close hold please do not distribute

THE WHITE HOUSE
WASHINGTON

August 13, 1999

TO: Interested Parties

FROM: Chris Jennings and Jeanne Lambrew

RE: **DATA ON THE IMPACT OF THE BALANCED BUDGET ACT OF 1997**

As we have discussed, the most up-to-date information on payments and access to health care providers is needed to assess the impact of the Balanced Budget Act (BBA). Current data systems only provide such information completely through 1996 (limited 1997 and 1998 data are available). To fully assess the impact, data for 1997 through 1999 are needed, as well as analyses by state if possible.

In addition to historical data, we are also interested in projections of the BBA impacts on provider finances and patient access to services. Since projections are very sensitive to assumptions for such factors as input cost growth and utilization, it would be helpful if you (1) list all of the assumptions you used in formulating your projections so that we can compare them to other sources of information (e.g., MedPAC, GAO, HCFA Office of the Actuary) and (2) base projections on five-year trends of actual data. For example, if CYs 1993-1997 are the latest years of available finalized data, projections should be based off trends computed using the CY 1993-1997 data.

We appreciate any assistance that you can give in tracking this information. I want to emphasize, however, that the provision of this information is, of course, purely voluntary. Please call with questions.

IMPACT OF THE BALANCED BUDGET ACT (BBA)

DATA POINT	ANALYTIC QUESTIONS
HOSPITALS[1]	
Total margin, inpatient margin Medicare total margin, inpatient margin	What has been the recent trend in total margins? How does that compare across types of hospitals, regions? How does the overall margin trend differ from Medicare margins trends? What is the difference between inpatient and outpatient margins?
Payments and costs by payer, aggregate, per discharge: Medicare Medicaid Private Self-pay / other	What are the relative roles of different payers? How different is the change in Medicare's payment per discharge copared to other payers? How does the ratio of Medicare payment to cost compare to that of the private sector and Medicaid?
Discharges by leading DRGs (see HCFA statistical supplement for list) plus the following that are not on the leading DRG list but are affected by the transfer policy: **211** Hip and Femur Procedures Except Major Joint Age >17 without CC (Surgical) **263** Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC (Surgical) **264** Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC (Surgical)	How has the transfer policy affected discharge patterns? How do discharges for these DRGs compare to others? What types of hospitals have seen the biggest change?
Average length of stay: By payment source and, within Medicare, broken out by ESRD, disabled and elderly patients Discharges: By payment source	How has the transfer policy and change in SNF reimbursement affected the length of stay of high-cost cases like ESRD patients? What is the pattern of discharges by payers and hospital type?
Medicare bad debt payments	Has this changed over time (controlling for the BBA policy change)?
Number, percent of discharges of managed care enrollees (private as well as Medicare)	Is there a relationship between managed care and hospital margins?
Bond ratings, stock prices, net worth	Often, markets are quicker at identifying problems in industries. What are recent trends and projections showing?
Number, percent of swing beds	How has the transfer policy and SNF reimbursement affected swing beds?

1 By: urban/rural and bed size: 1-35,36-50, 51-99, 100-299, 200-499, 500 +, teaching/non-teaching, voluntary/proprietary/gov't,

SKILLED NURSING FACILITIES[2]	
Payments and costs by payer, aggregate, per day: Medicare Medicaid Private Self-pay / other	What are the relative roles of different payers? How has Medicare's payment per discharge changed compared to other payers? How does the ratio of Medicare payment to cost compare to that of the private sector and Medicaid?
Number of Medicare covered days Number of Medicare covered admissions Average length of stay Distribution of Medicare benes by length of stay (1-8, 9-20, 21-40, 41-60, 61-80, 81+)	Has there been any change in beneficiaries' use of SNFs since the BBA PPS system was implemented? If so, by how much? Were these trend occurring prior to the BBA?
Distribution of admissions by major RUG groups (see Statistical Supplement Table 45 for categories) Case mix index: Nursing, nursing/therapy	How has casemix, distribution of patients in SNFs changed since the BBA took effect? How does this vary across areas, types of SNFs?
SNF admissions for ESRD patients	Using ESRD patients as a proxy, has there been a decline in admissions of complicated cases since the PPS was implemented? If so, by how much?
Medicare bad debt payments	How has this changed over time (controlling for the BBA policy change)?
Bond ratings, stock prices, net worth	What are recent trends and projections showing?
THERAPY	
Aggregate and average spending per bene by: Physical therapy Occupational therapy Speech therapy	How does spending across the different therapies compare? How close is the spending to the $1,500 cap? Should PT and speech be separated?
Distribution of benes with Medicare spending of: $0, $1-499, $500-999, $1,000-1499, $1,500-1,999, $2,000-2,999, $3,000 + by:: Physical therapy Occupational therapy Speech therapy	Are there natural breaks in spending that may be more appropriate for caps? At what levels?
Aggregate spending by therapy type (PT, OT, Speech) by setting: SNF Outpatient hospital Other outpatient settings	How has the setting for therapy services changed post-BBA (e.g., shift to hospital outpatient sites, which are not capped)?

2 By: rural/urban; proprietary, voluntary, gov't

HOME HEALTH	
Payments and costs by payer, aggregate, per day: Medicare Medicaid Private Self-pay / other	How much, if at all, have Medicare payments decreased as percent of payments as well as in aggregate? Has there been similar declines in private and Medicaid payments?
Beneficiaries using home health services Number of visits – in aggregate and per user	What are the patterns of use? How has the historical variation (with most visits in the South) changed?
Distribution of users by visits: 1-60, 61-120, 121-180, 181 +	How has the distribution of home health users by number of visits changed post-BBA?
Number of type of visits: Nursing care Home health aide Physical therapy Speech therapy Occupational therapy Other	How has the type of visits changed? Has there been an increase in skilled visits post-BBA and, if so, by how much?
Number of new home health agencies; number of consolidations, overall number of agencies	Has the change in reimbursement affected the number of agencies? In what ways?
MANAGED CARE[3]	
Payments and costs by payer, aggregate, per day: Medicare Medicaid Private Self-pay / other	What are the relative roles of different payers? How has Medicare's changed compared to other payers? How does the ratio of Medicare payment to cost compare to that of the private sector and Medicaid?
	What documentation do you have to support the contention that the Medicare enrollees are sicker than is assumed under the HCFA risk adjustment model?
Enrollment by payer	What has been the change in the mix of enrollees since BBA? How much more / less is the enrollment growth in Medicare enrollees versus private enrollees?
Bond ratings, stock prices, net worth	What are recent trends and projections showing?

3 By urban/rural; nonprofit / profit; state

AMERICAN HOSPITAL ASSOCIATION WHITE PAPER

HCFA's Authority to Develop a Budget Neutral Conversion Factor Under the Hospital Outpatient Department Prospective Payment System

By

Darrel J. Grinstead
Hogan & Hartson, L.L.P.

Background. The Balanced Budget Act of 1997 ("BBA") establishes a Medicare hospital outpatient department ("OPD") prospective payment system ("PPS") to determine both the amount of Medicare payments for outpatient department services and the amount of beneficiary copayments for those services. The new system is intended to be implemented in a budget-neutral way. While budget savings were achieved in the BBA through several OPD-related provisions (extension of current law payment reductions, elimination of formula-driven overpayments, and limitations on market basket rates of increase), there is no indication that Congress intended to achieve additional savings through the PPS formula itself. However, the proposed regulations published by the Health Care Financing Administration to implement this provision result in an additional reduction of 5.7% or $900 million per year in Medicare payments to hospitals for OPD services. This results from an interpretation by HCFA of a provision of the BBA that was not intended by the Congress nor required by the language of the statute. The following analysis supports this conclusion.

The Statutory Formula. Analysis of this problem requires an initial understanding of the basic formula that Congress devised for determining Medicare payments and beneficiary copayments for OPD services. The statute requires relative payment weights to be determined for each OPD service or group of services. Based on those weights and the frequencies of each service or group, a conversion factor is calculated so that the sum of the Medicare fee schedule amounts (conversion factor times relative weight) multiplied by the frequencies for each service or group equals the projected amount that would have been payable under the old system. The fee schedule amount is composed of both the Medicare payment amount and the beneficiary copayment. In order to correct a problem in the current statute that results in excessive copayment amounts, the statute requires the determination of an "unadjusted copayment amount" (20 percent of the

national median of the charges for each service or group). The formula for determining the amount of actual copayments for each year is designed to reduce copayments gradually until they reach that target amount.

HCFA's Proposed Process for Calculating the Conversion Factor. The problem with HCFA's interpretation of this statutory formula derives from the manner in which it proposes to determine the conversion factor. In calculating the conversion factor, rather than utilizing data that will result in payments under the new system in the first year equaling what would have been paid under the old system, HCFA proposes to build into the conversion factor a significant reduction in its estimate of beneficiary copayments. The ultimate result of this interpretation is a lower conversion factor and a permanent and unintended reduction in payments to hospitals for OPD services.

Under section 1833(t)(3)(A) of the statute, the Secretary's estimation of the conversion factor must begin with the calculation of base amounts (i.e., a hypothetical calculation such as that previously used in converting several other Medicare payment systems to fee schedules or prospective payment systems). These amounts traditionally have been based on assumptions of the amounts that would have been paid in the initial year under the old system and were intended to ensure budget neutrality in "converting" from one system to another. However, in this case, the statute specifies that, in calculating the total amount that hospitals would have received for an OPD service, **Medicare** payments in the base year will be based on an estimate of Trust Fund payments for OPD services in 1999 "without regard to this section," while beneficiary **copayments** will be based on the amounts "estimated to be paid under this subsection" in 1999. § 1833(t)(3)(A)(ii).

There is one critical problem with this statutory instruction. The statute and HCFA's proposed regulation would require the Secretary, in solving for an unknown (the conversion factor), to use as one of the components of the formula (the copayment base amount) an amount that can only be determined after the conversion factor has been calculated. On its face this instruction seems circular because the Secretary cannot know what amounts would be paid "under this subsection" until she can apply to the formula the conversion factor that is the subject of this calculation.

In its proposed regulation implementing this formula, HCFA states that it is following this statutory instruction. While HCFA does not expressly state that it is doing so, the only figure that would be immediately available for estimating copayment amounts "under this subsection" would be the "unadjusted copayment amount" that the Secretary is required to calculate for purposes of

determining the beneficiary copayment amounts under the formula, as discussed above. 1/

Under section 1883(t)(3)(B), the unadjusted copayment amount for each service or group is set at 20 percent of the national median of the charges for that service or group in 1996, updated to 1999 by the Secretary's estimate of the growth in charges during that period. However, the unadjusted copayment amount is not calculated for the purpose of establishing the amount of copayments to be paid by beneficiaries in any year. The sole purpose for calculating that figure is to determine the program payment percentage, which determines the proportion of the total fee schedule amount to be paid by both Medicare and beneficiaries. Nowhere in the statute is there an instruction to determine actual or estimated copayment amounts based on the unadjusted copayment amount. It is merely a fixed proxy amount which, when applied in the formula for each year, results in a gradual decrease over time in the relative share of the full fee schedule amount that is paid by Medicare beneficiaries as a copayment. 2/

There are a number of problems with using the unadjusted copayment amount as a proxy for total 1999 beneficiary copayment amounts in the calculation of the base amount under section 1833(t)(3)(A). First, it is merely a fictitious amount based on the national median of the charges for a service in 1996, updated to 1999 to reflect increases in charges over that period. It does not in fact reflect current payment levels. Because the median amount for these charges is less than the mean, we understand from HCFA's actuaries that the aggregate amount of this unadjusted copayment amount will be more than 10 percent less than current levels of beneficiary copayments. There is no indication in the legislative history or elsewhere that Congress intended this result

Second, as noted above, Congress did not instruct the Secretary to use that figure in that manner. If Congress had intended the "unadjusted copayment amount" calculated under section 1883(t)(3)(B) of the statute to be used as the Secretary's estimate of the total amount of copayments for 1999 for purposes of the conversion factor, it would have referred to that specific provision in the statute, rather than requiring, as section 1883(t)(3)(A) does, that the Secretary "estimate" that amount. It would be illogical to require the Secretary to estimate a payment amount if Congress intended to Secretary to use an amount that is specifically calculated under the statutory provision immediately following the provision requiring the estimation.

1/ See discussion in section V.C.2.b. of the preamble to the proposed regulation, 63 FR 173. Sept. 8, 1998, p. 47573.

2/ Under the statute, when the program payment percentage for a service or group reaches 80 percent, it then permanently remains at that amount, the gradual reduction in copayment percentage having been fully achieved. § 1833(t)(3)(B)(ii).

Legislative History. Thus, there is considerable ambiguity in the statute as to how the Secretary is instructed to calculate the total amount of beneficiary copayments for the purposes of determining the base amounts and the resulting conversion factor. We do not believe, however, that there is any ambiguity in the congressional intent that the conversion factor should be calculated in such a manner that the fee schedule amounts determined under the PPS "would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." That precise language appears as a statement of congressional intent in both the House and Senate reports on the OPD PPS provisions, and in the Conference Report. 3/ The use of the subjunctive "would be paid" in this phrase seems clearly to indicate Congress' intent to refer to amounts payable in other circumstances, i.e., had Congress not changed the formula.

Both the House and Senate versions of the bill that went to Conference on the Balanced Budget Act contained almost identical versions of an OPD prospective payment system. Both of those bills required a determination of base amounts (for purposes of determining the conversion factor) derived from an estimate of the amounts that would be payable by Medicare for OPD services under the old law and as though the required coinsurance, as in effect prior to enactment of the new PPS, continued to apply. However, in the final drafting of the Conference language, technical changes were made to the entire OPD PPS provision, apparently to correct drafting flaws, without any change being intended to the actual determination of payment amounts. 4/ The Conference Report states that it adopts the House bill with amendments to define covered OPD services and to provide market basket minus one percent updates to the fee schedule amount for the years 2000 through 2002, with full market basket percentage increases thereafter.5/ No mention is made in the Conference Report of any intention to reduce the copayment portion of the base amount in order to achieve additional savings. In fact, such savings are nowhere mentioned in the legislative history or in the budget analyses of this provision. Therefore, it seems probable that any change in the language of this provision made by the Conference Committee was intended only to correct the drafting problems and not to require a $900 million annual reduction in Medicare payments for OPD services.

3/ H.R. Rep. No 105-149, 105th Cong., 724 (1997); S. Rep No. 105-29, 105th Cong., 53 (1997); H.R. Rep. No. 105-217, 105th Cong., 784 (1997).

4/ The conversion factor that would have been used in the House and Senate bills would have used as an aggregate base amount Trust Fund payments only, calculated without regard to the PPS amendments, and calculated as though the coinsurance provisions in effect prior to enactment continued to apply. However, the conversion factor established in the Conference report is based on the sum of both Medicare Trust Fund payments and beneficiary copayment amounts.

5/ H.R. Rep. No. 105-217, 105th Cong., 785 (1997).

The legislative history does not explain why the Conference Committee adopted language for calculating base amounts that referred to copayment amounts "estimated to be paid under this section" rather than assuming that copayments would be calculated under the old system, as both the House and Senate bills did. Perhaps the drafters assumed, without being aware of the effect of using median charge levels rather than the mean for calculating unadjusted copayment amounts, that either method would produce the same result. Or perhaps the drafters simply failed to recognize that copayment amounts "under this subsection" would be something entirely different from the amount of copayments that should be taken into account in order to achieve the stated budget neutrality purpose of the conversion factor. In any event, there is no discernible logic in the use of base amounts derived from the former system for establishing the Medicare portion of the conversion factor base, while using amounts that are somehow to be determined under the new system for establishing the beneficiary copayment portion of that factor.

If HCFA's proposed rule is adopted, the amount of copayments estimated to be paid by beneficiaries for purposes of determining the conversion factor will be arbitrarily reduced by 6.9 percent. That downward adjustment will permanently reduce the fee schedule amounts and the amounts paid to hospitals by Medicare in a manner that is totally inconsistent with the clearly stated congressional intent indicated above.

Although courts and administering agencies are under an obligation in most cases to follow statutory language that is clear and unambiguous, in some "rare and exceptional circumstances," this presumption can be rebutted. *Ardestani v. INS*, 502 U.S. 129, 135-36 (1991). Even if the language in question here were unambiguous (which we have demonstrated is not the case), it is a well-established canon of statutory construction that "a court should go beyond the literal language of a statute if reliance on that language would defeat the plain purpose of the statute." *Bob Jones University v. United States*, 461 U.S. 574, 586 (1983). This directive is particularly appropriate when construing a complex statute that produces an unexpected result. *DeJesus v. Perales*, 770 F.2d 316, 321 (2d. Cir. 1985), cert. denied, 478 U.S. 1007, (1986) (interpreting conditions a state Medicaid plan must meet in order to qualify for federal matching funds, which the court describes as "a statute of unparalleled complexity").

This is not the first time HCFA has been faced with implementing changes in Medicare payment policy where the language of the statute was inconsistent with Congress' actual intention. HCFA had a similar problem when Congress enacted the Omnibus Budget Reconciliation Act of 1990 6/ which required

---

6/ OBRA 90, Pub. L. No. 101-508, 104 Stat. 1388 (1990).

HCFA to create national payment limits for durable medical equipment. 7/ The payment system was to be phased in over three years, starting in 1991, and payment rates were to be updated annually based on a "covered item update." 8/ The update for both 1991 and 1992, as it was enacted and signed into law, was a "reduction of 1 percentage point." 9/ What Congress had intended, however, was not a reduction in payments of one percent but an *increase* based on the Consumer Price Index for all urban consumers ("CPI-U") for the previous year reduced by one percentage point. Congress corrected this error, four years later, by a technical correction included in the Social Security Act Amendments of 1994. 10/

In the meantime, however, HCFA had no difficulty in implementing the statute as it had been intended rather than as it plainly read. Although the correction to the statutory provision was not made until 1994, HCFA promulgated regulations in 1992 that interpreted the covered item update for 1991 and 1992 to be based on the CPI-U, reduced by one percent. 11/ In short, the regulation assumed that the statutory provision as enacted was incorrect and read into the provision a payment update based on congressional intent.

Similarly, we do not believe HCFA is obliged to interpret the OPD provisions discussed above by following blindly a narrow reading of the language of the statute itself. This is especially true given that to do so would deprive hospitals of $900 million in annual revenues in a manner that was not intended by the Congress and not reflected in any of the agreements, discussions or analyses of the budget impact of this legislation. Moreover, as noted above, the language of the statute has an unusual circularity that renders it infeasible to be implemented literally. The courts have recognized the leeway that administrative agencies must be given in interpreting complex and ambiguous statutory language (see *Perales, supra*), in order to ensure that congressional intent is achieved.

Conclusion. In light of the complexity of this statutory scheme and the ambiguity in the statutory language, HCFA should interpret the statute in a manner that will achieve the stated objectives of the Congress and that will make sense in terms of calculating a conversion factor that will ensure that the fee

---

7/ *Id.* at § 4152(b).

8/ *Id.* at § 4152(b)(4) (prior to 1994 amendment).

9/ *Id.*

10/ Social Security Act Amendments of 1994, Pub. L. No. 103-432, § 135, 108 Stat. 4398, 4422 (1994).

11/ Payment for Durable Medical Equipment and Orthotic and Prosthetic Devices, 57 Fed. Reg. 57678 (1992).

schedule amounts determined under the PPS will "equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." 12/ HCFA's regulations should provide for a budget neutral conversion factor that will provide for the conversion of payments from the former system to the new without extracting $900 million annually in unjustified and unintended hospital payment reductions.

12/ H.R. Rep. No 105-149, 105th Cong., 724 (1997); S. Rep No. 105-29, 105th Cong., 53 (1997); H.R. Rep. No. 105-217, 105th Cong., 784 (1997).

HOGAN & HARTSON L.L.P.

MEMORANDUM

June 7, 1999

TO: David Seckman, President
American Health Care Association

FROM: Darrel J. Grinstead

RE: HCFA's Authority to Develop An Alternative Skilled Nursing Facility Market Basket Index and to Make Other Changes Affecting SNF Medicare Payment Rates

You have asked for an analysis of the authority of the Secretary of Health and Human Services (the "Secretary") to adopt a skilled nursing facility ("SNF") market basket index to be used for annual rate updates for the recently-implemented SNF prospective payment system under Medicare. Specifically, you have asked whether the Secretary has the discretion to establish or use a market basket index different from the one discussed in the interim final rule with comment published on May 12, 1998 (63 Fed. Reg. 26252). We also agreed to identify other aspects of the SNF prospective payment system ("PPS") on which the Secretary would have discretion to make changes that might affect payment rates.

Summary

The Medicare statute gives the Secretary broad discretion to establish an appropriate SNF market basket index. Her authority in that regard is not limited to the use of a pre-existing index. Nor does the legislative history of the statute indicate that any specific market basket index was intended. In short, we see no legal impediment to the Secretary adopting or establishing a different SNF market basket index from that described in the May 1998 interim final rule with comment. Likewise there are other analyses, assumptions, and estimates that the Health Care Financing Administration ("HCFA") made in its PPS implementing regulations that can be examined and revised to ensure that the amount actually paid for Medicare SNF services approximates the amount that Congress intended.

Background: Statutory Mandate for a SNF Prospective Payment System

The Balanced Budget Act of 1997 ("BBA") established a new prospective payment system for determining payment rates for skilled nursing facilities under Medicare. 1/ For the first three years of the new system, beginning with the cost reporting period starting on or after July 1, 1998, the per diem payment rate for SNF services is a blend of a facility-specific rate and a federal rate. Thereafter, all payments are based on the federal rate which is adjusted for factors such as case mix and wage differences. Both the facility-specific per diem rates and the federal per diem rates are established on the basis of the allowable costs of extended care services for cost reporting periods beginning in fiscal year 1995 (with certain adjustments) and an estimate of the corresponding amounts payable under Part B. These bases are updated to the first year of the PPS by the percentage change in the SNF market basket index minus one percent. Thereafter, the per diem rates are adjusted annually by the percentage change in the SNF market basket index, reduced by one percent each year through fiscal year 2002.

Thus, the SNF market basket index is an important factor in determining both the initial rates that SNFs will be paid under the new PPS, and in determining annual adjustments to account for the increased costs (presumably) of providing services. With respect to the setting of the initial PPS rates, the market basket index has a compounded effect on those rates because it is applied to base period amounts over a three year period, from 1995 to 1998. Stated simply, if the market basket index fails by one percent to reflect the actual percentage increase in prices of the goods and services included in covered SNF services in each of those years, it would result in more than a three percent underpayment by Medicare for those services in the first year of the PPS. The greater any underestimation of true market basket percentage, the more drastic will be the impact of that calculation on initial SNF payment rates. Moreover, that negative impact on payment rates would continue for each subsequent year for the duration of the PPS.

Analysis of the Secretary's Authority to Determine the SNF Market Basket Index

Section 1888(e)(5) of the Social Security Act, as added by the BBA, provides as follows with respect to the establishment of the SNF market basket index and percentage:

1/ Pub. L. No. 105-33, § 4432; Social Security Act ("SSA") § 1888(e).

> (A) SKILLED NURSING FACILITY MARKET BASKET INDEX.--The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

Subparagraph (B) goes on to define the SNF market basket percentage as the percentage change in the SNF market basket index from the midpoint of one year to the midpoint of the following year.

The statute merely requires the Secretary to "establish" a SNF market basket index. It makes no reference to an existing index, and provides no guidance as to what should be included in the index other than that it must reflect changes over time in the "prices" of an "appropriate" mix of goods and services included in covered SNF services. 2/ Thus, the Secretary has substantial discretion to determine what should be used as or included in the SNF market basket index, so long as it reflects changes over time in the prices of an appropriate mix of goods and services.

In the May 1998 interim final rule with comment implementing the SNF PPS, HCFA chose to adopt an existing SNF market basket index that had been used since 1979 to make annual adjustments to the SNF cost limits. 3/ However, HCFA recognized the inadequacy of the existing index. Because it was a "fixed-weight index" HCFA observed that the index did not consider, and was not designed to consider "[t]he effects on total expenditures resulting from changes in the mix of goods and services purchased subsequent or prior to the base period...." 4/ For that reason, HCFA explained that it was necessary to "rebase" the index, by moving the base year for the input prices from 1977 to 1992 and to "revise" the index, by including data sources and categories that are needed to reflect the current mix of goods and services but that were not included in the previous index (*e.g.*, ancillary services and capital costs). 5/ HCFA's interim final rule discusses

---

2/ The legislative history of the BBA sheds no light on Congressional intent in this regard. The Conference Report simply refers to the updates being based on the SNF market basket, which the Senate amendment substituted for a "SNF historical trend factor" that had been used in the House bill. H.R. Rep 105-217, 105th Cong., pp. 756-57.

3/ 63 Fed. Reg. at 26289.

4/ Id. at 26290.

5/ Id.

in detail the complex changes that it believed were required to make the pre-existing index usable for the new SNF PPS. Interestingly, no effort seems to have been made to revise the index to account for the estimated Part B base year costs, which also need to be adjusted from 1995 to 1998. Moreover, the interim final rule contained no discussion of alternative approaches that HCFA might have considered to the use of that index or of the availability of other indices that might be suitable for the purpose.

HCFA acknowledges in the interim final rule with comment that the market basket index that it has chosen to use is an "input" price index. Such an index works in a two step process: (1) the inputs needed to provide a mix of goods and services are identified as of some point in the past for which data are available, and (2) subsequently, the average rate of change in those prices is measured from year to year to determine a percentage increase. It has been suggested that an "output" price index might be more appropriate for this purpose because it is a more dynamic measure of changes in prices and would take into account, on a more timely basis, changes in the intensity of the inputs necessary to provide a new mix of goods and services. 6/

While the interim final rule with comment did not discuss the economic merit of these approaches, it is clear from the language of the statute that the Secretary would be free to chose either approach. The only issue in this regard raised by the statutory language is whether the index chosen reflects changes over time in the prices of an appropriate mix of goods and services.

Further, we believe that such a change could be adopted in the SNF PPS final rule without requiring a new notice and comment period. Given that HCFA chose to utilize its own index, after making certain revisions, in an interim final rule with comment, a strong argument can be made that a different index can be adopted at this time without the prior issuance of a formal proposed rule. If HCFA had the authority to adopt the current index without undertaking notice and comment rulemaking, it should be able to revisit its choice without undertaking notice and comment rulemaking.

6/ The Bureau of Labor Statistics has recently developed two such indices that reflect the average annual change in nursing facility outputs. The CPI component for Nursing Homes and Adult Day Care measures the rate of change of private sector output prices for those facilities, and the Producer Price Index for Skilled and Intermediate Care Facilities measures the average rate of change of private and public sector prices paid for the outputs of those facilities. We believe the change from the HCFA market basket to either of these indices could be made under existing law.

Finally, it has been suggested that adopting an index such as one of those discussed above would establish a precedent that such indices should be adopted for other Medicare benefits involving a market basket update. However, the other Medicare benefits that utilize a market basket update are given less statutory latitude than SNF PPS. For example, in the PPS for inpatient hospital services, the market basket index that is utilized is defined in SSA § 1886(b)(3)(B)(iii) in a more precise manner than the SNF index. The hospital market basket definition sets forth a specific methodology and specific components that the Secretary is required to use for purposes of that index. 7/ Similarly, the current home health agency payment system requires HCFA to utilize "the home health market basket index." 8/ Rather than afford the Secretary discretion to establish an index, Congress appears to have directed the Secretary to continue to use the existing home health agency market basket index. That Congress, in the same legislation, vested the Secretary with discretion to establish an index for SNF PPS, but did not do so for home health agencies, further demonstrates the wide latitude provided the Secretary in creating an index for SNF PPS.

In any event, the decision of the Secretary to use a particular index that she determines is most appropriate for SNF services should in no way require or even suggest that the inpatient hospital market basket index, which has been in place and has been the subject of annual Congressional review for over 15 years, should or even could be scrapped because the Secretary made a particular decision on what appropriate index to use to update Medicare covered SNF rates.

Additional Areas of HCFA Flexibility to Address SNF PPS Underpayments

The Congressional Budget Office ("CBO") report that accompanied the Balanced Budget Act of 1997 indicated that the impact of the SNF PPS would be a reduction in Medicare SNF payments of approximately $9.5 billion over 5 years. However, current projections are that the SNF PPS as implemented by HCFA will result in expenditure reductions of between $3.5 billion and $6.5 billion greater

---

7/ SSA §1886(b)(3)(B)(iii) defines the inpatient hospital market basket percentage increase to be "the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year."

8/ SSA § 1861(v)(1)(L(v).

than those initially projected by CBO. 9/ The reason for the difference between the initial CBO estimates and the actual payment reductions is probably unknown at this time, but the result is that SNFs are being required to provide a given level of services to Medicare beneficiaries for a substantially lower amount of payment than Congress contemplated. Given the substantial amount of discretion provided to HCFA in implementing the new system, it seems incumbent upon HCFA carefully to assess each analysis and estimate that it used in implementing the system to ensure that payment rates match what Congress intended.

As discussed above, there are numerous features of the PPS that require HCFA to establish indices (such as the market basket index) or determine data elements (such as 1995 base year allowable costs) where the source of data is either left to HCFA's discretion or requires HCFA to make estimates or adjustments. We will discuss some of those areas briefly below and suggest elements that HCFA could examine to determine whether changes in its assumptions or estimates might result in more appropriate payment rates.

1. Determination of base year payments

Just as the selection and accuracy of the market basket index will have a permanent impact on SNF payment rates, the determination of the base year allowable amounts will have a continuing effect on total SNF payments under Medicare. In the case of the facility-specific rates, the effect will be for a three year period, while the effect on the federal rate will be permanent. There are a number of aspect of the base rate determinations that should be examined for their impact on current rates.

a. Adjustments for non-settled cost reports

HCFA has the discretion to modify (and make more generous) the adjustment for non-settled cost reports. 10/ To the extent that reductions in allowable costs have been attributed to audit adjustments and other disallowances taken when cost reports are

---

9/ HCFA's interim final rule indicated that the PPS as implemented by that rule would result in savings of $12.9 billion. 63 Fed. Reg. at 26302. At HCFA's April 23, 1999, SNF PPS Town Hall Meeting, Congressman Benjamin J. Cardin (D-Maryland) indicated that CBO is projecting savings of approximately $16 billion.

10/ To account for the fact that some 1995 cost reports may not have been settled at the time the allowable costs for that year were determined, the statute authorizes the Secretary to adjust non-settled cost reports. SSA § 1888(e)(3)(A)(i) and (4)(A)(i). The final rule indicates that, based on the experience of prior years, routine costs in non-settled reports were reduced by 1.31 percent and ancillary costs were reduced by 3.26 percent.

finalized at the fiscal intermediary level, HCFA could adjust such reductions upward in light of the fact that disputes over many such disallowances may still be on appeal and ultimately will be decided in favor of the provider.

b. Estimate of Part B payments

HCFA has broad discretion to revise its estimate of the amount of Part B payments that should be included in the per diem rates. It should reexamine the assumptions regarding those estimates to ensure that all Part B costs have been captured and are reflected in the rates.

c. Inclusion of all Allowable Costs

HCFA could determine, on a basis other than the successful appeal of an issue by a provider, that additional allowable costs should have been included in the base year and adjust the rates accordingly.

2. Case Mix Adjustments

HCFA has wide authority to revise the case-mix index that is intended to measure intensity of care and translate that into an appropriate payment level. HCFA's use of data from many sources makes this index more susceptible to revision.

HCFA is developing a methodology for an adjustment to the unadjusted Federal rates because of changes in the aggregate case mix ("case mix creep"). Although HCFA likely envisions this as a means to reduce payments, current low payment rates, especially for high intensity cases, may justify a determination that payments for some categories should be increased.

Conclusion

HCFA has significant discretion in a number of areas to revisit and revise upward its initial determination of payment rates for the SNF PPS. Changes that impact base year costs could prove significantly beneficial in the same way that a revision to the market basket index would have a compounded effect. It is unclear whether HCFA would be more willing to make the base year and other changes in areas listed above than to adopt a different market basket index.

However, pursuing a single change to the market basket index may be the most effective means of significantly impacting SNF PPS rates and is squarely within the agency's discretionary authority.

ccs: Bruce A. Yarwood
Robert Deane
Elise Smith, Esq.

OVATIONS
A UnitedHealth Group Company

Ovations
MN008-T300 P.O. Box 1459 Minneapolis MN 55440-1459 or
9900 Bren Road East Minnetonka MN 55343

June 15, 1999

Mike Hash
Deputy Administrator
Health Care Financing Administration
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mike,

I wanted to let you know that Congressman Jim Ramstad (R-MN) has recently introduced H.R. 1998, Medicare's Elderly Receiving Innovative Treatment Act of 1999. The bill would provide an exemption from the PIP payment methodology for EverCare and programs like it and directs HCFA to develop a new risk adjusted payment methodology for these programs which more accurately reflects the health status of the frail elderly beneficiaries we serve. The bill also calls for continuous open enrollment for programs serving the frail elderly as well as new performance measurement standards.

Congressmen Benjamin Cardin is the lead Democratic sponsor.

We were also pleased to see that MedPAC's June report to Congress reached many of the same conclusions we have and validates the need for a different approach for programs serving the frail elderly in terms of payment, enrollment and performance measures.

Mike, I wanted to let you know that we would still prefer to address the issues related to EverCare through administrative means. With our ultimate goal being preservation of EverCare, we obviously need to pursue all available avenues to achieve that goal: hence the legislation. We know that HCFA is beginning to look into this issue and the EverCare staff is available to assist you in whatever way necessary.

I wanted to also let you know that I will be meeting with Chris Jennings on these issues later this week when I am in Washington.

Please let me know if you have questions.

Sincerely,

Lois Quam
Chief Executive Officer

cc: Chris Jennings

Attachments

106TH CONGRESS
1ST SESSION

H. R. 1998

To amend title XVIII of the Social Security Act to promote the coverage of frail elderly Medicare beneficiaries permanently residing in nursing facilities in specialized health insurance programs for the frail elderly.

IN THE HOUSE OF REPRESENTATIVES

MAY 27, 1999

Mr. RAMSTAD (for himself and Mr. CARDIN) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to promote the coverage of frail elderly Medicare beneficiaries permanently residing in nursing facilities in specialized health insurance programs for the frail elderly.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare's Elderly Receiving Innovative Treatments (MERIT) Act of 1999".

SEC. 2. MODIFICATION OF PAYMENT RULES.

Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)(1)(A), by striking "subsections (e) and (f)" and inserting "subsections (e) through (i)";

(2) in subsection (a)(3)(D), by inserting "and paragraph (4)" after "section 1859(e)(4)"; and

(3) by adding at the end of subsection (a) the following new paragraph:

"(4) EXEMPTION FROM RISK-ADJUSTMENT SYSTEM FOR FRAIL ELDERLY BENEFICIARIES ENROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—

"(A) IN GENERAL.—During the period described in subparagraph (B), the risk-adjustment described in paragraph (3) shall not apply to a frail elderly Medicare+Choice beneficiary (as defined in subsection (i)(3)) who is enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in subsection (i)(2)).

"(B) PERIOD OF APPLICATION.—The period described in this subparagraph begins with January 2000 and ends with the first month for which the Secretary certifies to Congress

that a comprehensive risk adjustment methodology under paragraph (3)(C) (that takes into account the types of factors described in subsection (i)(1)) is being fully implemented."; and

(4) by adding at the end the following new subsection:

"(i) SPECIAL RULES FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—

"(1) DEVELOPMENT AND IMPLEMENTATION OF NEW PAYMENT SYSTEM.—The Secretary shall develop and implement (as soon as possible after the date of the enactment of this subsection), during the period described in subsection (a)(4)(B), a payment methodology for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in paragraph (2)(A)). Such methodology shall account for the prevalence, mix, and severity of chronic conditions among such beneficiaries and shall include medical diagnostic factors from all provider settings (including hospital and nursing facility settings). It shall include functional indicators of health status and such other factors as may be necessary

to achieve appropriate payments for plans serving such beneficiaries.

"(2) SPECIALIZED PROGRAM FOR THE FRAIL ELDERLY DESCRIBED.—

"(A) IN GENERAL.—For purposes of this part, the term 'specialized program for the frail elderly' means a program which the Secretary determines—

"(i) if offered under this part as a distinct part of a Medicare+Choice plan;

"(ii) primarily enrolls frail elderly Medicare+Choice beneficiaries; and

"(iii) has a clinical delivery system that is specifically designed to serve the special needs of such beneficiaries and to coordinate short-term and long-term care for such beneficiaries through the use of a team described in subparagraph (B) and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(B) SPECIALIZED TEAM.—A team described in this subparagraph—

"(i) includes—

"(I) a physician, and

"(II) a nurse practitioner or geriatric care manager, or both; and

"(ii) has as members individuals who have special training and specialize in the care and management of the frail elderly beneficiaries.

"(3) FRAIL ELDERLY MEDICARE+CHOICE BENEFICIARY DESCRIBED.—For purposes of this part, the term 'frail elderly Medicare+Choice beneficiary' means a Medicare+Choice eligible individual who—

"(A) is residing in a skilled nursing facility or a nursing facility (as defined for purposes of title XIX) for an indefinite period and without any intention of residing outside the facility; and

"(B) has a severity of condition that makes the individual frail (as determined under guidelines approved by the Secretary).".

SEC. 3. CONTINUOUS OPEN ENROLLMENT FOR QUALIFIED INDIVIDUALS.

(a) IN GENERAL.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended by adding at the end the following new paragraph:

"(7) SPECIAL RULES FOR FRAIL ELDERLY MEDICARE+CHOICE BENEFICIARIES ENROLLING IN

SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY.—There shall be a continuous open enrollment period for any frail elderly Medicare+Choice beneficiary (as defined in section 1853(i)(3)) who is seeking to enroll in a Medicare+Choice plan under a specialized program for the frail elderly (as defined in section 1853(i)(2)).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of the enactment of this Act.

SEC. 4. DEVELOPMENT OF QUALITY MEASUREMENT PROGRAM.

(a) IN GENERAL.—Section 1852(e) of the Social Security Act (42 U.S.C. 1395w–22(e)) is amended by adding at the end the following new paragraph:

"(5) QUALITY MEASUREMENT PROGRAM FOR SPECIALIZED PROGRAMS FOR THE FRAIL ELDERLY AS PART OF MEDICARE+CHOICE PLANS.—The Secretary shall develop and implement a program to measure the quality of care provided in specialized programs for the frail elderly (as defined in section 1853(i)(2)) in order to reflect the unique health aspects and needs of frail elderly Medicare+Choice beneficiaries (as defined in section 1853(i)(3)). Such quality measurements may include indicators of the

prevalence of pressure sores, reduction of iatrogenic disease, use of urinary catheters, use of anti-anxiety medications, use of advance directives, incidence of pneumonia, and incidence of congestive heart failure.".

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first provide for the implementation of the quality measurement program for specialized programs for the frail elderly under the amendment made by subsection (a) by not later than July 1, 2000.

○

year cost recovery period. In addition, the legislation includes a proper definition of a "natural gas gathering line" in order to distinguish these assets from pipeline transportation lines for depreciation purposes. While I believe this result is clearly the correct result under current law, my bill will eliminate any remaining uncertainty regarding the treatment of natural gas gathering lines.

The need for certainty regarding the tax treatment of such a substantial investment is obvious in the face of the IRS's and Treasury's refusal to properly classify these assets. The Modified Accelerated Cost Recovery System (MACRS), the current depreciation system, includes "gathering pipelines and related production facilities" in the Asset Class for assets used in the exploration for and production of natural gas subject to a seven-year cost recovery period. Despite the plain language of the Asset Class description, the IRS and Treasury have repeatedly asserted that only gathering systems owned by producers are eligible for seven-year cost recovery and all other gathering systems should be treated as transmission pipeline assets subject to a fifteen-year cost recovery period.

The IRS's and the Treasury's position creates the absurd result of the same asset receiving disparate tax treatment based solely on who owns it. The distinction between gathering and transmission is well-established and recognized by the Federal Energy Regulatory Commission and other regulatory agencies. Their attempt to treat natural gas gathering lines as transmission pipelines ignores the integral role of gathering systems in production, and the different functional and physical attributes of gathering lines as compared to transmission pipelines.

Not surprisingly, the United States Court of Appeals for the Tenth Circuit recently held that natural gas gathering systems are subject to a seven-year cost recovery period under current law regardless of ownership. The potential for costly audits and litigation, however, still remains in other areas of the country. Given that even a midsize gathering system can consist of 1,200 miles of natural gas gathering lines, and that some companies own as much as 18,000 miles of natural gas gathering lines, these assets represent a substantial investment and expense. The IRS should not force businesses to incur any more additional expenses as well. My bill will ensure that these assets are properly treated under our country's tax laws.

I urge my colleagues to join me as cosponsors of this important legislation.

HONORING THE ANNIVERSARY OF THE BIRTH OF SAMUEL S. SCHMUCKER

HON. WILLIAM F. GOODLING

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 27, 1999

Mr. GOODLING. Mr. Speaker, I rise today in recognition of the bicentennial of the birth of Samuel S. Schmucker, who made great contributions to American culture, religion, and education.

Mr. Samuel Schmucker was born 200 years ago on February 28, 1799 in Hagerstown, Maryland into a Lutheran parsonage family. At age ten, he moved with the family to York, Pennsylvania. As a young man at a time when there were no colleges under Lutheran auspices, Samuel Schmucker attended the University of Pennsylvania and Princeton Theological Seminary. While attending these schools, he demonstrated exceptional intelligence and leadership skills. After leaving school, Mr. Schmucker was determined to do everything within his power to improve education in his denomination and in his commonwealth. In 1821, at the young age of 22, Samuel Schmucker was ordained and he quickly began to instruct candidates for the ministry. He founded and served the Lutheran Theological Seminary by preparing hundreds of men for the Lutheran ministry.

In 1832 Mr. Schmucker became the chief founder of Gettysburg College, one of the 50 oldest colleges in the United States today. Although the college was under Lutheran influence, he insisted that no student or faculty member be denied admission based on their religion. Samuel Schmucker remained an active member of the College Board of Trustees for more than 40 years. Throughout his life, he was an ardent supporter of education for women and minorities. He so adamantly opposed slavery and was outspoken on the subject that when confederate soldiers swept across the seminary campus on July 1, 1863, his home and library were ransacked.

I am pleased to recognize the sponsors of this special event: Gettysburg College, the Lutheran Historical Society, and Lutheran Theological Seminary at Gettysburg and I commend them for acknowledging the importance of Samuel Schmucker's accomplishments.

I am very proud of Samuel Schmucker's contribution to the educational system and culture of Pennsylvania. His legacy of leadership has benefited many generations of Americans.

INTRODUCTION OF THE MEDICARE'S ELDERLY RECEIVING INNOVATIVE TREATMENTS (MERIT) ACT OF 1999

HON. JIM RAMSTAD

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 27, 1999

Mr. RAMSTAD. Mr. Speaker, I rise today to introduce legislation to promote the coverage of frail elderly Medicare beneficiaries enrolled in innovative Medicare+Choice programs.

This bill will exempt certain innovative programs specifically designed for the frail elderly living in nursing homes from being impacted by the new risk-adjusted payment methodology designed by the Health Care Financing Administration (HCFA) during its phase-in period.

While the concept of a risk-adjusted payment methodology would actually be beneficial for such programs, the interim methodology is limited in scope and is primarily based on hospital encounter data. This focus on hospitalizations will put programs that are designed to provide care in non-hospital settings, thus reducing the need for expensive hospitalizations, at a distinct disadvantage.

One such program is EverCare, an innovative health care program for the frail elderly in Minnesota and other states. A recent study by the Long Term Care Data Institute (LTCDI) has concluded that EverCare's revenue alone will decrease 42% under this new methodology. The program could not continue with such dramatic cuts.

Recognizing that EverCare and programs like it may be adversely impacted by the new methodology, HCFA granted certain programs limited exemptions. However, HCFA acknowledged that additional steps may be necessary by stating they would also be "assessing possible refinements to the risk adjustment methodology" as it relates to these programs and was considering developing a 'hybrid' payment methodology for them.

I appreciate HCFA's understanding of the uniqueness of the programs and the need to treat them differently than traditional Medicare+Choice plans. However, I am concerned that over four months have passed and we have not seen action on the part of HCFA to develop such a methodology. In addition, I am concerned that they have not applied the exemption to other similar programs specifically designed for the frail elderly living in nursing homes.

Along with the bill and statement today, I am submitting some testimonials I have received from those involved with this critical program. I believe they will do a better job than I could of explaining the uniqueness and importance of these programs.

Mr. Speaker, the risk adjusted payment methodology is intended to ensure reimbursements which reflect the health care status and needs of Medicare beneficiaries, not deny access to pioneering new programs.

That's why I urge my colleagues to cosponsor this legislation to ensure cost-effective and care-enhancing programs like these are not unintentionally and fatally impacted as HCFA gradually moves into an appropriate, comprehensive methodology. I urge my colleagues to cosponsor this MERITorious bill.

THE EVERCARE STORY—CLINICAL SUCCESS STORIES SUBMITTED BY SITE

PHOENIX SITE

Sara Roth was a 75 year old EverCare resident of Shadow Mountain Care Center. Sara's primary diagnosis was S/P frontotemporal craniotomy for a massive subdural hematoma. She was now essentially bedridden and as a result had pressure sores complicating her current medical status. Less than 9 months prior to her enrolling with EverCare, she had been essentially alert and dependent. Sara's family was pursuing legal interventions with her previous health care providers.

Sara's family felt isolated, tremendously frustrated and out of control prior to her enrolling in EverCare. Sue was able to help this family who had unrealistic expectations, make difficult, but informed decisions. Ultimately, Sara was able to die with compassion and dignity. The family was comforted and supported by the team during this difficult time, as their attached letter attests.

This example truly represents the unique aspects of the EverCare model in action—protecting the quality of life, and when this is no longer possible, creating the most therapeutic environment to protect life's end.

SCOTTSDALE, AZ
July 20, 1998.

Re Ms. Sue Freeman, nurse practitioner.

Ms. KATHRYNE BARNOSKI,
Clinical Director,
EverCare, Phoenix, AZ.

DEAR MS. BARNOSKI: I write this letter to express our family's deep appreciation for all

of Ms. Freeman's help in regard to our mother, Sara Roth, who passed away on July 1 at the Shadow Mountain Nursing Home in Scottsdale.

Prior to EverCare, our family felt alone and frustrated in dealing with all Sara's medical needs at Shadow Mountain. It was difficult reach a doctor or getting answers from her nurses regarding her condition or explanation of medications. EverCare became like a fairy godmother who orchestrated a wonderful team approach to caring for our mother. Communication between Dr. Sapp, Ms. Freeman and myself was excellent and that in itself did wonders for my peace of mind.

I would like to take this opportunity to thank one of your shining stars—Ms. Sue Freeman. What a wonderful woman! She is articulate, highly skilled, organized, professional, and has a great heart! I always felt like Sara was a top priority with Sue and for that, we will always be grateful.

EverCare works. That is important for you to know. God only knows what would have happened to Sara's quality of life without Dr. Sapp and Ms. Freeman.

Thank you from the bottom of our hearts.

Sincerely,

Eleanor Shnier.

Rose Dealba is an 82-year old female resident of Mi Casa, patient of Dr. Greco with a history of cervical myopathy and chronic diarrhea. Mrs. Dealba was essentially bedridden and total care because of her cervical myopathy. Of note—Mrs. Dealba is cognitively intact. Her inability to care for herself had added depression to her problem list. Her quality of life was less than optimal due to her inability to get herself to the bathroom, to feed herself, etc. The patient and her family felt there was not hope for improvement in Mrs. Dealba's condition.

With slow and progressive/incremental physical therapy, occupational therapy and restorative nursing, Mrs. Dealba was able to feed herself, transfer and ambulate to the bathroom with a walker and assist of one. Her chronic diarrhea has finally been controlled. With another round of PT she has become more independent in her transfers and ability to get to the bathroom. She is now able to go outside with her family.

Both Mrs. Dealba and her family are thrilled with her progress. With Mrs. Dealba's previous medical carrier, physical therapy had been denied. She has been able to maintain these gains with assistance of the restorative nursing program.

It is very difficult to report only one success story. Team members report successes in practicing the EverCare model on a daily basis. A recent event leading to a letter of appreciation for Mary Ann Allan is one of many examples. Mary Ann has grown especially close to her residents and their families in a very short time as she joined EverCare in June of 1998.

Elizabeth DeBruler is an 89-year old resident at the Glencroft Care Center with a primary diagnosis of S/P CVA and Hypertension. Elizabeth is alert, oriented and very functional with no stroke residual. She is up and about daily in the facility ambulating with her walker. Mary Ann and Dr. Kaczar are the Primary Care Team and work together to monitor Elizabeth's blood pressure and medications.

In December, the nursing staff reported to Mary Ann that Elizabeth was confused with decreased food and fluid intakes. Mary Ann examined her, ordered a workup to rule out a treatable cause, and discussed a treatment plan with Dr. Kaczar. Labs showed a urinary tract infection and dehydration. The BUN was 56, Creatinine 2.4. A family conference was convened with Elizabeth's daughter Arlene Latham, Dr. Kaczar, Mary Ann and the nursing staff. Potential treatments were discussed and Advanced Directives were reviewed. Elizabeth's wishes were considered as well as her daughter's. Everyone agreed on a plan. Antibiotics by mouth would be started and if no improvement in food/fluid intake short term, intravenous fluids for hydration would be given. Elizabeth would remain a do not resuscitate. Intravenous fluids would be given in the care center with full support of the Director of the Nursing and the staff rather than transport to the hospital. Elizabeth did not improve with antibiotics alone and did require intravenous fluids. Mary Ann contacted the Case Manager, Rose Larkin, and it was determined that Elizabeth would qualify for Intensive Service Days for a change in condition and to prevent a hospitalization. As Elizabeth improved, she was moved into a Skilled Nursing benefit. Mary Ann visited Elizabeth daily and updated Arlene on her condition. Elizabeth recovered with the assistance and support of the family, facility staff and the primary care team.

EVERCARE,
2222 E. Camelback Rd. Suite 120, Phoenix, AZ.

DEAR MS. BARNOSKI: I would like to express my appreciation for the interest taken and care given to my mother, Elizabeth DeBruler by Dr. Philip Kaczar and Mary Ann Allen. Dr. Kaczar's prompt attention to her recent physical problems have been commendable and the follow-up by Mary Ann has also been impressive. The close attention and efforts to make her comfortable have been very satisfying to me.

EverCare is to be commended for their foresight in selection of these individuals. I feel they are an asset to Ever Care and Glencroft Care Center.

Sincerely,

ARLENE LATHAM.

TAMPA SITE

AWAKENING

Coming "live" in a new facility is always an opportunity for everyone involved: the member and family, the facility, facility staff, EverCare staff, and the primary care team. There are many reservations. "Should I have signed my Mom up for this EverCare?" The staff is wondering how this will work. The nurse practitioner is thinking "how will I fit in with this group?"

One of my new members in a new facility was a 72-year-old woman. She lived there for six months, after suffering a severe CVA, leaving her aphasic, NPO with a feeding tube. She was dependent in all ADL's, and spent a good portion of her day in a geri chair, watching her soaps. She did respond by nodding her head, but it was extremely difficult to assess her level of orientation.

This member's son had a discussion with the primary care team and all of her medications, including cardiac and seizure, were discontinued, at his request. The member responded to this change, she woke up!

A team effort ensured. Physical therapy and occupational therapy screened the member and requested an evaluation. Indeed there were documented changes.

Therapy and the primary care team discussed a plan of care and put it into action. Case management became actively involved. Speech therapy came on board as the member demonstrated gains in other areas. Communication was the key to this plan.

The member worked very hard and made continual gains. She is now able to assist with bathing and grooming. She can propel her wheelchair throughout the facility and attends activities. She is able to use a pad to communicate some of her needs. She still likes her soaps. Best of all, she is no longer a tube feeder and can feed herself after set-up.

The member was not just "the CVA." The office staff could visualize our member and truly felt great as she made gains.

The outcome of this team effort was an increase in the quality of life for our EverCare member.

EverCare can make a difference!

43RD ANNUAL PITTSBURGH FOLK FESTIVAL TO TAKE PLACE FROM MAY 28–30, 1999

HON. RON KLINK

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 27, 1999

Mr. KLINK. Mr. Speaker, I rise to recognize an extraordinary event that will soon take place in Pittsburgh, Pennsylvania. From May 28–30, 1999, the Pittsburgh Folk Festival, Inc. will entertain the community with the 43rd Annual Pittsburgh Folk Festival. For nearly half a century, this non-profit organization has been dedicated to the preservation and sharing of international cultures and heritages in the Pittsburgh area.

Throughout this three-day festival, the music, dance, cuisine, and crafts of Latin American, Scandinavian, African, Asian, and European countries will be displayed for all to enjoy. The 43rd Annual Pittsburgh Folk Festival will provide not only entertainment, but will also be an opportunity for enlightenment and education about the cultures and heritages of the people of the Pittsburgh area and around the world.

Western Pennsylvania is filled with culturally and ethnically diverse people, and this gala event aims to recognize the different histories and heritages from which we come. Through this celebration, everyone involved will have the ability to learn and experience this multiculturalism.

Mr. Speaker, educating Americans about the diversity of this world must be a top priority. The Pittsburgh Folk Festival has championed this philosophy for 43 years, and I am confident it will continue to do so in the future. I ask my colleagues to please join me in applauding the dedication and hard work of the participants of the Pittsburgh Folk Festival. This organization deserves our thanks for its contributions to the education and enlightenment of my Congressional District and the national community.

HONORING MIMI MOSKOWITZ FOR HER SERVICE TO THE BAYSIDE JEWISH CENTER

HON. GARY L. ACKERMAN

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 27, 1999

Mr. ACKERMAN. Mr. Speaker, I rise today to note the accomplishments of Mimi Moskowitz, who will be honored by the Bayside Jewish Center, of Queens County, New York, at a testimonial dinner on Monday, June 7.

Mimi is stepping down after two years as President of the Sisterhood of the Bayside

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

The Administrator
Washington, D.C. 20201

PHOTOCOPY
PRESERVATION

to discuss with Mike tonight, as well as grijalva & AHA

The Honorable Bill Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Thomas: mutual goal

Thank you for reviewing, at my request, the draft copy of the *Medicare & You* handbook (handbook) for 2000. In your May 21 letter, you raise several concerns about the handbook. This letter responds to those concerns as well as questions you raised in your April 1 letter. Let me assure you that my goal is to provide beneficiaries with accurate, unbiased, and credible information about their health plan options.

The draft of the 2000 handbook you reviewed reflected the results from last year's experience and included suggestions from industry representatives, low-literacy experts, advocacy groups, and most importantly, beneficiaries. This draft underwent market research testing with Medicare beneficiaries in April and May. The results of this testing were positive and demonstrated that the handbook was understandable, easy to navigate, and viewed as helpful by beneficiaries.

To better inform your understanding of the layout and content of the draft handbook, I have enclosed at Tab A a report outlining the results of last Fall's National Medicare Education Program demonstration in Arizona, Florida, Ohio, Oregon, and Washington. As you can see, we learned a great deal from the five state demonstration. Our assessment showed that beneficiaries see the *Medicare & You* handbook as a reference document -- they will refer to the handbook when necessary and pursue additional information when they need it. Survey findings showed that 77 percent reported the handbook to be somewhat or very helpful. In a survey of users of 1-800-MEDICARE, 84 percent of callers stated that they were very or somewhat satisfied with the service provided and 90 percent felt that all or some of their questions were answered.

Jane wants to make sure you know that Thomas' opening was read into the record at the hearing.

Statutory Issues

I was surprised that your May 31 letter raised several questions about aspects of the draft handbook that you believe are inconsistent with the statute. In a meeting with you on February 3, and in a letter on March 30, I pointed out that I believe it is in the best interest of the Medicare+Choice program and beneficiaries to postpone the deadline for Adjusted Community Rate (ACR) submissions from the statutory deadline of May 1 to July 1, 1999. As I explained, this promotes stability in the program by providing health plans more time to evaluate market trends and costs, but it also meant that the handbook could not include detailed information about each specific plan, as required in statute. Allowing the Medicare+Choice plans two additional months to file ACR submissions compressed the time HCFA would have to review and confirm the accuracy of that information to the extent that it is not possible to compile information at the level of detail we used last year, and meet the deadlines for printing and mailing the handbook to 39 million beneficiaries. I further explained that we were seeking a legislative change to address this issue as well as the change in the ACR filing date, and that I hoped you would support such a change. Our request for a legislative change also was raised with your staff on several occasions, beginning in February 1999. In fact, based on your April 1 letter, I thought you agreed with our approach to adjusting the ACR deadline and were aware of the issue with the handbook. As you know, the Senate Finance Committee has acted on a bipartisan basis to draft legislation to address both the issue of the handbook content and the ACR deadline.

As I indicated to you in our meeting and in my March 30 letter, based on last year's experience and our preliminary evaluation of the 1999 handbook, including focus groups with beneficiaries in the pilot states, and taking into account the compressed production schedule resulting from the later ACR deadline, I believe it is better to provide less detailed, but more accurate information to beneficiaries in the handbook and supplement it with information through other sources. Thus, while the amount of detailed benefit information included in the *Medicare & You* handbook will be reduced, beneficiaries will still have access to detailed plan information by: calling 1-800-MEDICARE and requesting a printed copy of detailed information; accessing the Medicare Compare database on the Internet; or participating in regional special information sessions. An example of the detailed benefit information beneficiaries will receive when they call the toll-free number is enclosed at Tab B.

In your April 1 letter, you asked for details regarding the production schedule for the 2000 handbook. Relative to last year, we have to print 28 million more books in less time. In addition to losing 2 months due to the later ACR deadline, the handbook must be mailed by October 15, more than two weeks earlier than last year. As a result, as I have explained before, there is not enough time to produce a handbook with comparative information as detailed as was included in 1998 that can still be mailed by the statutory deadline.

In June, we will award the print contracts and begin printing sections of the handbook that do not include comparative information. In August, as ACRs are approved, we will begin printing the comparative sections of the handbook. By the middle of September, we will start mailing the handbooks to beneficiaries; the last group of handbooks will be mailed by the October 15 deadline. To award the print contract in June, in advance of the ACR deadline or even acceptance of ACRs under the new schedule, we had to decide at that time on the length and geographic areas covered by each version of the book. This was only possible if we provided information at the organization, rather than plan level, and if we reduced the amount of benefit information provided relative to the 1999 handbook. Providing information at the organization level reduces the volatility of the comparative information, as plans offered by organizations are more likely to change than the organizations participating in Medicare. By limiting information to premium ranges and the availability of drug benefits, we will be able to simplify our verification process, which takes place as our ACRs are approved.

Content

I do not agree with your assessment that the draft *Medicare & You* handbook is biased against Medicare+Choice. Our objective is for the handbook to be neutral, and if anything, I believe the handbook is biased toward Medicare+Choice. As I have mentioned to you, I received a number of complaints last year from beneficiaries and advocacy groups who felt that the handbook was confusing because it kept mentioning new plan options and Medicare+Choice when HMOs and other types of plans were not available to all beneficiaries.

Starting with the cover, which highlights the fact that the handbook includes information on "Your Medicare Plan Choices" and "Medicare Managed Care Plans in Your Area," the draft handbook for 2000 is peppered with references to new options under Medicare+Choice. For example, on page 1, the handbook states, "Medicare gives you choices in how you get your health care," and refers beneficiaries to the appropriate page. On page 2, it states, "You may have choices in how you get your health care" and lists two choices, "the Original Medicare Plan" and "Medicare Managed Care Plans." On pages 2, 14, and 18, we also note that some plans cover extra benefits. Contrary to your assertion, on Page 17 we state that beneficiaries who enroll in a managed care plan will still receive all the regular Medicare covered services.

You express concerns that fee-for-service Medicare is described in detail before even explaining the advantages of managed care versus fee-for-service. As a result of findings from beneficiary focus groups, the evaluation of last year's handbook, and review of the handbook by low-literacy experts, we made a number of structural changes from last year that generally resulted in moving more summary information to the front of the handbook. We decided to include a basic overview of Medicare and directions for using the handbook on pages 1-3 of the handbook. Pages 4-5 provide a description of Medicare benefits that are available both in Original Medicare and through Medicare+Choice plans, as your letter suggests we emphasize. It then makes sense to describe Original Medicare before managed

care, since beneficiaries should have a basic understanding of covered services prior to a discussion of their health plan options. As I indicated above, during consumer testing of the handbook, beneficiaries did not indicate any difficulty navigating through the handbook and finding information.

You are also concerned that only 11 pages in the handbook are dedicated to comparative information, versus 41 of 55 pages in the most recent OPM booklet. I would suggest that these two books are not comparable, as we have chosen to produce multiple handbooks for different areas of the country, so our books will only contain comparative data about a specific area. From our focus groups with Medicare beneficiaries, we learned that they have a strong preference not to receive information about plans that are not available to them. In contrast, the OPM booklet contains information about plans in every state.

You also express the view that there is wasted space at the end of the document, because the same phone numbers are repeated. I am sorry you misunderstood this: when this handbook draft was circulated for review, the same toll free number was used in most of the spaces as a "filler" until the actual templates were completed. This, as well as the rationale for changes to the layout and content of the book, was explained to your staff at a meeting on May 5 -- the date when we requested comments on the handbook. In the final handbook, actual numbers will be provided. For example, the handbook will list the state phone number for the Insurance Commissioner and Long-term Care Ombudsman Program.

Quality and Performance Information

Let me emphasize again that the version of the handbook you reviewed was a draft, and based on comments from reviewers, including industry representatives and Congressional staff who made some of the same suggestions you have made, we have modified the performance and satisfaction information. For example, we have combined the fee-for-service and plan quality measures into one chart. An example of what this will look like is enclosed with Tab C. We also clarified that other measures are available and that the measures in the book do not represent a complete picture of quality.

While we are collecting information from plans on a number of HEDIS measures, only seven measures have been audited and are available to beneficiaries through 1-800-MEDICARE or www.medicare.gov. We had hoped to be further along in making quality measures available to beneficiaries, but as you know, we were surprised last year at the extent to which the initial submissions from plans were inaccurate. Because it is so important that we provide beneficiaries with accurate data about quality, we contracted with an independent contractor to audit the data that plans submitted, and we are including in the handbook only those measures that have been audited and determined to be reliable. The requirement that we have imposed for the submission of audited data has probably had a positive impact on the reliability of quality data for all payers.

We decided to include one satisfaction measure in the handbook to give beneficiaries a sense of what is available; they can then call for additional measures if they are interested. The satisfaction measure that we included was based on focus testing. The measure, "Doctors Who Communicate Well," actually combines the results of four questions. For this measure, beneficiaries are asked how often their doctors listened carefully, explained things in a way they could understand, showed respect for what they had to say, and spent time with them.

You also questioned our decision to devote several pages explaining our quality measures. We strongly believe that it is important to explain to beneficiaries what the measure is, where it comes from, and how to interpret it. OPM does provide more measures in its current handbook, but as I explained above, we intend to include additional quality measures as soon as we can verify that plans are submitting accurate information. I would also note that the OPM presentation is not consistent with our commitment to use 14 point font in the handbook to maximize readability for Medicare beneficiaries.

Finally, in a letter to me on April 1, you asked for our response to concerns that Walt Francis raised about our website at the March 18 hearing. The Director of our Center for Beneficiary Services, Carol Cronin, has spoken to Mr. Francis about his concerns, and I have attached at Tab D our detailed response to Mr. Francis' testimony. I would ask that this letter be included in the record for that hearing.

Thank you for your interest in providing beneficiaries with the information they need to make informed choices about their Medicare options. I appreciate the commitment you bring to this issue, and as always, I look forward to working with you to strengthen the Medicare program.

Sincerely,

Nancy-Ann Min DeParle
Administrator

Enclosures

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

May 21, 1999

The Honorable Nancy Ann DeParle
Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. DeParle:

We have reviewed your agency's recent draft of the proposed *Medicare and You* handbook for the year 2000. As currently drafted, we find the handbook to be legally insufficient, delusive, wasteful and confusing. It ignores the statutory requirements spelled out for the publication as part of Medicare+Choice ("M+C") program. As disturbing, rather than "promoting informed choice" as envisioned by the Medicare+Choice law, it seems designed to frustrate a beneficiary's ability to evaluate the comparative benefits of different health plan options available to them through Medicare.

The specific problems described below underlie, in part, my sentiments:

VIOLATIONS OF THE STATUTE

As part of its broader effort to ensure that seniors could comparatively evaluate all of their options under the Medicare program, Congress mandated that the Health Care Financing Administration ("HCFA") specifically include in the material mailed to each beneficiary prior to the new open enrollment period *more than a dozen specific facts about each specific Medicare+Choice plan* available in the beneficiary's area. In spite of this mandate, the draft handbook contains absolutely no detailed benefit information about any specific plan. It doesn't even contain basic elements such as how much a given plan costs, or what, if any, additional benefits it covers. In fact, nowhere does it contain a decent summary of the benefits *a typical* Medicare+Choice plan offers.

Instead, the handbook contains only aggregated, cryptic, poorly organized, and relatively meaningless information organized by Medicare+Choice *contractor*. Even then, comparative information is limited to the name of the contractor, the total number of plans they offer in each state, the *range* of premiums they charge for these plans, the number of plans they offer that cover prescription drugs (not which ones), and a phone number.

This format makes it impossible to learn even the most basic plan information. The reader

cannot tell if a specific plan is available to them, what the premium is for a given plan, what the applicable co-payments or deductibles are, or what, if any, extra benefits are covered. This is not what the statute requires, and clearly not what Congress envisioned when it enacted the mailing requirement.

CONTENT BIASED AGAINST MEDICARE+CHOICE

In some ways we find it even more troubling that the content of the handbook seems designed to frustrate the very purpose for which it was clearly created -- to help educate seniors and enable them to make informed choices under the new Medicare+Choice program. Sadly, the draft contains no significant discussion of the options available because of Medicare+Choice until page 17 (after an extensive description of the traditional Medicare program, and its benefits and a description of the low-income assistance programs).

Where the handbook does discuss the M+C program, it fails to make clear even the most basic distinctions and relationships between "The Original Medicare Plan" and Medicare+Choice plans. For example, nowhere is it clearly stated that all Medicare+Choice plans must cover all of the benefits covered in both Medicare Parts A and B.

WOEFULLY INADEQUATE QUALITY AND PERFORMANCE INFORMATION

The paucity of comparative quality data that is included in the draft is poorly presented and "oversold." More importantly, it fails to adequately include and present comparisons to the traditional Medicare plan.

Only one quality indicator comparing Medicare+Choice plans to traditional Medicare is included. It reports plan mammography rates. Even then, the traditional Medicare program data is not presented in the bar graphs comparing individual M+C plans, but is compared to aggregate M+C data for each state. It is as if HCFA does not want the traditional program to be judged on its own relative merits.

The only additional comparative "quality" measure for Medicare+Choice plans is derived from the results of an enrollee survey, and reflects the perceived communication skills of a plan's participating doctors. Representing this information as a major quality indicator is dubious at best. Yet, the draft devotes 7 full pages to reporting this one fact -- via a nearly indecipherable multi-variable bar graph. By comparison, the Office of Personnel Management's ("OPM") standard beneficiary booklet for the Federal Employee Health Benefit Plan presents on one page the results of 11 different consumer satisfaction measures. I ask you -- can't HCFA do a better job of giving seniors some truly valuable information?

OVERALL CONTENT CONFUSING AND WASTEFUL

Finally, the overall structure and layout of the booklet is long, duplicative and poorly organized. As a result, it only further frustrates the purpose for which it was mandated and is a poor reflection on the program. A few examples:

- It devotes nearly a dozen pages to describing in detail the benefits structure of the traditional fee-for-service program -- before adequately explaining the general advantages and disadvantages of fee-for-service Medicare as compared to Medicare+Choice.

- The vast majority of the text contains general explanatory text -- much of which is redundant and not clearly written. Only 11 pages are devoted to providing comparative information. And then a grand total of 7 facts per *contractor* are provided - this includes the contractor's name and phone number. By comparison, the most recent OPM booklet devotes 41 of 55 pages to comparative, plan specific information. It provides roughly 35 facts concerning every plan in the country (approximately 300 plans).

- One final example of wasted space is the listing of phone numbers one can call to get additional information. In addition to numerous references to phone numbers spread throughout the text, a full 7 pages are devoted to nothing but describing government phone numbers where seniors can get more information - yet, approximately 75% of this material refers seniors to the same 1-800-MEDICARE number. This could easily be condensed into two pages at most and either save money or free up space for more detailed, comparative plan information that seniors could actually use.

At a time when many seniors are struggling to determine how to pay for medical needs such as prescription drugs, the government does not serve them well by providing only incomplete and misleading information about their options under the Medicare+Choice program.

Given the potential of the Medicare+Choice program to help millions of seniors and disabled citizens, I ask that you take the necessary steps to ensure that these inadequacies are addressed before authorizing the expenditure of any printing funds for this project.

Sincerely,

Bill Thomas

Bill Thomas
Chairman

cc: The Honorable Donna Shalala

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE: Doreen **PHONE:** _____	**FROM:** Mike Hash **OFFICE OF THE ADMINISTRATOR** **200 INDEPENDENCE AVE., S.W.** **ROOM 314G** **WASHINGTON, DC 20201** **PHONE: 202-690-6726** **FAX : 202-690-6262**

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
5	456-5557	6-2-99

REMARKS:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

The Administrator
Washington, D.C. 20201

The Honorable Bill Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Thomas:

Thank you for reviewing, at my request, the draft copy of the *Medicare & You* handbook (handbook) for 2000. In your May 21 letter, you raise several concerns about the handbook. This letter responds to those concerns as well as questions you raised in your April 1 letter. Let me assure you that my goal is to provide beneficiaries with accurate, unbiased, and credible information about their health plan options. I know we share mutual goals

The draft of the 2000 handbook you reviewed reflected the results from last year's experience and included suggestions from industry representatives, low-literacy experts, advocacy groups, and most importantly, beneficiaries. This draft underwent market research testing with Medicare beneficiaries in April and May. The results of this testing were positive and demonstrated that the handbook was understandable, easy to navigate, and viewed as helpful by beneficiaries.

To better inform your understanding of the layout and content of the draft handbook, I have enclosed at Tab A a report outlining the results of last Fall's National Medicare Education Program demonstration in Arizona, Florida, Ohio, Oregon, and Washington. As you can see, we learned a great deal from the five state demonstration. Our assessment showed that beneficiaries see the *Medicare & You* handbook as a reference document -- they will refer to the handbook when necessary and pursue additional information when they need it. Survey findings showed that 77 percent reported the handbook to be somewhat or very helpful. In a survey of users of 1-800-MEDICARE, 84 percent of callers stated that they were very or somewhat satisfied with the service provided and 90 percent felt that all or some of their questions were answered.

Statutory Issues

I was surprised that your May 31 letter raised several questions about aspects of the draft handbook that you believe are inconsistent with the statute. In a meeting with you on February 3, and in a letter on March 30, I pointed out that I believe it is in the best interest of the Medicare+Choice program and beneficiaries to postpone the deadline for Adjusted Community Rate (ACR) submissions from the statutory deadline of May 1 to July 1, 1999. As I explained, this promotes stability in the program by providing health plans more time to evaluate market trends and costs, but it also meant that the handbook could not include detailed information about each specific plan, as required in statute. Allowing the Medicare+Choice plans two additional months to file ACR submissions compressed the time HCFA would have to review and confirm the accuracy of that information to the extent that it is not possible to compile information at the level of detail we used last year, and meet the deadlines for printing and mailing the handbook to 39 million beneficiaries. I further explained that we were seeking a legislative change to address this issue as well as the change in the ACR filing date, and that I hoped you would support such a change. Our request for a legislative change also was raised with your staff on several occasions, beginning in February 1999. In fact, based on your ~~April 1 letter, I~~ and our conversations with you thought you agreed with our approach to adjusting the ACR deadline and were aware of the issue with the handbook. As you know, the Senate Finance Committee has acted on a bipartisan basis to draft legislation to address both the issue of the handbook content and the ACR deadline.

As I indicated to you in our meeting and in my March 30 letter, based on last year's experience and our preliminary evaluation of the 1999 handbook, including focus groups with beneficiaries in the pilot states, and taking into account the compressed production schedule resulting from the later ACR deadline, I believe it is better to provide less detailed, but more accurate information to beneficiaries in the handbook and supplement it with information through other sources. Thus, while the amount of detailed benefit information included in the *Medicare & You* handbook will be reduced, beneficiaries will still have access to detailed plan information by: calling 1-800-MEDICARE and requesting a printed copy of detailed information; accessing the Medicare Compare database on the Internet; or participating in regional special information sessions. An example of the detailed benefit information beneficiaries will receive when they call the toll-free number is enclosed at Tab B.

In your April 1 letter, you asked for details regarding the production schedule for the 2000 handbook. Relative to last year, we have to print 28 million more books in less time. In addition to losing 2 months due to the later ACR deadline, the handbook must be mailed by October 15, more than two weeks earlier than last year. As a result, as I have explained before, there is not enough time to produce a handbook with comparative information as detailed as was included in 1998 that can still be mailed by the statutory deadline.

In June, we will award the print contracts and begin printing sections of the handbook that do not include comparative information. In August, as ACRs are approved, we will begin printing the comparative sections of the handbook. By the middle of September, we will start mailing the handbooks to beneficiaries; the last group of handbooks will be mailed by the October 15 deadline. To award the print contract in June, in advance of the ACR deadline or even acceptance of ACRs under the new schedule, we had to decide at that time on the length and geographic areas covered by each version of the book. This was only possible if we provided information at the organization, rather than plan level, and if we reduced the amount of benefit information provided relative to the 1999 handbook. Providing information at the organization level reduces the volatility of the comparative information, as plans offered by organizations are more likely to change than the organizations participating in Medicare. By limiting information to premium ranges and the availability of drug benefits, we will be able to simplify our verification process, which takes place as our ACRs are approved.

Content

some groups believe

I do not agree with your assessment that the draft *Medicare & You* handbook is biased against Medicare+Choice. Our objective is for the handbook to be neutral, and if anything, ~~I believe~~ the handbook is biased toward Medicare+Choice. As I have mentioned to you, I received a number of complaints last year from beneficiaries and advocacy groups who felt that the handbook was confusing because it kept mentioning new plan options and Medicare+Choice when HMOs and other types of plans were not available to all beneficiaries.

Starting with the cover, which highlights the fact that the handbook includes information on "Your Medicare Plan Choices" and "Medicare Managed Care Plans in Your Area," the draft handbook for 2000 is peppered with references to new options under Medicare+Choice. For example, on page 1, the handbook states, "Medicare gives you choices in how you get your health care," and refers beneficiaries to the appropriate page. On page 2, it states, "You may have choices in how you get your health care" and lists two choices, "the Original Medicare Plan" and "Medicare Managed Care Plans." On pages 2, 14, and 18, we also note that some plans cover extra benefits. Contrary to your assertion, on Page 17 we state that beneficiaries who enroll in a managed care plan will still receive all the regular Medicare covered services.

You express concerns that fee-for-service Medicare is described in detail before even explaining the advantages of managed care versus fee-for-service. As a result of findings from beneficiary focus groups, the evaluation of last year's handbook, and review of the handbook by low-literacy experts, we made a number of structural changes from last year that generally resulted in moving more summary information to the front of the handbook. We decided to include a basic overview of Medicare and directions for using the handbook on pages 1-3 of the handbook. Pages 4-5 provide a description of Medicare benefits that are available both in Original Medicare and through Medicare+Choice plans, as your letter suggests we emphasize. It then makes sense to describe Original Medicare before managed

care, since beneficiaries should have a basic understanding of covered services prior to a discussion of their health plan options. As I indicated above, during consumer testing of the handbook, beneficiaries did not indicate any difficulty navigating through the handbook and finding information.

You are also concerned that only 11 pages in the handbook are dedicated to comparative information, versus 41 of 55 pages in the most recent OPM booklet. I would suggest that these two books are not comparable, as we have chosen to produce multiple handbooks for different areas of the country, so our books will only contain comparative data about a specific area. From our focus groups with Medicare beneficiaries, we learned that they have a strong preference not to receive information about plans that are not available to them. In contrast, the OPM booklet contains information about plans in every state.

You also express the view that there is wasted space at the end of the document, because the same phone numbers are repeated. I am sorry you misunderstood this: when this handbook draft was circulated for review, the same toll free number was used in most of the spaces as a "filler" until the actual templates were completed. This, as well as the rationale for changes to the layout and content of the book, was explained to your staff at a meeting on May 5 -- the date when we requested comments on the handbook. In the final handbook, actual numbers will be provided. For example, the handbook will list the state phone number for the Insurance Commissioner and Long-term Care Ombudsman Program.

Quality and Performance Information

Let me emphasize again that the version of the handbook you reviewed was a draft, and based on comments from reviewers, including industry representatives and Congressional staff who made some of the same suggestions you have made, we have modified the performance and satisfaction information. For example, we have combined the fee-for-service and plan quality measures into one chart. An example of what this will look like is enclosed with Tab C. We also clarified that other measures are available and that the measures in the book do not represent a complete picture of quality.

While we are collecting information from plans on a number of HEDIS measures, only seven measures have been audited and are available to beneficiaries through 1-800-MEDICARE or www.medicare.gov. We had hoped to be further along in making quality measures available to beneficiaries, but as you know, we were surprised last year at the extent to which the initial submissions from plans were inaccurate. Because it is so important that we provide beneficiaries with accurate data about quality, we contracted with an independent contractor to audit the data that plans submitted, and we are including in the handbook only those measures that have been audited and determined to be reliable. The requirement that we have imposed for the submission of audited data has probably had a positive impact on the reliability of quality data for all payers.

We decided to include one satisfaction measure in the handbook to give beneficiaries a sense of what is available; they can then call for additional measures if they are interested. The satisfaction measure that we included was based on focus testing. The measure, "Doctors Who Communicate Well," actually combines the results of four questions. For this measure, beneficiaries are asked how often their doctors listened carefully, explained things in a way they could understand, showed respect for what they had to say, and spent time with them.

You also questioned our decision to devote several pages explaining our quality measures. We strongly believe that it is important to explain to beneficiaries what the measure is, where it comes from, and how to interpret it. OPM does provide more measures in its current handbook, but as I explained above, we intend to include additional quality measures as soon as we can verify that plans are submitting accurate information. I would also note that the OPM presentation is not consistent with our commitment to use 14 point font in the handbook to maximize readability for Medicare beneficiaries.

Finally, in a letter to me on April 1, you asked for our response to concerns that Walt Francis raised about our website at the March 18 hearing. The Director of our Center for Beneficiary Services, Carol Cronin, has spoken to Mr. Francis about his concerns, and I have attached at Tab D our detailed response to Mr. Francis' testimony. I would ask that this letter be included in the record for that hearing.

Thank you for your interest in providing beneficiaries with the information they need to make informed choices about their Medicare options. I appreciate the commitment you bring to this issue, and as always, I look forward to working with you to strengthen the Medicare program.

Sincerely,

Nancy-Ann Min DeParle
Administrator

Enclosures

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

May 21, 1999

The Honorable Nancy Ann DeParle
Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. DeParle:

We have reviewed your agency's recent draft of the proposed *Medicare and You* handbook for the year 2000. As currently drafted, we find the handbook to be legally insufficient, delusive, wasteful and confusing. It ignores the statutory requirements spelled out for the publication as part of Medicare+Choice ("M+C") program. As disturbing, rather than "promoting informed choice" as envisioned by the Medicare+Choice law, it seems designed to frustrate a beneficiary's ability to evaluate the comparative benefits of different health plan options available to them through Medicare.

The specific problems described below underlie, in part, my sentiments:

VIOLATIONS OF THE STATUTE

As part of its broader effort to ensure that seniors could comparatively evaluate all of their options under the Medicare program, Congress mandated that the Health Care Financing Administration ("HCFA") specifically include in the material mailed to each beneficiary prior to the new open enrollment period *more than a dozen specific facts about each specific Medicare+Choice plan* available in the beneficiary's area. In spite of this mandate, the draft handbook contains absolutely no detailed benefit information about any specific plan. It doesn't even contain basic elements such as how much a given plan costs, or what, if any, additional benefits it covers. In fact, nowhere does it contain a decent summary of the benefits *a typical* Medicare+Choice plan offers.

Instead, the handbook contains only aggregated, cryptic, poorly organized, and relatively meaningless information organized by Medicare+Choice *contractor*. Even then, comparative information is limited to the name of the contractor, the total number of plans they offer in each state, the *range* of premiums they charge for these plans, the number of plans they offer that cover prescription drugs (not which ones), and a phone number.

This format makes it impossible to learn even the most basic plan information. The reader

cannot tell if a specific plan is available to them, what the premium is for a given plan, what the applicable co-payments or deductibles are, or what, if any, extra benefits are covered. This is not what the statute requires, and clearly not what Congress envisioned when it enacted the mailing requirement.

CONTENT BIASED AGAINST MEDICARE+CHOICE

In some ways we find it even more troubling that the content of the handbook seems designed to frustrate the very purpose for which it was clearly created -- to help educate seniors and enable them to make informed choices under the new Medicare+Choice program. Sadly, the draft contains no significant discussion of the options available because of Medicare+Choice until page 17 (after an extensive description of the traditional Medicare program, and its benefits and a description of the low-income assistance programs).

Where the handbook does discuss the M+C program, it fails to make clear even the most basic distinctions and relationships between "The Original Medicare Plan" and Medicare+Choice plans. For example, nowhere is it clearly stated that all Medicare+Choice plans must cover all of the benefits covered in both Medicare Parts A and B.

WOEFULLY INADEQUATE QUALITY AND PERFORMANCE INFORMATION

The paucity of comparative quality data that is included in the draft is poorly presented and "oversold." More importantly, it fails to adequately include and present comparisons to the traditional Medicare plan.

Only one quality indicator comparing Medicare+Choice plans to traditional Medicare is included. It reports plan mammography rates. Even then, the traditional Medicare program data is not presented in the bar graphs comparing individual M+C plans, but is compared to aggregate M+C data for each state. It is as if HCFA does not want the traditional program to be judged on its own relative merits.

The only additional comparative "quality" measure for Medicare+Choice plans is derived from the results of an enrollee survey, and reflects the perceived communication skills of a plan's participating doctors. Representing this information as a major quality indicator is dubious at best. Yet, the draft devotes 7 full pages to reporting this one fact -- via a nearly indecipherable multi-variable bar graph. By comparison, the Office of Personnel Management's ("OPM") standard beneficiary booklet for the Federal Employee Health Benefit Plan presents on one page the results of 11 different consumer satisfaction measures. I ask you -- can't HCFA do a better job of giving seniors some truly valuable information?

OVERALL CONTENT CONFUSING AND WASTEFUL

Finally, the overall structure and layout of the booklet is long, duplicative and poorly organized. As a result, it only further frustrates the purpose for which it was mandated and is a poor reflection on the program. A few examples:

- It devotes nearly a dozen pages to describing in detail the benefits structure of the traditional fee-for-service program -- before adequately explaining the general advantages and disadvantages of fee-for-service Medicare as compared to Medicare+Choice.

- The vast majority of the text contains general explanatory text -- much of which is redundant and not clearly written. Only 11 pages are devoted to providing comparative information. And then a grand total of 7 facts per *contractor* are provided – this includes the contractor's name and phone number. By comparison, the most recent OPM booklet devotes 41 of 55 pages to comparative, plan specific information. It provides roughly 35 facts concerning every plan in the country (approximately 300 plans).

- One final example of wasted space is the listing of phone numbers one can call to get additional information. In addition to numerous references to phone numbers spread throughout the text, a full 7 pages are devoted to nothing but describing government phone numbers where seniors can get more information – yet, approximately 75% of this material refers seniors to the same 1-800-MEDICARE number. This could easily be condensed into two pages at most and either save money or free up space for more detailed, comparative plan information that seniors could actually use.

At a time when many seniors are struggling to determine how to pay for medical needs such as prescription drugs, the government does not serve them well by providing only incomplete and misleading information about their options under the Medicare+Choice program.

Given the potential of the Medicare+Choice program to help millions of seniors and disabled citizens, I ask that you take the necessary steps to ensure that these inadequacies are addressed before authorizing the expenditure of any printing funds for this project.

Sincerely,

Bill Thomas

Bill Thomas
Chairman

cc: The Honorable Donna Shalala

Health Care Financing Administration
Office of Legislation

FAX COVER SHEET

May 25, 1999

FAX TO:	**Chris Jennings**
FAX #:	(202) 456-5557
PHONE #:	
ORGANIZATION:	White House
FROM:	**Bonnie Washington**
FAX #:	(202) 690-8168
PHONE#:	(202) 690-5960
RE:	Letters from Bill Thomas regarding Medicare Handbook

PAGES (INCLUDING COVER): 8

COMMENTS:

Three letters are attached:

(1) Letter from Nancy-Ann Min DeParle to Bill Thomas (dated March 30) asking for his support for moving the ACR deadline from May 1 to July 1 and changing the statutory requirements regarding the types of plan comparison information the handbook must include.

(2) Letter from Bill Thomas to Nancy-Ann Min DeParle (dated April 1) supporting the decision to move the ACR deadline to July 1 but asking for more information about changing the statutory requirements regarding the handbook.

(3) Letter from Bill Thomas to Nancy-Ann Min DeParle (dated May 21) outlining his concerns with the handbook draft.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAR 30 ,

The Honorable William Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Thomas:

As you know, the Balanced Budget Act of 1997 (BBA) made significant changes to the Medicare program, including the introduction of Medicare+Choice. As part of the Medicare+Choice program, the BBA moved the date when health plans are required to submit their Adjusted Community Rate (ACR) proposals, from mid-November to May 1. As I understand it, this deadline was changed to accommodate the production of education materials and the implementation of other activities for each fall's coordinated open enrollment period.

As you and I have discussed, the May 1 ACR deadline presented difficulties for health plans last year because they had less time than they felt was needed to evaluate market trends and costs. I believe that this early deadline also increases the likelihood that the data we provide beneficiaries in October 1999 as a part of the beneficiary education campaign mandated by the BBA will be inaccurate. For these reasons, I believe that it would be in the best interest of both beneficiaries and health plans that we move the ACR deadline to July 1. We have proposed to move this date as part of the President's FY 2000 budget. Based on the support for this proposal in the Congress, we assume that legislation to effect this change can be enacted later this year. However, we have to inform plans within a week about the deadline that will be used this year for the 2000 ACR filing. Therefore, we are planning to notify plans that the deadline for the calendar year 2000 ACR submissions will be July 1, 1999. It would be helpful, however, to have a letter from you and the Ranking Member of the Subcommittee indicating your support for this action. We have received such a letter from the Chair and Ranking Member of the Finance Committee and from the Chair and Ranking Member of the Commerce Health Subcommittee.

The BBA also includes detailed requirements regarding the information to be included in the beneficiary mailings. In 1998, we provided this information on a pilot basis through the 1999 *Medicare & You* handbook. In some of the pilot sites, the late decision of some managed care plans to leave the market after the handbook had been sent to the printer caused some of the detailed benefit information in the handbooks to be inaccurate. We hope that moving the ACR deadline to July will mitigate this problem for 1999. But I am concerned that even a July deadline will not eliminate accuracy problems with regard to detailed benefit information. Given the complex production schedule for getting *Medicare & You* into the mail to beneficiaries by October 15, there would not be time to validate benefit information submitted directly by plans. As a result, some portion of this information could be inaccurate compared to final, approved benefits. Based on last year's experience and our preliminary evaluation of the 1999 handbook, including focus groups with beneficiaries in the pilot states, and taking into account the compressed production schedule resulting from the later ACR deadline, I believe it would be better to provide less detailed, but more accurate information to beneficiaries in the handbook and supplement it with information through other sources.

While detailed benefit information would not be available in *Medicare & You*, it would still be available to beneficiaries by: calling 1-800-MEDICAR(E) and requesting a printed copy of information; accessing the Medicare Compare database on the Internet; or participating in regional special information sessions. As with the change in the ACR deadline, we have proposed legislation to modify the BBA information requirement, but such legislation will probably not be enacted before the time when we need to finalize the content of the 2000 handbook. An indication of support for paring back the amount of detailed benefit information in the handbook would also be helpful.

I look forward to working with you to enact legislation to make these changes possible.

Sincerely,

Nancy-Ann DeParle

Nancy-Ann DeParle
Administrator

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

April 1, 1999

The Honorable Nancy-Ann DeParle
Administrator
Health Care Financing Administration
Room 314-G
200 Independence Ave, S.W.
Washington, D.C. 20201

Dear Ms. DeParle:

As you know, the Balanced Budget Act of 1997(BBA) moved the deadline for Medicare+Choice plans to submit their annual Adjusted Community Rate (ACR) proposals to the Health Care Financing Administration from November 1 to May 1. During the BBA negotiations, the Administration argued that the Health Care Financing Administration needed a full seven months to process the ACR filings and to produce the detailed comparative information booklets that Congress then envisioned for the new Medicare+Choice program.

During the first year of implementation of the Medicare+Choice program, many plans found that it was extremely difficult to predict their Medicare costs seven months in advance of the payment. When plans received additional data later in the year, some decided to limit their participation to fewer counties or to withdraw from the program. In your letter dated March 30, 1999, you note that the Administration was unable to include information reflecting these changes in the Medicare&You booklets, resulting in seniors receiving inaccurate information. You also ask for Congress to enact legislation to move the filing date to July1, and to support reducing the amount of detailed information provided to seniors.

I support moving the ACR filing date from May 1 to July 1 and intend to enact legislation to make this change. However, providing seniors with accurate and comparative information about all of their Medicare options is of upmost importance and is one of the fundamental pieces of the Medicare+Choice legislation. Unfortunately, at a

March 18 Health Subcommittee hearing we heard testimony questioning the effectiveness of HCFA's inaugural information campaign. In particular, concerns were raised about the timing of the information mailings, the complexity and structure of the booklet, and the difficulty in accessing and using the HCFA website. Before considering changing the BBA information requirements, a comprehensive review of last year's information campaign and a detailed analysis of the impact of moving the filing date from May 1st to July 1st is warranted. As a first step, I would like your response to the concerns raised at the hearing.

Thank you for your attention to this matter.

Sincerely,

Bill Thomas

Bill Thomas
Chairman

CHARLES B. RANGEL
15TH CONGRESSIONAL DISTRICT
NEW YORK

DEPUTY WHIP

COMMITTEE:
WAYS AND MEANS
RANKING MEMBER
SUBCOMMITTEE ON TRADE
JOINT COMMITTEE ON TAXATION

Congress of the United States
House of Representatives
Washington, DC 20515–3215

2354 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–3215
TELEPHONE: (202) 225–4365

DISTRICT OFFICES:
MS. VIVIAN E. JONES
DISTRICT ADMINISTRATOR

163 WEST 125TH STREET
NEW YORK, NY 10027
TELEPHONE: (212) 663-3900

2110 FIRST AVENUE
NEW YORK, NY 10029
TELEPHONE: (212) 348-9630

PLEASE RESPOND TO
OFFICE CHECKED

June 8, 1999

Mr. Chris Jennings
Special Assistant to the President for Health Policy
Old Executive Office Building
1600 Pennsylvania Ave., NW
Washington, DC 20500

Dear Mr. Jennings:

Recently, the Health Care Financing Administration (HCFA) issued proposed regulations regarding the Medicare capital special exceptions process. I want to take this opportunity to once again urge you to revise the Medicare special exceptions process as part of the final FY 2000 hospital regulation. The Medicare capital special exceptions process was established pursuant to report language I helped to insert in the Omnibus Budget Reconciliation Act (OBRA) of 1993 Conference Report. However, modifications to the special exceptions process are still needed in order to provide the type of equitable and effective special exception process that I intended for institutions such as New York Presbyterian Hospital which did not receive adequate relief when the regulation was originally issued in 1994. After all this time, I can see no further reason to delay providing the type of relief I had intended to achieve through the 1993 Conference Report language.

The OBRA Conference Report language called on HCFA to address the needs of hospitals that, through lengthy approval processes and other problems beyond their control, were not eligible for the "grandfather" provisions of the prospective payment transition. This language was included because hospitals that have had to undertake major replacement or renovation projects during the transition to capital prospective payment are significantly financially disadvantaged compared to hospitals whose projects were completed before the transition and those that will build after the transition. It was our intention that such hospitals be put in a position of relative parity with grandfathered hospitals and later builders. It was also our intention that this treatment be available to any hospital in this situation. It was not the intention of Congress to limit the relief solely to hopsitals based on financial need. Unfortunately, the 1994 regulations did not achieve parity and conditioned payments on other measures of need, such as Medicare margins or DSH levels, despite the intent of the OBRA language.

Over the past five years, I and other members of Congress and the affected hospitals have worked with you and HCFA to find ways to make the existing regulations more fair for hospitals whose projects have been caught in the transition. HCFA's recent proposed regulation for fiscal year 2000 hospital payments describes some of the suggestions for improvement that have been made and asks for comment, but does not actually propose new regulatory language. The proposed rule does, however, provide the opportunity to resolve this issue in the final regulation that will be issued later this summer. To achieve an equitable transition process, i.e., one that meets the intent of the 1993 Conference Report, the final regulation needs to address five major issues:

The payment floor should be raised to 85 percent from the current 70 percent so that it will be comparable to the treatment of grandfathered hospitals.

The offset against payments for Medicare inpatient surpluses should be eliminated, or, alternatively, all Medicare operating costs, both outpatient and inpatient, should be counted in determining whether a surplus exists.

The DSH requirement should be eliminated. As an alternative, the requirement should at least be lowered to 15 percent, the threshold for eligibility for other DSH payments. In addition, the current eligibility "cliff" should be replaced with a sliding payment scale, similar to the concept used in calculating DSH add-ons to prospective payments.

The placed in service date should be extended for hospitals that have experienced regulatory or other delays in completing their projects if they received CON approval by a date certain.

There should be a reasonable cap on payments that minimizes the effect of any changes on payments to other hospitals. An annual cap equal to one percent of all capital payments would accomplish this. A rollover provision should be provided to ensure that the effect of the cap does not deny eligible hospitals the intended relief.

As you know, this is a matter of great importance to me. I hope you will take the steps necessary to ensure that the final FY 2000 regulations include revisions to the special exceptions regulations that meet the concerns I have outlined.

Sincerely,

CHARLES B. RANGEL
Member of Congress

CBR:jrs

American Health Care Association
1201 L Street, NW • Washington, DC 20005-4014
FAX: 202-842-3860

Facsimile Cover Sheet
Please Deliver Immediately Upon Receipt

To: Chris Jennings

Company: White House

Fax #: 456-7028

If you did not receive a complete and legible transmission, please call 202-898-2826

From: Bruce Yarwood Tele #: 898-2858

Date: 6/22/99 Total pages (include cover page) : 5

Message:

The information contained in this facsimile is confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, the reader is hereby notified that any dissemination, distribution or copy of this telecopy is strictly prohibited. If you have received this telecopy in error, please notify us by telephone or facsimile and destroy the original telecopy. Thank you.

( ) Fax delivered Time_____ Operator_____

Chris

How bout this?

How are we coming with the market basket fix?

6/22

Congress of the United States
Washington, DC 20510

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

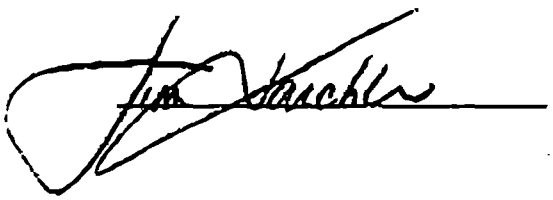
We are writing to express our shared concern regarding the impact of the Balanced Budget Act (BBA), and its proposed implementing regulations, on our nation's nursing homes and the Medicare beneficiaries they serve.

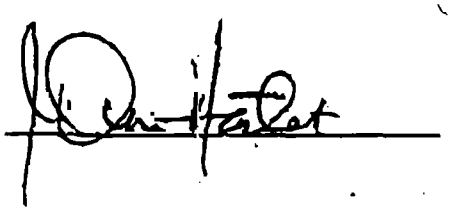
Unfortunately, it was impossible to foresee all the possible unintended effects implementation of the BBA would have on particular categories of care available to Medicare beneficiaries.

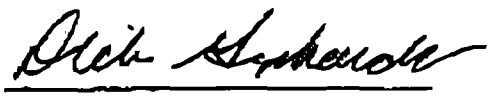
We believe the growing crisis in the nursing home industry stems, in part, from the implementation of the BBA. If steps are not taken to improve reimbursement during the transition to a prospective payment system for skilled nursing facilities, we fear that dedicated care-givers may be laid off, facilities may close, access may be reduced, and quality may decline. This clearly is not what was intended when the BBA passed.

We have been advised the Administration has the ability to address some of these concerns by revising its regulations that are likely contributing to the problem, and by making every effort to ensure that the transition to a prospective payment system does not ultimately harm patients. We would like to work with you to address this matter in whatever manner is appropriate.

Sincerely,







ROBERT G. TORRICELLI
NEW JERSEY

COMMITTEES:
GOVERNMENT AFFAIRS
JUDICIARY
RULES AND ADMINISTRATION
FOREIGN RELATIONS

United States Senate
113 DIRKSEN SENATE OFFICE BUILDING
WASHINGTON, DC 20510-3003
(202) 224-3224

ONE RIVERFRONT PLAZA
3RD FLOOR
NEWARK, NEW JERSEY 07102
(973) 624-5555

420 BENIGNO BLVD.
KORMAN INTERSTATE BUSINESS PARK
SUITE A-1
BELLMAWR, NEW JERSEY 08031
(609) 933-2245

http://torricelli.senate.gov/
Senator_Torricelli@Torricelli.Senate.Gov

June 3, 1999

The Honorable William J. Clinton
The White House
Washington, DC 20500

Dear Mr. President:

Once again, I would like to alert you to some issues which are of particular concern to health care providers in my home State of New Jersey.

The Balanced Budget Act of 1997 was an important step toward ensuring the long-term strength of the Medicare program; however, the unintended consequences of reimbursement reductions included in the BBA have been economically devastating to skilled nursing facilities (SNFs) in my state. Thus, I want to share with you some potential administrative options which the Health Care Financing Administration (HCFA) may choose to implement to help preserve access to community-based skilled care services.

First, the market basket update index currently used by HCFA understates the annual change in the costs of providing an appropriate mix of goods and services taking place in a SNF. For this reason, the BBA specifically instructs the Secretary to establish a SNF market basket index that "reflects changes over time in the prices of an appropriate mix of goods and services included" in a SNF. Therefore, HCFA may choose to replace the current market basket index with an index that reflects the average annual change in the prices of SNF outputs. Currently, the Bureau of Labor Statistics has such an index, which, if used, could provide immediate relief to providers and beneficiaries.

A second possible solution would be to give facilities the option of continuing to be reimbursed under the current transition rate or to be reimbursed the full federal rate. As you know, SNFs are being transitioned to a 100 percent federal rate over three years which are a blend of 1995 facility specific historical costs and a federal rate. Facilities that changed the type and volume of services after 1995 are disadvantaged by the transition rate and would be better served under the federal rate.

As you continue to pursue proposals to ensure the long-term solvency of the Medicare, I encourage you to carefully consider these administrative options that could bring immediate relief to health care providers in my state. Thank you for your leadership with this important issue, and I look forward to working with you.

Sincerely,

ROBERT G. TORRICELLI
United States Senator

RGT:km

New Jersey Association of Health Care Facilities

LEXINGTON SQUARE COMMONS
2131 ROUTE 33
HAMILTON, NEW JERSEY 08690-1740

TEL 609-890-8700
FAX 609-584-1047

June 18, 1999

Chris Jennings
Depury Assistant to the President
for Health Policy
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. Jennings:

Just a short note to tell you how much I enjoyed listening to your remarks at the American Health Care Association's Executive Board meeting on June 8, 1999. While I may not agree with everything you said, I greatly appreciate your candor and the very positive and constructive tone of your remarks.

As you may recall, I brought to your attention HCFA's Abuse Awareness Pilot Program. I have attached another copy of the poster that local Ombudsman Programs will be asking nursing facilities to post beginning in early July. I firmed believe that this program sends the wrong message to providers, their employees and, most importantly, the residents and families that they serve. It is not constructive, is very "stereotypish" and is very adversarial. **Once again, I ask that the Administration direct HCFA to stop the Program.**

Thank you for your consideration.

Respectfully,

William R. Abrams
President

Chris
did you follow up on this?
6/21

HANYS
HEALTHCARE ASSOCIATION OF NEW YORK STATE

499 South Capitol Street, S.W., Suite 405
Washington, D.C. 20003
(202) 639-1502 / fax (202) 639-9542
(Washington, D.C. Office)
(518) 431-7600 / fax (518) 431-7915
(Albany, NY Headquarters)
http://www.hanys.org

Daniel Sisto, President

June 7, 1999

Ms. Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue, SW, Room 314G
Washington, DC 20201

Dear Ms. Min DeParle:

On behalf of the more than 500 not-for-profit and public hospitals, health systems and continuing care providers that comprise the Healthcare Association of New York State (HANYS), I am writing to you to ask for your intervention on some of the most significant issues associated with the proposed outpatient prospective payment system (PPS). After careful analysis of the Health Care Financing Administration's (HCFA's) proposed regulation, HANYS is extremely concerned with HCFA's proposal for implementing the outpatient PPS, and the impact it will have on hospitals nationwide and in New York.

Our analysis of HCFA's proposal projects a loss of over $100 million per year in outpatient payments to New York's hospitals, representing a reduction of 12 percent in outpatient Medicare revenue. Nationally, hospitals will, on average, lose 24 cents on every dollar spent for outpatient services provided to Medicare beneficiaries. In New York State, hospitals will see reductions of even more and, on average, will lose 30 cents on every outpatient dollar spent. Hospitals in New York that are among the most drastically affected by the outpatient PPS are those that provide services in some of the most under-served rural and urban areas of our State.

As currently proposed by HCFA, the outpatient PPS makes drastic and inappropriate reductions in payments for hospital outpatient services. We believe that several of the proposed provisions are contrary to Congress' intent in the Balanced Budget Act of 1997 (BBA). The following is a description of three key concerns associated with the PPS as proposed that can be corrected administratively. I urge you in the final drafting of the outpatient PPS regulations, to make these necessary changes that would assure that congressional intent is fulfilled when the outpatient PPS becomes operational next year.

- **Remove the 5.7% Across-the-Board Reduction in Payments:** Rather than keeping total funding for outpatient PPS at current levels, as is the intent of Congress, HCFA has proposed that hospital payments will be reduced as a result of lower beneficiary co-payments enacted in the BBA. In effect, according to the latest information released by HCFA, this would reduce payments overall to hospitals by 5.7%. It is important that, as soon as possible, HCFA indicate its intent to correct this interpretation, and provide outpatient PPS reimbursement to hospitals at their current level of funding.

- **Eliminate the Volume Cap:** Under the BBA, Congress required HCFA to develop methods for controlling unnecessary volume. HCFA has proposed constraining future Medicare hospital outpatient spending through formula-driven spending targets. Because these targets don't specifically focus on the inappropriate use of services or control unnecessary volume, they will also limit payments to efficient providers who are appropriately responding to the needs of patients. We recommend the elimination of the volume and expenditure caps, which run the risk of limiting necessary services and penalizing hospitals for the implementation of new technologies. Appropriate utilization control policies should directly target any providers that overuse services, not treat all providers as guilty by association.

- **Provide a Teaching and Disproportionate Share Adjustment:** In its proposed rule, HCFA indicated that, although it found a relationship between the cost of care and teaching intensity and disproportionate share (DSH) percentage, it did not include an adjustment for hospitals in these categories. The absence of these adjustments is reflected in the high losses (10.6%) projected for large teaching hospitals, which not only train significant numbers of residents, but also treat substantial numbers of indigent patients. We understand that there is concern about the data used to develop teaching and DSH adjustments and, therefore, the accuracy of the adjustment formulas. We are concerned about **all** the data used in the development of the outpatient PPS and recognize that corrections will be required in future years, as more reliable data become available. It is essential to incorporate teaching and DSH adjustments as part of the initial outpatient PPS and to refine these adjustments in the future as other aspects of the outpatient PPS are also improved.

We believe that these revisions to the outpatient PPS are important in the development of a fair and equitable reimbursement system, while clearly fulfilling the intent of Congress. We also believe that HCFA can make these changes, without further congressional instruction or authorization and urge you to make these changes as you move forward in finalizing the outpatient PPS.

I would very much like to meet with you and your staff to discuss these important issues, as well as other issues of concern such as the absolute necessity of including a transition period for the implementation of outpatient PPS, data issues, as well as ongoing refinements to the proposed system. Joanne Cunningham, my Washington staff, will contact your office to follow up on my request for a meeting at your convenience. In the meantime, feel free to contact her at 202-639-1502.

Of course, we will incorporate all of these concerns in our comprehensive comment letter that will also include other technical and clinical issues that we identify as part of our continuing analysis of the proposed rule. However, we think that it is important to bring the aforementioned critical issues to your attention now as they relate to crucial interpretations of the BBA as well as important methodology decisions. If we may be of assistance to you in answering questions about HANYS' analysis of HCFA's proposed regulation, please contact Mark Callan, Vice President of Economics, Finance and Information at 518-431-7703.

Sincerely,

Daniel Sisto

Daniel Sisto
President

DS/clb

TOM DASCHLE
U.S. Senator for South Dakota

320 North Main Avenue, Suite B
Sioux Falls, SD 57104
605-334-9596

320 S. First Street, Suite 101
Aberdeen, SD 57401
605-225-8823

816 6th Street
Rapid City, SD 57701
605-348-7551

Washington, DC 20510
202-224-2321
1-800-424-9094

TELECOPY COVER SHEET

DATE: 6-18-99

TO: Chris Jennings

FAX NO: 456-5557

FROM: Shelly TenNapel

Senator Tom Daschle
509 Hart Senate Office Building
Washington, DC 20510
Telephone: (202) 224-2321
FAX: (202) 224-7895

PAGES TO FOLLOW: 1

MESSAGE: FYI. -

Congress of the United States

Washington, DC 20510

June 18, 1999

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

We are writing to express our shared concern regarding the impact of the Balanced Budget Act (BBA), and its proposed implementing regulations, on our nation's nursing homes and the Medicare beneficiaries they serve.

Unfortunately, it was impossible to foresee all the possible unintended effects implementation of the BBA would have on particular categories of care available to Medicare beneficiaries.

We believe the growing crisis in the nursing home industry stems, in part, from the implementation of the BBA. If steps are not taken to improve reimbursement during the transition to a prospective payment system for skilled nursing facilities, we fear that dedicated care-givers may be laid off, facilities may close, access may be reduced, and quality may decline. This clearly is not what was intended when the BBA passed.

We have been advised the Administration has the ability to address some of these concerns by revising its regulations that are likely contributing to the problem, and by making every effort to ensure that the transition to a prospective payment system does not ultimately harm patients. We would like to work with you to address this matter in whatever manner is appropriate.

Sincerely,

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

June 18, 1999

The Honorable Nancy-Ann Min DeParle
Administrator
US Department of Health and Human Services
Health Care Financing Administration
200 Independence Avenue, SW
Washington, DC 20201

Dear Nancy-Ann:

As you know, I am concerned about the approach the Department has taken, at least initially, in crafting its Notice of Proposed Rulemaking (NPRM) for Outpatient Prospective Payment.

The regulation apparently is not likely to take effect until at least the spring of 2000. However, my understanding is that the impact of the draft NPRM would effectively reduce Medicare outpatient payments to hospitals by an additional 5.7%. This reduction in payment amounts to almost $900 million per year to hospitals.

There are a number of technical issues which have caused unexpected hospital reimbursement issues and payments problems, but none are of the magnitude and impact of the Outpatient PPS issue. I encourage you to use your flexibility under the statute to resolve this problem.

I look forward to working with you and the Department to develop an outpatient PPS payment methodology that will fulfill our policy goals and provide hospitals with fair reimbursement as they transition to this new payment mechanism.

Sincerely,

Bill Thomas

Bill Thomas
Chairman

United States Senate

WASHINGTON, DC 20510

June 18, 1999

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue, S.W.
Room 314G
Washington, D.C.

Dear Madame Administrator:

We are concerned about the Department's Notice of Proposed Rulemaking (NPRM) for the implementation of the outpatient prospective payment system (PPS) enacted in the 1997 Balanced Budget Agreement (BBA).

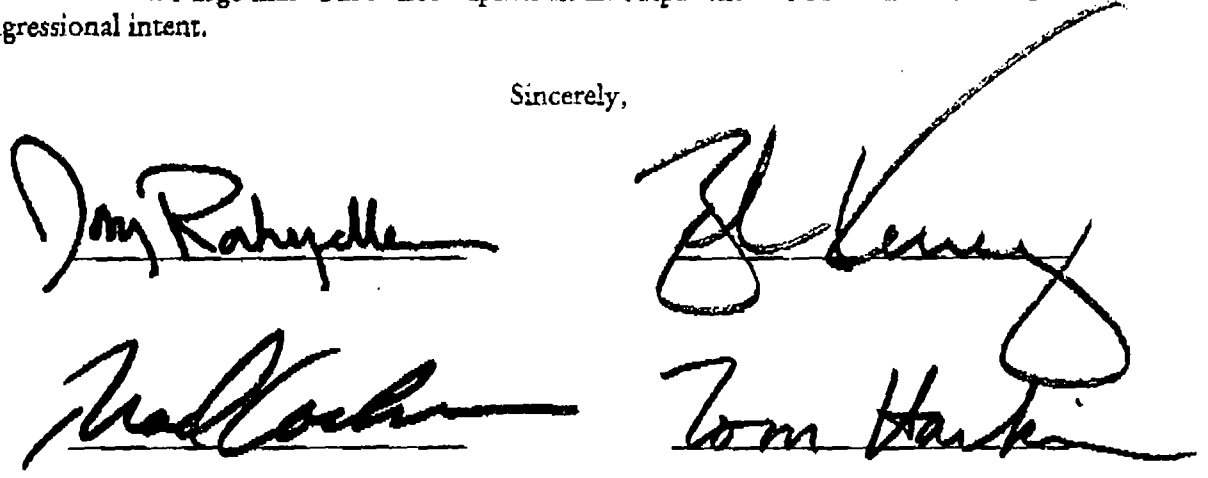
With the encouragement of Congress, HCFA, seniors' representatives and providers cooperatively developed the outpatient PPS policy. The new policy was designed to address a longstanding flaw in outpatient payment policy and to gradually rationalize Medicare's outpatient copayments, without imposing unmanageable outpatient payment cuts on hospitals. This policy change was accomplished in the Balanced Budget Act, which contained a $7.2 billion outpatient payment reduction. No additional payment reductions were contemplated, analyzed or scored.

We strongly support the outpatient PPS approach. However, HCFA's proposed rule contains an additional, unintended 5.7 percent "across the board" reduction in payments to hospital outpatient departments. This $850 million per year reduction represents a misinterpretation of Congressional intent and threatens the integrity of a broadly supported compromise. Total outpatient hospital payments were to be budget neutral to a clearly identified new baseline in the law. No additional reduction was contemplated.

Congress clearly intended that these changes to outpatient copayments be achieved on a budget-neutral basis -- the identical language that originally passed the House and the Senate clearly precluded any payment reduction for this policy. While a minor technical drafting change in the Conference agreement resulted in confusion over the outpatient payment formula, we believe the Department has the flexibility under the statute to implement Congress' clear intent.

We urge that HCFA not implement an outpatient PPS rule which is inconsistent with Congressional intent.

Sincerely,



--more--