have lost all faith in the garbled, incomplete, mishmash of information and misinformation held forth as fact by this agency.

The facts as reported by this Committee, facts well documented through hearings and a four-month investigation, are clear. First, built into the DRGs are incentives to compromise high quality care to maximize profits. Second, symptoms of program abuse riddle every level of care, from hospital to nursing home to home health. And finally, the watchdog Peer Review Organizations feel hamstrung to identify and sanction even the worst offenders.

Juxtaposed against this national scenario of suffering, frustration and greed is a graveyard silence from the halls of the Health Care Financing Administration. Acting Administrator Haddow repeatedly refers to "anecdotal episodes" of abuse, assuring Congress and the American public that no "systemic problem exists."

Webster's dictionary defines "anecdote" as a short account of an interesting or amusing incident. Now to my mind, when a 68-year-old man discharged prematurely dies on his way home from the hospital, or when a 71-year-old blind woman with a pacemaker is discharged to her home alone--the incident is far from amusing. It is tragic.
How many "anecdotes" will it take for the Administration to justify further expenditures on quality review and enforcement? Do we need a body count in the tens of thousands to elevate the crisis beyond an "anecdotal" status? How many voices must be heard, what abuses observed to gain consensus on the need for reform?

A third Committee Staff Report, for release this morning, summarizes the eight major quality problems under DRGs and the Administration's position on each. Too often Administration rhetoric is the antithesis of Committee facts, with reassurances based on what the watchdog PROs themselves call a "restrictive, underfunded, relatively inflexible and too-narrowly focused program of health care review."

We anxiously await the Administration's testimony today. Reforms must be made in the program, and the simplest, most effective way is through joint legislative/executive initiatives. But let the Administration stand forewarned: we will schedule more hearings, we will broaden our investigation, we will introduce legislation—we will do what it takes to assure Medicare beneficiaries the high quality health care they have paid for and anticipate.

We have a full schedule this morning. I would like to now call our first witness.
SUMMARY OF MAJOR PROVISIONS OF LEGISLATION* TO ENSURE QUALITY OF PATIENTS' CARE

TO PROTECT QUALITY IN HOSPITALS, THE HEINZ BILL WILL:

• Adjust DRGs to reflect severity of illness in the same DRG category.
• Penalize hospitals which discriminate against patients based on their disabilities or source of payment.
• Require PROs to perform comprehensive quality assurance monitoring and enforcement activities.
• Create state Consumer Advisory Boards (CABs) to oversee PROs and protect beneficiaries' rights.

TO IMPROVE HOSPITAL DISCHARGE PLANNING, THE HEINZ BILL WILL:

• Expand existing provisions for "Administratively Necessary Days" for extended hospital stays when no appropriate post-hospital care is available at the time of proposed discharge from the hospital.
• Expand discharge planning to include input from all caregivers and to improve patient education.

TO EXTEND QUALITY PROTECTIONS OUTSIDE THE HOSPITAL, THE HEINZ BILL WILL:

• Extend PROs' responsibilities for quality assurance into the continuum of nursing home, home health, and other community-based services.
• Create a federal interagency panel to develop criteria for a uniform quality of care review system.
• Eliminate "level of care" distinctions governing Medicaid nursing home reimbursement and mandate states to phase-in a payment system based upon individual patient needs and characteristics.
• Expand advocacy assistance for older Americans under long term care ombudsman program.
• Restructure Medicare's eligibility determination and appeals process to strengthen patient protections outside the hospital.
• Enact a minimum set of sanction authorities to improve protections for nursing home patients.

*(to be introduced by Senator Heinz in the near future)
MEDICARE DRGS: THE GOVERNMENT'S ROLE IN ENSURING QUALITY

STAFF REPORT

Special Committee on Aging,
United States Senate
John Heinz, Chairman

November 12, 1985
MEDICARE DRGS: THE GOVERNMENT'S ROLE IN ENSURING QUALITY

TABLE OF CONTENTS

PROBLEMS, POSITIONS AND FINDINGS:
Problem #1: Inappropriate Discharge from Hospitals ..... page 1-3
Problem #2: Patients are Denied Access to Hospitals .... page 3
Problem #3: Appeal Rights: Denial of Coverage ........ page 4-5
Problem #4: Pressures on Physicians ....................... page 5-6
Problem #5: DRG Incentives to Provide Inadequate Care .. page 6-7
Problem #6: HCFA & PROs Focus on Quality Assurance..... page 7-8
Problem #7: PROs are Limited by Existing Laws........... page 8-9
Problem #8: Post Hospital Care ............................. page 9-11

STAFF RECOMMENDATIONS:
Quality Care in Acute-Care Settings ....................... page 12
Improving Hospital Discharge Planning ................... page 13
Extend Quality Protections to Post-Acute Care .......... page 13-14
Protecting Quality Care in Nursing Homes ............... page 15
INTRODUCTION:

The following report has been compiled by the staff of the Senate Special Committee on Aging as a result of an ongoing investigation conducted over a six month period. Staff visited and collected data from five Peer Review Organizations (PROs), and a number of community and university hospitals. In addition, the Committee has heard from witnesses from 14 states.

Throughout this investigation, it has become apparent that the Committee's findings directly and starkly contrast with the claims of the Department of Health and Human Services that quality has not diminished under the new prospective payment system. This report summarizes the findings of the Committee and gives as a point of comparison the position of the Department on these major Prospective Payment System quality issues. The Report also summarizes the recommendations of the staff on what can be done to improve quality of care under the Prospective Payment System.

PROBLEMS, POSITIONS AND FINDINGS:

PROBLEM #1

SERIOUSLY ILL MEDICARE PATIENTS ARE INAPPROPRIATELY AND PREMATURELY DISCHARGED FROM HOSPITALS.

Administration Position:

Carolyn Davis, Administrator of HCFA, 4/19/85 before the Subcommittee on Health of the Senate Finance Committee

"PROs are reviewing the medical records of readmissions within 7 days of discharge and transfer to ensure not only proper utilization, but also to determine that high quality care is not being compromised. Also, fiscal intermediaries review all transfers to hospital based skilled nursing facilities (SNF) and 30 percent of all transfers to non-hospital based SNFs to assure good quality care and proper utilization. Fewer than 200 cases have been referred to the regional offices so far. This number is insufficient to indicate any patterns [of inappropriate transfers]."

Carolyn Davis 8/9/85 Letter to Senator Heinz

"...While there have been isolated instances of premature discharge and inappropriate transfer, there has been no evidence of systemic abuse."
C. McClain Haddow, Acting Administrator of HCFA, 9/30/85 before the House Budget Task Force on Health

"...There is no data which indicates that the PPS system has adversely impacted in the high quality of care that has been a tradition in our nation's health community."

C. McClain Haddow 10/2/85 on the MacNeil-Lehrer News Hour

"For the first time in history, we are able to identify where [there] are problems of quality of care in the system and we are now not only able to identify them but through the implementation of sanctions against inappropriate providers of care, either the doctors or the hospitals, we are able to correct the problem, to prevent future abuses."

Committee Findings:

GAO Testimony of 11/12/85

HHS lacks any statistically valid basis to confirm or deny effect of DRGs on the quality of health care older Americans need or receive upon discharge from the hospital. Specifically, GAO concludes that HHS does not have the necessary data to evaluate whether PPS has either increased or decreased the quality, access, demand, use or cost of post-hospital care for Medicare beneficiaries. Furthermore, HHS is not planning to do the types of evaluations that are necessary to determine whether PPS is the cause of changes in these five areas.

The Department of Health and Human Services has failed in its Congressionally mandated responsibility to monitor and report on PPS impact.

- Congress mandated that HHS complete by December 1984 a study on PPS impacts, including on quality of care. This report has yet to be completed and sent to Congress. Based on an evaluation of a draft report GAO concludes that there is no analysis of DRG impact on patients' conditions at discharge.

- Congress mandated a study of the impact of PPS on nursing home care. That study, due December 1983, is now 22 months overdue.

- HCFA scrapped a study of PPS impact on skilled nursing facilities and decided not to publish a report on PPS impact on home health care agencies.

- The only regular reports on the effects of PPS -- the "Report on PPS Monitoring Activities" -- are for internal HCFA use only and contain no reference to quality of care.
Investigation by Committee's Staff Physician
Numerous cases of inappropriate discharge from North Carolina hospitals have not been reported by the PRO to HCFA's Regional Office. The fact that almost 50% of the PROs are not reporting casts doubt on the strength of HCFA's assurances on the nature or extent of quality problems.

OTA Report to the Committee 10/24/85
"The amount of funding currently available for an evaluation of PPS within HCFA is inadequate. Budget cuts would exacerbate the problem." The OTA report also notes that while PROs are responsible for protecting against certain extreme effects of DRGs on inpatient care, their responsibility stops at the hospital door.

Richard Kusserow, Inspector General of HHS, Memorandum to Carolyn Davis, HCFA Administrator, 10/23/84.
"The impact of this type of abuse [premature discharges and inappropriate transfers] on quality is so significant that its potential visibility could jeopardize the integrity of the medical review process and the payment system..."

PROBLEM #2
SOME HOSPITALS HAVE DENIED ADMISSION TO PATIENTS WITH MULTIPLE SERIOUS CONDITIONS.

Administration Position:
The Administration has not commented on this issue.

Committee Findings:
Testimony before the Committee 9/26/85
Lydia Thomas described the painful story of her 75-year-old mother who was denied admission to a hospital after a major traffic accident.

Several physicians and hospital administrators described cases where patients deemed "DRG losers" were denied admission or inappropriately discharged from the hospital. (See the Committee Staff Report of 9/26/85 for additional illustrations of this problem.)

OTA Report to the Committee 10/24/85
According to the OTA, PPS provides hospitals with an incentive to deny admission to patients who require heavy resources or have an illness that places them in an "unprofitable DRG".

3
PROBLEM #3

MANY PATIENTS, ESPECIALLY THE TERMINALLY ILL AND THEIR FAMILIES, ARE BEING GIVEN FALSE, INCOMPLETE -- OR NO -- INFORMATION ON THEIR RIGHTS OF DISCHARGE APPEAL.

Administration Position:

C. McClain Haddow 10/2/85 on MacNeil - Lehrer News Hour

"We absolutely agree that we need patients to be informed of their rights. We require that hospitals post very visible notices upon admission clearly outlining the rights. Every Medicare beneficiary receives a booklet upon eligibility that informs them of their rights and we're working hard to make sure they get the proper kind of..."

Committee Findings:

GAO Report to Committee 2/85

"We were told in site meetings with providers and advocates that beneficiaries are upset and confused about their Medicare benefits and how PPS has affected them. We heard reports that some patients are being told, improperly, that they have to leave the hospital because their Medicare coverage has run out."

Testimony before the Committee 9/26/85 and 10/24/85

Witnesses confirmed that these problems are indeed plaguing patients and their families. For example, several patients were told to leave the hospital within two days or lose their Medicare coverage. They were not told of their right to appeal this discharge decision to the PRO. Other evidence confirmed that patients get the impression that PPS is a change in beneficiaries' coverage when in actuality it is only a change in the method for calculating hospital reimbursement.

Hospitals are required by law (4/17/85 regulations) to "inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to PRO review and indicate the potential outcomes of that review" -- i.e., that the PRO can deny reimbursement. This does not offer the beneficiary any explanation of how to appeal to the PRO as the agent of Medicare, authorized to ensure that Medicare does not pay too much. There is no standard consistent language for hospitals to inform patients about DRGs and PROs and their rights to appeal.

Medicare Handbook

The Administration has not produced helpful explanatory material for beneficiaries about their rights to health care under prospective payment. The Medicare Handbook, Haddow referred to above, was printed in April, 1985. It makes no mention whatsoever of prospective payment or DRGs. It does mention PROs but only to say that they can deny payment for care which is not medically necessary. It does not explain patient appeal rights or the appeal process.
Further, the Administration, citing budget constraints, reduced the number of handbooks printed by more than half - from 6 million to 2.7 million. Local Social Security Offices must make xerox copies to give to beneficiaries.

Apparently recognizing the Handbook's uselessness in terms of explaining prospective payment, the Administration has developed a tiny pamphlet specifically on the issue of FFPS. Unfortunately, this pamphlet gives the technical details on how DRGs will be calculated, and how the rates will be phased-in from regional to national rates, but gives beneficiaries absolutely no explanation as to how DRGs affect the limits on days of coverage that Medicare provides or the copayments that are required or how to react to claims that "the DRG is up" or how to appeal to the PRO or even what a PRO is!

Not only is the information on exercising one's right practically nonexistent, but those substantive rights themselves are deficient. Current law contains too many loopholes through which hospitals can escape the responsibility of providing notice and appeal rights to beneficiaries.

**PROBLEM #4**

**SOME HOSPITALS ARE PRESSURING DOCTORS TO TREAT PATIENTS IN WAYS THAT VIOLATE GOOD MEDICAL JUDGEMENT.**

**Administration Position:**

C. McClain Haddow 10/2/85 on MacNeil- Lehrer News Hour

"...[A] doctor can simply say 'I'm not going to do it.' There is no discharge that is allowed under our system without the doctor's signature. We expect that a doctor and a hospital would both be ethical within the standards that are set for them. We actually improve the system because we have standards that they have to meet. If a doctor or a hospital violates those standards, it's a malpractice question. And that, of course, is a very significant deterrent to that kind of behavior...They can go to the PROs, and they can complain and the hospital will be sanctioned."

**Committee Findings:**

Testimony before the Committee 9/26/85

A physician from a Pennsylvania hospital testified that his hospital had recently decided to warn doctors their privileges could be jeopardized if their patients frequently overstayed the DRG average lengths of stay.

A physician from California testified that one hospital he practices in has begun to pressure physicians toward quicker discharges by publicly ranking and comparing those physicians with longer and more costly patient stays to those with shorter money-saving patient stays.
Physicians' decisions to admit or not to admit patients for hospital care often have been based upon inflexible sets of DRG "cookbook" admission criteria.

A ten-county survey in Tennessee suggests that DRG categories "failed to adequately take into account complications arising during the course of an illness" and result in pressures on doctors to "inappropriately classify the elderly patients with multiple chronic conditions."

See Committee Staff Report of 9/26/85 for further examples.

Code of Federal Regulations: Mr. Haddow's statement is directly contradicted by HCFA's own regulations which provide that the PRO can override the decision of the attending physician that inpatient care is still medically necessary, and can issue a notice of noncoverage to the beneficiary [see 42 CFR 405.472(b)(iii)(B)].

PROBLEM #5

INFLEXIBLE AND INACCURATE DRG PAYMENTS PROVIDE FINANCIAL INCENTIVES FOR HOSPITALS TO PROVIDE INADEQUATE AND SUBSTANDARD CARE TO SEVERELY ILL MEDICARE BENEFICIARIES.

Administration Position: Testimony of C. McClain Haddow 9/30/85 before House Budget Task Force on Health

"We are also studying other refinements such as adjusting the rates for severity of illness, and are involved in a comprehensive research effort to determine how to recognize differences in severity among patients with similar diagnoses."

Committee Findings:

Testimony before the Committee 11/12/85

Susan Horn, Ph.D. testified that the DRG system does not account for differences in severity of illness. [Severity of illness refers to the fact that two patients with the same diagnosis may require different levels of care, particularly if one is older or there are other complicating conditions present.] "As a result, equitable reimbursement - system where hospitals are reimbursed inadequately, but not excessively for patient care - cannot be assured under DRGs. This places the heavy care patient in jeopardy of falling victim to a hospital's fear of financial loss and being prematurely discharged, inappropriately transferred, or refused admission. To correct this situation, some reliable measure of severity of illness is needed as part of a system of equitable prospective payment to hospitals."
OTA Report to the Committee 10/24/85
A severity of illness adjustment will give a more accurate reading of the range of patients admitted to a hospital and the efficiency of a hospital in treating them.

Testimony before the Committee 9-26-85
One doctor testified that "doctors are being forced into decisions with regard to the kind of care they give and where they will give it by rigid unreasonable federal guidelines."

PROBLEM #6

THE HEALTH CARE FINANCING ADMINISTRATION HAS FOCUSED THE PROS ON A VERY NARROW AND INCOMPLETE SET OF QUALITY ISSUES, AND THEREFORE HCFA'S ASSESSMENT OF QUALITY OF CARE IS GROSSLY DEFICIENT.

Administration Position:
Carolyn Davis 7/30/85 before the House Select Committee on Aging
"The PRO program is in place and working. We believe that it is assuring quality of care under PPS."

HHS Secretary Heckler 9/12/85 before Senate Committee on Finance
"There is no evidence of any decrease in the quality of care, according to the information that we have received from the PROs."

C. McClain Haddow 9/30/85 before the House Budget Task Force on Health
"Our monitoring of hospital behavior through peer review organizations indicates that beneficiaries are continuing to receive high quality care."

"What do the PROs do for Medicare? For the time being, the Federal Government has asked the PROs to check three things....(3) Make sure that all of the services a Medicare patient receives meet generally accepted professional standards of quality."

Secretary Heckler 10/2/85 Letter to Senator Heinz
"...the Department has taken appropriate action to assure that Medicare beneficiaries receive quality care in a safe environment."

C. McClain Haddow 10/2/85 on MacNeil-Lehrer News Hour
"But we believe that we are able to control the problem because the PROs identify quality problems and [are] able to act on them."

C. McClain Haddow 11/4/85 on NBC News
"The bottom line is the numbers: how many cases suspected of premature discharges. There are 4,200 out of 2.5 million discharges. That's less than 2/10 of a percent and that's the whole story."
Committee Findings:

Testimony before the Committee 9/26/85

PRO's contractual scope of review is limited to cases where the patient is readmitted to the same hospital within seven days. Thus, cases of readmission after seven days or to another hospital, deaths after premature or inappropriate discharge, denials of admission, inappropriate placement out of the hospital, lack of adequate care in the community etc., are not reviewed by a PRO.

Thomas Dehn, M.D., President of the American Medical Peer Review Association, testified on September 26, 1985 that HCFA primarily wants data from the PROs on utilization of stay--i.e., number of admissions, costs per admission etc.--and is less concerned with quality review. He observed that the PROs "...are somewhat hamstrung by what we consider to be at this juncture a restrictive, underfunded, relatively inflexible, and frankly, too narrowly-focused program of health care review."

In addition, Dr. Dehn said, "...the greatest problem in the PRO program is the fact that it is only a snapshot in the terms of the whole health care continuum....We do not know whether there are premature discharges...because we do not have the opportunity to review the care in that nursing home...".

AMPRA's report, "PROs: The Future Agenda", dated September 1985 and prepared by their Task Force on PRO Implementation, states that "The present quality assurance system required under PRO contracts is limited, restrictive, and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. Given the advent of prospective payment, no such data is available across a wide spectrum of inpatient care to the elderly. Only now are quality care concerns surfacing."

PROBLEM #7

EXISTING FEDERAL LAW DOES NOT PERMIT PROS TO DENY PAYMENT TO A HOSPITAL OR PHYSICIAN ON THE BASIS OF POOR QUALITY OF CARE.

Administration Position:

The Administration is on record as supporting S. 1623, Medicare Quality Health Care Act of 1985, introduced by Senator Heinz on September 11, 1985.

Committee Findings:

Under current law, when PROs find a utilization problem (such as admission for a procedure that should have been done on an outpatient basis), they can unilaterally deny reimbursement under Medicare. However, when PROs find a quality of care problem, no
immediate action can be taken. Instead, they must refer it to the Secretary for an eventual decision on whether to seek repayment from the provider or exclude the provider from participation. Further, the PROs are to report quality of care problems only if there is a pattern of substandard care or one particularly egregious instance.

Testimony before the Committee 9/26/85
Representatives of the American Medical Peer Review Association confirmed that this is a serious loophole in our ability to protect Medicare beneficiaries from poor quality care. (Senator Heinz has introduced S. 1623, the "Medicare Quality of Health Care Act of 1985", which will close this loophole and give the PROs the same authority to pursue quality of care problems that they have to pursue over-utilization problems. This bill has been included in the Senate deficit reduction package.)

PROBLEM #8

LARGE NUMBERS OF MEDICARE PATIENTS WHO ARE DISCHARGED QUICKER, AND THUS SICKER, OFTEN FIND POST HOSPITAL CARE IS UNAVAILABLE OR SUBSTANDARD.

Administration Position:

Carolyn Davis 4/19/85 before the Subcommittee on Health, Senate Finance Committee
"...[Medicare] reviews all transfers to hospital-based skilled nursing facilities (SNF) and 30 percent of all transfers to non-hospital based SNFs to assure good quality care and proper utilization. Fewer than 200 cases have been referred to the regional offices so far. This number is insufficient to indicate any patterns."

Secretary Heckler 6/19/85 Letter to Senator Heinz
"With respect to your concerns regarding the availability of post-hospital care, we believe that home health agencies and skilled nursing facilities (SNFs) are able to handle the slight increase in volume shown by our PPS statistics."

C. McClain Haddow 10/2/85 on MacNeil - Lehrer News Hour
"Each hospital is required under what we call conditions of participation, is required to have a discharge planning specialist there and that person will assist the person who is about to be discharged to make sure they go to an appropriate setting..."

Committee Findings:

Testimony before the Committee 11/12/85
The General Accounting Office concludes that HHS does not have the necessary data to evaluate whether PPS has either increased or decreased the quality, access, demand, use or cost of post-hospital care for Medicare beneficiaries. Instead, HHS lacks data on quality
of care and can make no legitimate assessment of the quality of care under PPS.

February, 1985, GAO letter report to the Aging Committee
GAO concluded that "evidence of a trend toward increased use of home health services may not be showing up on early reports of the use of Medicare home health services that are based on hospitals' discharge data. . . .A large proportion (in one hospital, 89 percent) of monthly hospital referrals to home health care were not showing up as discharges to home health care on the hospital discharge abstracts processed by the peer-review organizations."

Also in that report, GAO stated that at each site they visited, "the view was expressed . . . that patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health than prior to PPS."

At two hearings held during September and October of this year by the Committee, witnesses from fourteen States, including beneficiaries, advocates, and health care professionals, testified that premature and inappropriate discharges from hospitals are causing a great deal of suffering, confusion, and loss of life.

Committee Staff Report 10/24/85
Results of a Committee investigation confirm with data from HCFA internal reports a nearly 40% increase in discharges to skilled-nursing and home health care since October 1983. This data also demonstrates the inability of HCFA to estimate the rapid rise in the use of this benefit since the enactment of PPS (Committee Report 10/24/85).

Testimony before the Committee 10/24/85
Providers of post-hospital care confirmed that Medicare admissions to nursing homes have increased dramatically since DRGs began. These witnesses reported that "PPS has resulted in more and sicker patients being released into the community, often to the care of families who are not prepared or able to adequately care for them. . . With the shorter length of stay and reduced staff in many hospitals, patients are often too sick to respond positively to educational efforts and nurses are too shorthanded to spend the extra time needed to train the patient and the family to provide the care that will be needed at home.

Janet Adair, a home health nurse, told the Committee "In the ten years that I have been in home health care, quality of care was much better before the DRGs were activated. . . .We have had to increase our staff to meet the urgent needs of the patients coming home from the hospital."

Despite Mr. Haddow's assertion that all hospitals must have a discharge planning specialist, only hospitals that voluntarily opt to have a Department of Social Work are required to meet Federal rules for discharge planning, and these rules have been criticized
as inadequate by the National Association of Social Workers. HCFA plans to do away with even these lax rules.

Existing Hospital discharge planning programs - important mechanisms for assuring that patients are placed in appropriate community settings - are seriously overtaxed under PPS with the result that Medicare patients often receive inadequate post-hospital care.

Testimony before the Committee 9/26/85
Barbara Jones, R.N., a County Health Care Coordinator, described the pressures on home health under DRGs by stating "Home health nurses face a dilemma. Morally, they cannot refuse to provide services ordered and needed, but they sometimes do so knowing that it may not be safe. Patients are not getting adequate care and families are being pushed to the point of exhaustion."

Testimony before the Committee 10/1/84
Home health and nursing home care in the community is often unavailable. Testimony at an earlier hearing of the Committee showed this shortage is aggravated by widespread illegal discrimination against [Medicare and] Medicaid eligible patients. Nursing homes prefer to take patients who will pay higher private rates as well as patients whose conditions are less costly to care for.

Community services are even less available when one looks at the quality of facilities. For example, more than 970 nursing homes have been chronically substandard for years, according to HCFA data, but these facilities still retain their certification to receive Medicare and Medicaid patients.

Administration Cutbacks:
William Dombi, attorney from Legal Assistance for Medicare Patients in Connecticut, testified 10/24/85 that HCFA has "circumvented the law and subverted the intent of Congress....through oral and written policy directives, all designed to curtail home health and skilled nursing facility coverage." Mr. Dombi went further to assert that "there are two Medicare programs, the one that is in the books under 42 USC Section 1395 [and the one based upon the] directives of the Health Care Financing Administration". Other witnesses from the long-term-care provider community confirmed that "patients cannot be admitted for care because of restrictive HCFA guidelines".

Study provided for Committee use by Elayne Kornblatt, PhD
A Virginia study of post-hospital home health care showed that patients need significantly more care since the DRGs were implemented. All patients required more frequent visits and more intense nursing care under prospective payment in the study group.
Recommendation 1: Congress should promptly enact a set of adjustments to the DRG classification system to better reflect differences in severity of illness between patients in the same DRG category.

Recommendation 2: The Secretary should immediately remind Medicare certified hospitals of the illegality, under Section 504 of the Rehabilitation Act of 1973 (as amended), of discriminating against patients on the basis of their disabilities, and initiate enforcement action where appropriate through the HHS Office of Civil Rights.

Recommendation 3: The Secretary should revise the PRO scope of work, now being drafted by HCFA for the second round of PRO contracts, to require comprehensive quality assurance monitoring and enforcement activities.

Recommendation 4: The Congress should pass S. 1623, now incorporated in the Senate budget reconciliation package, which would for the first time authorize PROs to deny reimbursement for substandard care provided to beneficiaries under Medicare, while helping to guarantee the financial viability of the PROs.

Recommendation 5: Congress should authorize and appropriate funding levels for the second round of PRO contracts which will reflect the urgent need for at least as high a volume of quality review as utilization review, and which will reflect, as well, the greater cost per quality review conducted by PROs.

Recommendation 6: Congress should require within each state the creation of a Consumer Advisory Board (CAB) to conduct oversight of the PROs, provide input into the award and evaluation of PRO contracts, and receive input from Medicare beneficiaries and other interested parties. The Board should be coordinated with or otherwise provide for a patient advocacy system to assist the acutely ill elderly and their families. Each Board would be required to make annual reports to the governor and to DHHS. DHHS would be required to utilize CAB input in its decision to award PRO contracts. The CAB should consist of the long term care ombudsman, and protection and advocacy officials in each state, and organizations representing the elderly and disabled.
Recommendation 1: Expand existing law, which provides for "Administratively Necessary Days" payments to hospitals for a patient's extended hospital stay when no nursing home bed is available, and to provide for such payments when no appropriate post-hospital care placement -- in terms of the level of skilled care and quality -- can be found at the time of proposed discharge from the hospital.

Recommendation 2: Congress should upgrade Federal rules for hospital discharge planning to include (1) pre-discharge consultation between all professionals giving care to the patient; (2) informing beneficiaries, prior to discharge, of (a) their entitlement to Medicare and Medicaid post-hospital benefits, (b) rights of appeal, (c) the identity of the local long term care ombudsman and (d) the nearest location of deficiency reports on local providers under consideration for placement of the patient.

Recommendation 3: DHHS should voluntarily suspend plans to deregulate hospital quality assurance and discharge planning until it reports to Congress on the effects of PPS.

EXTEND QUALITY PROTECTIONS TO POST-ACUTE CARE SETTINGS

Recommendation 1: PROs' responsibilities for quality assurance should be extended so that they are required to track a pre-specified percentage of patients discharged from the hospital through the continuum of nursing home, home health, and other community-based services.

Recommendation 2: Authorize and fund PROs to do expanded quality of care reviews (1) of nursing homes and home health care agencies to ensure that quality care is planned and delivered after the patient's discharge from a PPS hospital; (2) increase PRO reviews of readmissions to those occurring within a period of 30 days.

Recommendation 3: Congress should authorize the creation of an interagency panel, consisting of representatives of Congress, the Health Care Financing Administration, the Prospective Payment Assessment Commission, the American Medical Peer Review Association, the Department of Health and Human Services' Office of the Inspector General, beneficiaries, and health care practitioner and provider representatives. This panel would make a concerted effort to seek out quality problems, in hospital as well as post-hospital settings, and would develop criteria for a uniform quality of care review system. This panel would report to Congress as soon as practicable on its findings and recommendations.
Recommendation 4: Withhold a portion of HHS appropriations for FY86 until the PPS impact on Nursing Homes report, with recommendations for reimbursement reform (due 12/31/83), and the first Annual PPS Impact Report (due 12/31/84), are delivered to the Congress.

Recommendation 5: Eliminate current "level of care" distinctions governing nursing home reimbursement under Medicaid, concurrently with mandatory state phase-in of a reimbursement system based upon patients' individual needs and characteristics.

Recommendation 6: Expand advocacy assistance for older Americans. (1) Authorize long term care ombudsman to have access to hospitalized Medicare patients, interview hospital personnel and, with patient's permission, examine complete hospital record; mandate a state ombudsman representative on PRO advisory or corporate board; (2) fund training of ombudsman in (a) Medicare PPS and (b) all Medicare Part A appeals; (3) establish funding formula for ombudsman programs based upon workload; (4) provide ombudsman with immunity from suits for good faith performance of duties.

Recommendation 7: Restructure Medicare's eligibility determination and appeals process. (1) Adopt uniform needs assessment tool for post-hospital benefits, based upon patients' functional abilities, and relieve providers of burdensome "UB-82" form; (2) institute PRO pre-discharge eligibility determination for Medicare and Medicaid benefits, with an opportunity for patients to initiate appeal prior to discharge; (3) eliminate 3-day prior hospitalization requirement for Medicare SNF benefit; (4) mandate appeal opportunity for beneficiaries when provider fails to submit claim; (5) create penalties for fiscal intermediaries or PROs that improperly deny benefits; (6) retain waiver of liability protections for providers.
Recommendation 1: Improve protections for nursing home residents. Congress should enact a minimum set of sanction authorities, which would (1) empower state enforcement officials to impose receivership on substandard nursing homes; (2) provide federal financial participation for care of residents during the period of a receivership; (3) strengthen patients' rights; (4) authorize states to impose civil penalties and suspend reimbursement to noncompliant providers; (5) expedite sanction and provider appeal at chronically substandard nursing homes; (6) prohibit discrimination in admission or treatment of patients based on source of payment; (7) empower residents to enforce provider agreement with private right of action; (8) impose moratorium on HCFA's scheduled January 1986 implementation of new nursing home inspection survey system ("FACS"), for public review and comments.