REMARKS OF SEN. JOHN HEINZ (R-PA)
AMERICAN HOSPITAL ASSOCIATION
WASHINGTON, D.C.
FEBRUARY 3, 1986

Jack, thank you for those kind words. I'm aware of your outstanding record, at the helm of New Jersey's Hospital Association. Without that state's pioneering use of DRGs to control health care costs, we might still be struggling up hill with a bloated national program on our backs and only a few months in our Federal pocketbook.

I want to congratulate you and the Hospital Association, for your appointment of Dr. Carol McCarthy as your new President. My home state of Pennsylvania and the Delaware Valley Hospital Council have benefitted from Dr. McCarthy's leadership and we look forward to working with her in her new post.

I felt a little like Daniel walking into the lion's den when I stepped up to the podium just now. The Hospital Association and the Aging Committee have not always seen eye-to-eye on how DRGs affect quality. But if I remember my Sunday school lessons, Daniel reached an understanding with the lions and they ended up with sort of a mutual admiration society.

And so today, and in the days ahead, we need to talk to each other -- to find a realistic way of maintaining high quality health care while facing severe budget constraints.

For the past 25 years, we have committed an ever growing portion of our GNP to health care. This commitment was fueled by America's resolve that all her citizens deserve the highest quality care available. In our country, so rich in financial, technical and human resources, only our ingenuity and dedication limit access, we've said, to the best medical care in the world.

Since 1960, the Federal Government's commitment to health care has risen from $5.5 billion to $100 billion and represents more than 12 percent of the Federal budget. Last year, we invested nearly $70 billion in the Medicare program alone. Our commitment paid off with longer lives and better quality life in old age.

But our financial naivete during the earlier years of growth almost brought down the whole house of cards. Like trusting parents, sending a young child to the candy store with a blank check, we structured the Medicare program with a blank check for hospitals and put the onus on them to be prudent providers of quality care.

We further strained the financial soundness of Medicare by trying to make Medicare more than intended. We helped to pay for extended hospital stays in the absence of appropriate long-term care facilities and funneled dollars to capital expansion and graduate medical education.

We got quality -- at a price we couldn't afford. By 1980, we faced Medicare's demise, eroded by runaway costs. Just three years later, Congress acted to save the program with a 180-degree legislative turn -- the Prospective Payment System.

The American Hospital Association, along with this Senator, argued early on that PPS encourages a prudent buyer approach to health care services and is sound policy for cost containment.

Bottom line reports for 1985 justify this confidence. We may not have broken in costs, but we've herded them into the corral and have them saddled and bridled.

Much of the credit goes to you. Congress can legislate, the Administration can regulate ... but when it comes to doing, we've got to delegate. The hospital industry has remained steady under fire in an extremely confusing new regulatory environment.

For more than two years now you've ferreted out waste and abuse and made an effort to keep it out. That diligence paid off for the taxpayer. Hospital costs in 1985 increased only 6 percent -- the lowest rate of increase in the past 20 years.

As the health care providers for America's 27 million seniors, your challenge is to streamline your operations, to be more efficient -- with one caveat. Americans must receive the high quality care they deserve.

Which brings me to my point: In cutting our spurs on costs, I fear we are trampling down our commitment to quality.

In January 1985, the Senate Aging Committee launched a major investigation into reports that quality care suffered unde PPS. Our Committee accumulated a thousand pages of testimony from patients and their families, doctors, hospital administrators, discharge planners, community health care providers at three hearings this fall. We requested two General Accounting Office reports, a report from the Office of Technology Asessment, reports from he Inspector General of Health and Human Services, and on-site interviews with the Peer Review Organizations in five states. Here are the Committee's findings.

First, some doctors and hospital administrators out there are discharging patients saying their Medicare benefits have run out. This is wrong. Patient stays are based on need, not days. We need to end this confusion.

Second, Medicare beneficiaries are discharged prematurely or transferred inappropriately. More than a year ago the Inspector General alerted the Administration of evidence of such abuses. Most recently, the IG cited the PROs' failure to take corrective action on the thousands of cases already on record.

A third Committee finding is that Congress' watchdog Peer Review Organization feel 'hamstrung' when it comes to quality review, with only a partial 'snapshot' of the whole health care continuum and too few resources available for monitoring.

Fourth, DRGs drive patients out of hospitals quicker and sicker. This truth is not dangerous in and of itself, since days-of-stay often exceeded what was medically necessary under the old system. But 'quicker and sicker' can be hazardous when combined with the fifth major Committee finding: post-hospital services are strained by the burden of more patients needing greater care. Some patients may not be getting adequate care.

Finally, DRGs do a poor job of accounting for the cost of caring for severely ill patients whose 'principal diagnosis' may be complicated by other chronic conditions.

The Committee's findings polarized Administration, providers, beneficiaries. Our conclusions were labeled as insightful or inciting, farsighted or farfetched, but we are beginning to see some agreement.

To go back to Daniel's story, we're ahead of Daniel despite our differences. We've agreed on a philsophy of health care that says quality must not bow to economy working together towards this end,

there are some steps the Administration must take, some tasks for the Congress, and some for you in the hospital industry.

We can't predict what the new HHS leadership will do, but I personally am encouraged by Secretary Otis Bowen's commitment to quality as a top priority for his Administration. He is a real health care professional. Unfortunately, Secretary Bowen's appointment comes after the Administration dropped the ball on quality. The failure to act has undermined public confidence in America's health care system.

In two weeks I will join with Congressman Pete Stark, Chairman of the House Ways and Means Subcommittee on Health, to legislate what the Administration could have done on its own.

Our bill, the Medicare Quality Assurance Act, has six major components. First, it acknowledges that DRGs are often rigid when it comes to compensating hospitals for treating patients with more complex illnesses. As difficult as it may be, we need to adjust the DRGs through some form of severity of illness index.

Second, we are for the Administration's expansion of the PRO scope of work, but it is not enough. Our bill has these watchdogs look at readmissions occurring over a longer period and checking quality beyond the hospital door -- in home health, nursing home, board and care homes, and outpatient settings.

Third, bad discharge planning, with patients hastily and inappropriately placed for follow up care, can be fatal for the sicker patients. We need standards for discharge planning and we need to require compliance for participation in the Medicare program. The Medicare Quality Assurance Act does that, but it can't work without you. We need your commitment to improve discharge planning. I'm proud of the efforts of my own State of Pennsylvania's Hospital Association for the leadership they are showing in this area.

Good discharge planning depends on having the right place to send patients. Unfortunately, our post-acute services fall woefully short of demand. Strengthening the continuum of care is the fourth component of our legislation. We increase incentives for skilled nursing facilities and home health agencies to take the heavier care patients once kept in hospitals. Hospitals should develop their own comprehensive plans for post-acute care. And the Administration must halt its cuts in home health and nursing home reimbursements.

Fifth, consumer involvement in quality assurance is limited by that old addage "ignorance is bliss." Far from bliss, some patients and their families feel panic and rage when discharged without explanation of their appeal rights. Our bill will expand protections to patients and ensure that patients know what appeals are available.

Here again, you can do more to improve patient information and ensure that patients' voices are heard. The Hospital Association and the Aging Committee, along with the American Association of Retired Persons and other groups, took a big step for patients' rights in the beneficiary appeals notice we sent to the Administration last week. Let's build on the momentum we've achieved and get these notices out to hospitals nationwide.

Last, we need better data to shed light on the problems created by the radical transformation of our health system. HCFA is responding to the criticisms ... yet I admit to serious impatience with those bureaucrats who continue to say there's no data showing problems.

This reminds me of the man down on this hands and knees on the sidewalk at night under a lamp post. A passerby asks what he is doing and he replies, "I'm looking for my wallet." "Where did you lose your wallet?" The passerby asks. "Down the street," the man replies, "but this is where the light is."

The Medicare Quality Assurance Act would illuminate those areas where quality is most threatened by extending the Administration's reporting requirements in both hospital and post-hospital setting.

We've got one priority: to restore public confidence in the system and assure quality health care. Look closely at proposals for modifying Prospective Payment with this priority. The Medicare Quality Assurance Act is an important step forward and I ask that you support it.

You must take the lead on maintaining quality. Be prepared for a tough struggle with compulsive budgeteers. We're talking about the lives of present and future older Americans.

Thank you.