Statement of John Nordwick, CEO
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before the Senate Finance Committee
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My name is John Nordwick. I am the Chief Executive Officer of Bozeman Deaconess Hospital. Like most hospitals in Montana, we provide health services across the full continuum of care. In addition to 86 acute care beds, we also operate Aspen Pointe, an independent living facility and Birchwood, an assisted living facility. In addition, ** physicians practice in the clinic buildings attached to the hospital.

I also am the Immediate Past Chair of MHA, formerly the Montana Hospital Association. MHA members provide the full spectrum of health care services, including hospital, nursing home, home health and hospice care. In addition, since a growing number of hospitals employ their physicians, we also advocate on their behalf on some issues.

Thank you for this opportunity to testify. The regulatory process has an enormous impact on health care in Montana. I welcome this opportunity to share a few thoughts about how we can improve this system.

I think I speak for most providers when I say that a certain amount of structure is needed to implement the policy directives developed by Congress. However, health care providers are increasingly alarmed about the growth of this regulatory structure, its cost and its impact on access to medical treatment.

Regulatory Requirements: An Unfunded Mandate

In my hospital, the amount of resources dedicated to implementing and complying with federal regulations has grown enormously just in the last decade – and with good reason. Since 1996, Congress has enacted several major pieces of legislation that have resulted in massive numbers of regulatory requirements.

For example, the Balanced Budget Act of 1996 resulted in more than 300 changes in the Medicare program alone. The Health Insurance Portability and Accountability Act imposed broad and far-reaching new privacy regulations and fundamentally alters the way we handle the billing process.

In addition, as mandated by the BBA, the Department of Health and Human Services developed new prospective payment systems for outpatient hospital, home health and nursing home services.

HHS also made major changes in the Conditions of Participation, which set the licensure and certification requirements for hospitals. HHS also modified a wide variety of current regulations, including those related to billing, coding, coverage and EMTALA.

Each of these required hospitals to invest huge amounts of capital in computer hardware and software, training and additional staff. Taken together they represent a virtual avalanche that threatens to bury hospitals.

In a study published last year, the American Hospital Association found that for every one hour of care delivered in an emergency room, one hour of paperwork is required. For every hour of surgical and inpatient care delivered, 36 minutes of paperwork is required. For every hour of skilled nursing care delivered, 30 minutes of paperwork is required. And, for every hour of home health care delivered, 48 minutes of paperwork is required.

Complete records and documentation are necessary for patient safety and quality. But this kind of administrative burden shifts the focus from patient care to paperwork.

Meanwhile, on the revenue side of the equation, Congress has not approved funding to pay for compliance with all of these requirements and all of this staff time devoted to paperwork. In fact, the BBA reduced Medicare spending by at least $40 billion – and probably a lot more. In each year since 1997, Congress has set provider rate increases at less than the increase in our inflation.

The net effect of this has been to widen the gap between what Medicare pays hospitals and what we are forced to charge for services. In Montana, this gap grew from $230 million in 1997 to $275 in 2000. These losses are passed on to the privately-insured persons who live and work in our community who make up the difference by paying higher insurance premiums.

The bottom line is that the federal government has mandated a whole new set of regulatory requirements, but given us – the people who have to implement these mandates – no vehicle for funding their implementation.

CMS's Ability to Implement Congressional Mandates

We face a second challenge in dealing with this regulatory morass: CMS's ability to implement congressional mandates.

For several reasons – most likely the complex nature of congressional mandates, understaffing, underfunding or just their own incompetence – CMS has had enormous difficulty in recent years implementing congressional mandates.

The outpatient prospective payment system is one example of this difficulty. Mandated by the BBA, CMS had a couple of years to get ready to put this new system in place. But despite this lead time, there were major gaps in the technology and software that appeared. Even more troubling was the inability of CMS to provide adequate training and helpful and timely interpretations of the new rules.

As a result, providers were left to stumble through implementation on their own. CMS continues to refine and implement this system even today.

A second example is CMS's implementation of the all-inclusive payment rate for physicians working at Critical Access Hospitals. As passed by Congress, this was to take effect for facility fiscal years beginning in 2001. However, CMS still has not implemented the mandate – and now says it can't implement it retroactively. What Congress intended to be a fix for CAH's has turned into a nightmare.

The scenario for HIPAA is remarkably similar. The HIPAA privacy regulations take effect on April 1, 2003, yet the Department of Health and Human Services still has not clarified a number of key

issues that must be resolved before providers can actually proceed with implementation.

As if this confusion weren't bad enough, if providers don't comply accurately with these requirements, we are considered to be in violation of federal fraud statutes – and subjected to very expensive fines and other penalties.

Providers should be given accurate, complete and timely instructions for implementing new rules. We should be able to get our questions – whether to CMS or the fiscal intermediary – answered in a timely fashion. And we should be able to resolve our conflicts over these issues quickly and reasonably. Today, all too often, that's not the case.

Working Toward Solutions

I applaud the interest you have shown in addressing these concerns. I appreciate the initiative you have shown in developing your regulatory reform bill; this bill is a good first step.

But, requiring CMS to publish its rules in a more organized fashion is only a small step toward resolving the problems facing our regulatory system. Far more fundamental questions must also be addressed.

I would argue that the federal government should not be allowed to impose any new rules unless it also pays for their implementation. I also would argue that CMS and the FI be held much more accountable for their performance in meeting congressional mandates. Finally, I would argue that providers would support additional funding for CMS – if it is contingent on improved performance by CMS.

I recognize the important role the federal government has in setting standards for the health care system. However, there must be the kind of balance in this system that ensures that the interests of providers and consumers are both met.

Thank you.