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To:	Chris Jennings c/o Barbara Wooley	From:	Jim Pyles
Fax:	456-5557	Pages:	3
Phone:	456-5594	Date:	June 2, 1999
Re:	Administration's Potential Plan for Home Health Copayment		

☐ Urgent ☒ **For Review** ☐ Please Comment ☐ Please Reply

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J. MICHAEL HALL, GOVERNMENT RELATIONS

MEMORANDUM

To: Chris Jennings

From: Jim Pyles
Home Health Services and Staffing Association

Date: June 2, 1999

Re: Administration's Potential Plan for Home Health Copayment

We are concerned that the Administration is contemplating imposing a copayment on home health services covered under Medicare, and believe that such a decision would be bad public policy and bad political strategy.

As the attached chart of CBO projections shows, home health expenditures had a negative rate of growth in FY '98 of **minus 15%**. (The rate of growth actually dropped 20% from a positive growth rate of 5% in FY 1997.) The cuts in home health expenditures for FY '98 were more than six times higher than projected when BBA '97 was passed. Finally, the average rate of expenditure growth for home health over five years is approximately 0% and is lower than the rate projected for any other service covered by Medicare. All these reductions are occurring during a period when the need for home health services by Medicare beneficiaries will be increasing.

As further shown by the attached information, Medicare claims for home health services are down by 20%, at least 2,195 Medicare-certified agencies have been forced to close, the value of home health company stocks has dropped by 45% to 55% in one year, at least one major home health company has had to seek bankruptcy protection, at least 61,000 home health jobs have been lost, the wages of home health workers have not kept pace with inflation, and agencies are having to discharge patients who need the most expensive care.

Also, HCFA is seeking to impose the OASIS data reporting system which will add \$45 million in costs in the current year and \$110 million in costs over the next five years. HCFA estimates that 70% of home health agencies will not receive any Medicare reimbursement for these additional costs because their cost of services per beneficiary

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will be over the new, lower per beneficiary limits established by BBA '97. A copayment in any amount would simply add more administrative costs and divert additional dollars away from services to patients.

In short, Medicare funding is already insufficient to permit home health agencies to provide the services to patients that are covered under Medicare. Copayments will simply make home health care inaccessible for even more of the sickest patients.

Attachment

HOME HEALTH "SAVINGS" UNDER BBA '97

CBO Estimates of Impact of BBA '97

Home Health Outlays in Billions

Fiscal Year	1998	1999	2000	2001	2002
Jan. 1997 Baseline	\$21.1	\$23.1	\$25.3	\$27.5	\$29.9
Post BBA '97 Baseline	\$20.0	\$21.1	\$21.2	\$23.3	\$25.2
Cum. Savings from BBA'97	\$1.1	\$3.1	\$7.2	\$11.4	\$16.1
March 1999 Baseline	\$14.9	\$15.0	\$16.5	\$15.6	\$17.1
Revised Cum. Savings	\$6.2	\$14.3	\$23.1	\$35.0	\$48.8

5 year savings projected at time BBA'97 passed = \$16.1

5 year savings projected in March 1999 = \$48.8

5 year savings from BBA'97 are 300% higher than projected

Rate of Growth in Home Health Expenditures Compared to Other Services (March 1999)

Fiscal Year	1998	1999	2000	2001	2002	5yr Average
Hosp.	-2.5%	-1.5%	5.7%	4.7%	4.5%	2.2%
SNF's	8.9%	-3.8%	1.7%	5.3%	5.1%	3.4%
Phys.	3%	.6%	4.2%	2.3%	2.4%	2.5%
HHA's	-14.9%	.8%	10.3%	-5.3%	10.1%	.2%

Average growth rate for other services = 2.7%

Average growth rate for Home Health = .2%

Home Health services have been subjected to far greater cuts than any other service covered by Medicare, and home health expenditures have a far lower growth rate than any other Medicare service.

The Crisis in Home Health Care

- 1. According to HCFA's most recent utilization data for home health, the total number of claims received in fiscal year 1997 was 20,959,349 and the total number of claims received in fiscal year 1998 was 16,880,856 – about a 20% decrease in the number of claims received. (HCFA Contractor Reporting of Workload Data, February 1, 1999)**
- 2. 2,195 Medicare-certified home health agency offices have closed since January 1998, according to a survey of state health licensure departments. Hardest hit was Texas, where 352 agencies and another 438 branch offices closed. Other States with large numbers of closures: Louisiana 250, California 153, Florida 97, Missouri 91, Oklahoma 87, Tennessee 67, and Indiana 60. (Eli's Home Care Week, Volume VIII, Number 6, February 8, 1999)**
- 3. Home care stocks dropped 43.8 percent in 1998 according to an annual survey by Hilton Head, South Carolina-based HealthCare Markets Group, Inc. (Eli's Home Care Week, Volume VIII, Number 2, January 11, 1999)**
- 4. Home care stocks dropped 55.8 percent between April 1, 1998 and March 31, 1999 according to a financial analysis of home care public companies by Houlihan, Lokey, Howard & Zukin Investment Bankers. (March 31, 1999)**
- 5. Home Health Corporation of America filed for Chapter 11 bankruptcy protection February 18, citing Medicare cutbacks as one cause of its mounting debt. HHCA will not go out of business, but will downsize by releasing 300, or about 10 percent of its employees. (HomeCare Monday, February 22, 1999)**
- 6. Employment at freestanding home health agencies declined by 7,000 jobs in January 1999. Since September 1997, freestanding HHAs have lost 61,000 – or 8.5%, according to the Bureau of Labor Statistics. (Eli's Home Care Week, Volume VIII, Number 7, February 15, 1999)**
- 7. In Home Health Inc. reported a loss of \$132,000 on revenue of \$18.6 million in the quarter ended December 31. That compares with net income of \$186,000 on revenue of \$27.9 million during the same period the year before. (...home health line, February 15, 1999)**
- 8. Home care workers received only a .7 percent wage increase in 1997, while Americans as a whole saw a 3.4 percent increase, according to new Labor Department statistics. (The Washington Times, Eli's Home Care Week, Volume VIII, Number 6, February 8, 1999)**
- 9. A Visiting Nurses Association branch in Illinois found that Medicare payments are now so low that it made the painful decision to abandon 25 patients who needed the most expensive care, rather than face the possibility of having to go out of business in a few months and strand some 300 patients. (The Washington Post, A1, May 10, 1999)**

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Gary L. Ackerman
Congress of the United States
5th District, New York
June 3, 1999

**COMMITTEE ON
INTERNATIONAL RELATIONS**
RANKING DEMOCRAT, SUBCOMMITTEE ON
THE WESTERN HEMISPHERE
SUBCOMMITTEE ON ASIA AND
THE PACIFIC
**COMMITTEE ON BANKING AND
FINANCIAL SERVICES**
SUBCOMMITTEE ON CAPITAL MARKETS,
SECURITIES AND GOVERNMENT
SPONSORED ENTERPRISES
SUBCOMMITTEE ON FINANCIAL
INSTITUTIONS AND CONSUMER CREDIT
**CAUCUS ON INDIA AND
INDIAN-AMERICAN ISSUES**
CHAIRMAN

President Bill Clinton
The White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Mr. President:

As you prepare the Administration's Medicare reform proposal, I ask you to resist further cuts in payments to our nation's hospitals and health care providers.

Throughout the past several years, you have demonstrated your leadership on this issue by fighting attempts to either privatize or dramatically scale back the program. It is my hope that you will continue your commitment to our nation's seniors by approaching Medicare reform in the most balanced and responsible manner possible.

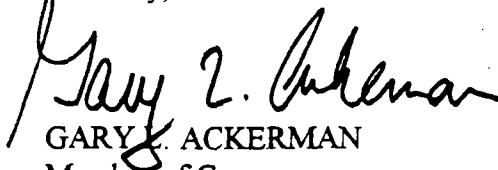
New York hospitals are already under significant financial pressure, due to cuts that were contained in the Balanced Budget Act (BBA) of 1997. Moreover, most of the cuts mandated under the BBA have not yet been implemented. In fact, New York hospitals are expected to experience an additional \$3.9 billion in payment reductions with the full implementation of the BBA.

The BBA has also had a dramatic impact upon home health care agencies throughout the nation, enduring approximately \$49 billion in payment reductions. The changes contained in the BBA have saved more than double the funding that was originally projected by the Congress. Even worse, these cuts are being felt the greatest in the poorest and most destitute of communities.

I believe that we have a unique opportunity to protect and preserve the Medicare program. However, we need to view Medicare reform in the context of payment reductions that are already in the process of being implemented. Most importantly, I hope you will oppose any new cuts to providers and hospitals.

Once again, thank you for your continued commitment to our nation's frail and elderly. I look forward to working with you in the near future.

Sincerely,


GARY L. ACKERMAN
Member of Congress

CC: Chris Jennings
Donna Shalala



DATE: 6/11/99

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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☐ ALICE ARTIS

☐ FRANKIE MELTON

☐ HAZEL FARMER

REMARKS:

Chris/Jeanne — Ha Ha! No, I did not write the AP story that misrepresented the Finance hearing. I did write Scanlon's formal testimony (see attached excerpt) and the accurate Congress Daily report (ghostwriter for Julie Porter).
Happy givebacks!
Rich

Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Thursday, June 10, 1999

BALANCED BUDGET ACT

Any Proposed Fee-for-Service Payment Modifications Need Thorough Evaluation

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



operations in response to the IPS, beneficiaries who are expected to be costlier than average to treat may have increased difficulty obtaining home health care. The pending implementation of the PPS, which will adjust payments to account for costlier patients, has the potential to ameliorate future access problems.⁹

CONCLUSION

The BBA made necessary and fundamental changes to Medicare's payment methods for SNFs and HHAs to slow spending growth while promoting more appropriate beneficiary care. Further refinements are required to make these systems more effective. However, the intentional design of these systems is to require inefficient providers to adjust their practice patterns to remain viable.

The very boldness of these changes has generated pressure to reverse course. In the current environment, the Congress will face difficult decisions that could pit particular interests against a more global interest in preserving Medicare for the long term. As PPSs are implemented for rehabilitation facilities and hospital outpatient services, and as SNFs continue their transition to full PPS rates, provider complaints about tight payment rates and impaired beneficiary access will continue to be heard.

It is important that the implementation of these new payment mechanisms is monitored to ensure that the correct balance between appropriate beneficiary access and holding the line on Medicare spending is being achieved. Our work suggests that it would be premature at this juncture, however, to significantly modify the BBA's provisions without thorough analysis or a fair trial of the provisions over a reasonable period of time.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee may have.

GAO CONTACT AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Individuals who made key contributions to this statement include Carol Carter and Walter Ochinko.

(101855)

⁹For additional information on the impact of the home health IPS on beneficiary access, see Medicare Home Health Agencies: Closures Continue With Little Evidence Beneficiary Access Is Impaired (GAO/HEHS-99-120, May 26, 1999).

plan. Before surrendering the gavel, Archer counseled the committee on its historic duty to seize a rare opportunity to shore up Social Security — but without tax hikes or benefit cuts. “This is the greatest committee in the greatest legislative body in the world,” said Archer. “I know we will shoulder our responsibility on the major issue facing all Americans today.”

His call prompted a round of applause from the panel and guests, but the question and answer period that followed made it clear that distrust between the parties must be overcome. Rangel lamented Democrats were not adequately consulted as Archer and Shaw put their bill together. Shaw acknowledged that “both sides stood back for a long time,” but added that Republicans had to seize the initiative themselves when it appeared that President Clinton’s support for reform this year had limits. Rangel cautioned that an executive session would only work if Speaker Hastert and Minority Leader Gephardt showed more interest in acting on Social Security this year than they have expressed so far. “If you are going to make history and political points, there has to be an agreement on the questions and solutions,” Rangel said to Archer. It has been years since the committee has gone into executive session with the goal of a bipartisan bill. The committee would have to vote on the guidelines for such a session, according to a committee aide. — *by Stephen Norton*

APPROPRIATIONS

Negotiations Continue On Cuts In Legis. Branch Funding

House Speaker Hastert indicated today the House could take up the FY2000 Legislative Branch appropriations bill as early as this afternoon, if the leadership, appropriators and conservative members can agree on a package of cuts to the \$1.9 billion measure. Conservatives have opposed the bill, which is below the FY99 spending level of \$2.05 billion, because it would increase funds for members’ and leadership offices and for House committees at the same time that other domestic appropriations bills are facing severe cuts to stay under the \$538 billion total cap. Rep. Tom Coburn, R-Okla., who has spearheaded the conservatives’ campaign to rein in spending, said today the principals “are going through the machinations right now to get a bill Republicans can support — it’s an ugly process, and I can’t say” whether they can work through it in time for a vote today.

The main sticking point, said both Coburn and Rep. Mark Souder, R-Ind., is the bill’s increase in members’ representational allowance, which among other things, funds members’ mailings to their districts. With the bill appropriating spending for an election year, Souder said, “We believe we should lead by example ... If we don’t touch member accounts, and we don’t touch leadership accounts, and we don’t touch committee accounts, and defense goes up, it’s hard to defend cutting Labor-HHS.” Souder, who is close to Hastert, said he believes Hastert and appropriators are dealing in good faith, but they are caught between “the counterpressures of members wanting different things” as they try to trim the FY2000 bills. Souder and Coburn said newly elected members would have a hard time telling voters why they cut food stamps but increased their own allowances.

Conservative sources predicted most freshman and sophomore members would vote against the bill if the accounts are not cut — although there were indications at presstime that some cut in the allowance account is likely. While conservatives want to see about \$90 million cut from the bill, Souder said, “Hopefully, we’ll get \$20 to \$30 million and a good faith effort.” — *by Lisa Caruso*

HEALTH

Congress Urged To Move Slowly To Fix Medicare Cuts ...

The administration and all of Congress’ major advisers on Medicare policy today delivered a unified message to the Senate Finance Committee: Go slow on legislative “fixes” to restore provider payment cuts imposed by the 1997 Balanced Budget Act. With regard to complaints from the home

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health and nursing home industry about inadequate payments, "The calls to amend or repeal the new payment systems are, in our view, premature," Bill Scanlon of the GAO told the panel. Agreed Gail Wilensky, chairwoman of the Medicare Payment Advisory Commission, "the information we have is not consistent with the dire reports we are hearing" about patients being unable to access care.

Paul Van de Water of the CBO said that while Medicare spending has been considerably slower than the CBO projected when the 1997 act was passed, not all of the spending slowdown is due to the provisions of the measure. "Other factors appear to have contributed to the sudden flattening of Medicare expenditures, including greater compliance with Medicare payment rules and a longer time for processing claims," Van de Water told the committee. Also urging Congress to go slowly was the Clinton administration. "We should be cautious about making changes to the BBA until we consider information and evidence of problems in beneficiary access to quality care," testified Robert Berenson of the Health Care Financing Administration.

While the analysts recommended against a wholesale reopening of the 1997 act — "you could find yourself right back where you were before 1997," warned Wilensky, with Medicare on the brink of insolvency — they did say some targeted changes are in order. For example, both the GAO and MedPAC said there are some indications Medicare is not paying enough for the sickest nursing home patients, making it difficult for those patients to find care and sometimes leaving them stranded in hospitals. Similarly, MedPAC is worried the new payment system for outpatient hospital care is "too aggregative," said Wilensky, paying too much for some services and not enough for others. Congress, however, still appears on track to "give back" at least some money to beleaguered providers. "It's likely there will be some funds put back into the Medicare program," Finance member Roh Graham, D-Fla., told a separate news conference today. — by Julie Rovner

... As Dems Move To Force Managed Care Action In Panel

House Education and the Workforce Committee Democrats, outraged by Republican maneuvers to block them from offering their comprehensive managed care bill when the committee takes up the issue in the coming weeks, today launched their own parliamentary counterattack, invoking a little-used committee rule that could potentially allow them to call the markup on their bill. Breaking up a managed care package unveiled Wednesday by Education and the Workforce Chairman Goodling and Employer-Employee Relations Subcommittee Chairman John Boehner, R-Ohio, into eight separate bills "constitutes a parliamentary maneuver solely designed to avoid more significant reforms contained in the Democrats' Patients' Bill of Rights," said ranking member William (Bill) Clay, D-Mo., at a news conference.

Democrats are particularly upset that by not having a single bill, any attempt by them to add a provision allowing patients to sue their health plans will be ruled out of order. But if Democrats can get three GOP signatures on a petition filed today — they are targeting, among others, Reps. Charles Norwood, R-Ga., Marge Roukema, R-N.J., and Jim Greenwood, R-Pa. — "then we can walk into Goodling's office and tell him when the markup's going to be," said a Clay spokesman. Boehner's subcommittee is tentatively scheduled to begin deliberations on the package next week. — by Julie Rovner

BANKING

Financial Privacy Plays Big Role In Bank Reform Markup

Debate over financial privacy policy figured prominently in today's House Commerce Committee markup of financial services modernization legislation — and is expected to play a central role

**DRAFT TESTIMONY OF
ROBERT A. BERENSON, M.D., DIRECTOR
CENTER FOR HEALTH PLANS & PROVIDERS
HEALTH CARE FINANCING ADMINISTRATION**
on the
**BALANCED BUDGET ACT'S IMPACT
ON FEE-FOR-SERVICE MEDICARE**
before the
SENATE FINANCE COMMITTEE
June 10, 1999

do not want to
talk about it
give backs
in a
specific
way here
b/c of plan.

Chairman Roth, Senator Moynihan, distinguished committee members, thank you for inviting us to discuss the impact of the Balanced Budget Act on Medicare fee-for-service beneficiaries and providers. The BBA includes important new preventive benefits and payment system reforms that promote efficiency and prudent use of taxpayer dollars. These reforms are critical to strengthening and protecting Medicare for the future. The Medicare Trust Fund, which was projected to be insolvent by 1999 when President Clinton took office, is now projected to be solvent until 2015.

We have implemented more than half of the BBA's 335 provisions affecting our programs, including the new preventive benefits such as diabetes education, and a prospective payment system for skilled nursing facilities. In most cases, the statute prescribes in great detail the changes we are required to make. We are committed to affording providers maximum flexibility within our limited discretion as we implement the BBA, and to using the authority we have to continually make refinements that lessen the burden on providers.

Change of this magnitude always requires adjustment. It is not surprising that market corrections would result from such significant legislation. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. Our regional offices are gathering extensive data from around the country to help us determine whether specific corrective actions may be necessary. Consideration of changes to the BBA ~~must be~~ ^{should} based on evidence of problems in beneficiary access to care.

quality
any consideration
of quality —

It is clear that the BBA is succeeding in promoting efficiency and extending the life of the Medicare Trust Fund. However, the BBA is only one factor contributing to changes in Medicare spending. Our actuaries tell us that aggressive efforts to pay correctly and fight fraud, waste, and abuse are also having an impact on total spending. We have set records for convictions,

cautious about making changes to BBA

exclusions, and restitutions. And, for the first time ever, the hospital case mix index is down due to efforts to stop “upcoding,” the practice of billing for more serious diagnoses than patients actually have in order to obtain higher reimbursement. It is also important to note that some of the slowdown in spending growth results from slower claims processing and payment during the transition to new payment systems.

The BBA also is only one factor contributing to provider challenges in the rapidly evolving health care market place. Efforts to pay right and promote efficiency may mean that Medicare no longer makes up for losses or inefficiencies elsewhere. We are concerned about reports about the financial conditions of some providers. However, it is essential that we delineate the BBA’s impact from the effects of excess capacity, discounted rates to other payers, aggressive competition, and other market factors not caused by the BBA. ~~In sorting through the effects of the market, we must remember that Medicare exists to ensure that beneficiaries have access to covered services.~~

New Preventive Benefits

One set of significant changes brought about by the BBA is coverage of key preventive health benefits. We have:

- * expanded coverage for test strips and education programs to help diabetics control their disease;
- * begun covering bone density measurement for beneficiaries at risk of osteoporosis;
- * begun covering several colorectal cancer screening tests;
- * expanded preventive benefits for women so Medicare now covers a screening pap smear, pelvic exam and clinical breast exam every three years for most women, and every year for women at high risk for cervical or vaginal cancer; and,
- * begun covering annual screening mammograms for all women age 40 and over, and a one-time initial, or baseline, mammogram for women ages 35-39, paying for these tests whether or not beneficiaries have met their annual deductibles.

Payment Reforms

The BBA made substantial changes to the way we reimburse providers in the fee-for-service program. We have made solid progress in implementing these payment reforms. For example, we have:

- * modified inpatient hospital payment rules;
- * established a prospective payment system for skilled nursing facilities to encourage facilities to provide care that is both efficient and appropriate;

- * refined the physician payment system, as called for in the BBA, to more accurately reflect practice expenses for primary and specialty care physicians; and
- * initiated the development of prospective payment systems for home health agencies, outpatient hospital care, and rehabilitation hospitals that will be implemented once the Year 2000 computer challenge has been addressed; and,
- * begun implementing an important test of whether market forces can help Medicare and its beneficiaries save money on durable medical equipment.

Monitoring Access

Access, quality, aff for bennies

The payment reforms have created change for many of our providers. In response to concerns raised by providers, we are taking proactive steps to look for objective evidence of any adverse impact on beneficiary access to care resulting from BBA payment reforms. As mentioned above, consideration of changes to the BBA must be based on evidence of problems in beneficiary access to care and, in fact, the percentage of providers who signed Medicare participation agreements increased by more than 6 percent to a record 85 percent for 1999. [We are very aware of provider concerns regarding BBA reforms and we are committed to ensuring that beneficiaries have access to care.] Therefore, we are systematically gathering data from media reports, beneficiary advocacy groups, providers, Area Agencies on Aging, State Health Insurance Assistance Programs, claims processing contractors, State health officials, and other sources to look for objective evidence of the impact of BBA changes on access to care.

We are examining information available from the Securities and Exchange Commission and Wall Street analysts on leading publicly traded health care corporations. This can help us understand trends and Medicare's role in net income, revenues and expenses, as well as provide indicators of liquidity and leverage, occupancy rates, states-of-operation, lines of business exited or sold by the company, and other costs which may be related to discontinued operations.

[We are monitoring Census Bureau ^{live} data, which allow us to gauge the importance of Medicare in each health service industry, look at financial trends in revenue sources by major service sectors, and track ^{live} profit margin trends for tax-exempt providers.]

We are monitoring the Bureau of Labor Statistics monthly employment statistics for employment trends in different parts of the health care industry. Such data shows, for example, that the total number of hours worked by employees of independent home health agencies is at about the same level as in 1996. That provides a more useful indicator of actual home health care usage after the BBA than statistics on the number of agency closures and mergers.

We are being assisted by our colleagues at the HHS Inspector General's office. They have agreed to study the impact of the BBA's \$1500 limits on outpatient rehabilitation therapy. They have also agreed to interview hospital discharge planners as to whether they are having difficulty placing beneficiaries in home health care or skilled nursing facilities. Results of that study should help provide information in addition to a survey done for the Medicare Payment Advisory Commission of home health agencies which suggested that some might be avoiding or prematurely discharging high-cost beneficiaries. And, because home health beneficiaries are among the most vulnerable, we have established a workgroup to develop an ongoing strategy for monitoring beneficiary access and agency closures.

do we want to
use the IG to
do quality?

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mention
them @
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~~Spending Changes~~

put up front reasons why spending
Medicare spending has slowed significantly since the BBA's enactment of the BBA, but not just because of the BBA. The most recent Trustee's report projects the Part A Trust Fund will remain solvent until 2015, seven years beyond their projection just last year. Part B spending growth
~~also slowed from an average five-year growth rate of X percent to Y percent.~~ dropped

The HCFA actuaries attribute this slowdown in overall spending to a number of factors, including low inflation from a strong economy, successful program integrity efforts, and a temporary slowdown in claims processing due to BBA changes. The cumulative effect of these changes resulted in the first ever real-dollar spending decline in fiscal 1998.

However, our actuaries tell us it is not possible to accurately determine what portion of savings is due to the BBA and what portion is due to the other factors. The Trustee's overall five-year baseline for fiscal 1998-2002 is now projected to be \$X. That is about \$X billion, or X percent, lower than the actuaries' projection of \$X billion when the BBA was enacted.

A significant portion of the difference is due to lower spending estimates for home health and skilled nursing facilities, two areas where spending controls were most needed. Between 1990 and 1997 home health and skilled nursing facility spending had both more than quadrupled. The decrease in home health spending is partly a result of slower claims payment. This slowdown was related to increased medical review to ensure claims are accurate and to billing procedure changes, such as a sequential billing rule that helped facilitate the transfer of payment for care not related to inpatient hospital care from Part A to Part B. We have revised our sequential billing requirements, effective July 1, which should speed up claims processing time.

As with home health, some of the drop in skilled nursing facility spending is attributable to our program integrity efforts, and some payment lags.

Specific BBA Provisions

Home Health: The BBA closed loopholes that had invited fraud, waste and abuse. For example, it stopped the practice of billing for care delivered in low cost, rural areas for care from urban offices at high urban-area rates. It tightened eligibility rules so patients who only need blood drawn no longer qualify for the entire range of home health services. And it created an interim payment system to be used while we develop a prospective payment system. We expect to have the prospective payment system in place by the October 1, 2000 statutory deadline. We expect to publish a proposed regulation this October so we can begin receiving and evaluating public comments, and a final rule in July 2000.

The interim payment system is a first step toward giving home health agencies incentives to provide care efficiently. Before the BBA, reimbursement was based on the costs they incurred in providing care, subject to a per visit limit, and this encouraged agencies to provide more visits and to increase costs up to their limit. The interim system includes a new, aggregate per beneficiary limit designed to provide incentives for efficiency until the prospective payment system can be implemented.

Last year Congress raised the limits on costs somewhat in an effort to help agencies, particularly those that had been providing care efficiently all along and thus were being paid less than other agencies under the interim system. We are also taking steps to help agencies adjust to these changes, and in March we held a town hall meeting to hear directly from home health providers about their concerns. We are giving agencies up to a year to repay overpayments resulting from the interim payment system. We have limited random prepayment medical reviews to no more than 10 percent of claims for an agency and no more than 10 percent of claims in a State. And, as mentioned above, we are ending the sequential billing policy that had raised cash flow concerns for some agencies. At the same time, are implementing the Outcome and Assessment Information Set (OASIS). OASIS fulfills a statutory mandate for a "standardized, reproducible" home care assessment instrument. It will help home health agencies determine what patients need. It will help improve the quality of care. And it is essential for accurate payment under prospective payment.

Investigations by us and the GAO have not found that reduced home health spending is causing access problems. However, as mentioned above, because home health beneficiaries are among the most vulnerable, we are planning for ongoing detailed monitoring of beneficiary access and

agency closures.

market basket
admin but REJECTED
b/c PPI is for all providers
\$ is going down

Skilled Nursing Facilities: We implemented the new skilled nursing facility prospective payment system called for in the BBA on July 1, 1998. The old payment system was based on actual costs and included no incentives to provide care efficiently. The new system uses mean-based prices adjusted for each patient's clinical condition and care needs, as well as geographic variation in wages. It creates incentives to provide care more efficiently by relating payments to patient need, and enables Medicare to be a more prudent purchaser of these services.

The BBA mandated a per diem prospective payment system covering all routine, ancillary, and capital costs related to covered services provided to beneficiaries under Medicare Part A. The law is very prescriptive. It requires use of 1995 as a base year, and implementation by July 1, 1998 with a four year transition. It did not allow for exceptions to the transition, carving out of any service, or creation of an outlier policy. ~~We are committed to making changes administratively, to the very limited extent allowed under the law, to ease the burden on providers.~~

We held a town hall meeting earlier this year to hear a broad range of provider concerns. There were concerns that the prospective payment system does not fully reflect the costs of non-therapy ancillaries such as drugs for high acuity patients. We share these concerns and are conducting research that will serve as the basis for refinements to the resource utilization groups that we expect to implement next year. And we fully expect that we will need to periodically evaluate the system to ensure that it appropriately reflects changes in care practice and the Medicare population. We are concerned about anecdotal reports of problems resulting from the prospective payment system. As stated earlier, we have asked the HHS Inspector General to investigate.

Outpatient Rehabilitation Therapy: The BBA imposed \$1500 caps on the amount of outpatient rehabilitation therapy services that can be reimbursed. We are very concerned about anecdotal reports about the adverse impact of these limits. While spending controls are in order, \$1500 may not be sufficient to cover necessary care for all beneficiaries. Because of our concern, our HHS Inspector General colleagues have agreed to study the impact of the BBA's \$1500 limit on outpatient rehabilitation therapy to help us judge whether and how any adjustments to the cap should be made.

Hospitals: We have implemented the bulk of the inpatient hospital-related changes included in the law. ~~There is no one more concerned than Admin~~
~~closed government~~

the BBA in updated regulations. We have implemented substantial refinements to hospital Graduate Medical Education payments and policy to encourage training of primary care physicians, promote training in ambulatory and managed care where beneficiaries are receiving more and more services, curtail increases in the number of residents, and slow the rate of increase in spending. We have implemented provisions designed to strengthen rural health care systems. And we froze inpatient hospital payments in fiscal year 1998, as required under the BBA, resulting in substantial savings to taxpayers and the Medicare Trust Fund.

The BBA also called for a prospective payment system for outpatient care, which we expect to implement next year. The outpatient prospective payment system will include a gradual correction to the old payment system in which beneficiaries were paying their 20 percent copayment based on hospital charges, rather than on Medicare payment rates.

Regrettably, implementation of the prospective payment system as originally scheduled would have required numerous complex systems changes that could substantially jeopardize our Year 2000 efforts. We are working to implement this system as quickly as the Year 2000 challenge allows. We issued a Notice of Proposed Rule Making in September 1998 outlining plans for the new system so that hospitals and others can begin providing comments and suggestions. We are making data files available to the industry, and we have extended the comment period until June 30, 1999 so the industry and other interested parties will have sufficient time and information to comment.

We do have greater concern for rural, inner city, cancer, and teaching hospitals because our analysis suggests that the outpatient prospective payment system will have a disproportionate impact on these facilities. ~~One possible avenue to assist these hospitals might be to make budget-neutral adjustments during the transition to outpatient prospective payment to increase payments to these facilities.~~

If we obtain evidence that help in the transition to outpatient prospective payment is warranted for all hospitals, we could delay implementing what is known as a "volume control mechanism." The law requires such a mechanism because prospective payment includes incentives that can lead to unnecessary increases in the volume of covered services. Delaying volume caps would provide some financial relief as providers adjust to the new system.

Physicians: As directed by the BBA, we have begun implementing the resource-based system for practice expenses under the physician fee schedule, with a transition to full implementation by 2002 in a budget-neutral fashion that will raise payment for some physicians and lower it for

Weinstein ~~for~~ Terry
Tang

others. The methodology we used addresses many concerns raised by physicians and meets the BBA requirements. We fully expect to update and refine the practice expense relative value units in our annual regulations revising the Medicare fee schedule. We plan to include the BBA-mandated resource-based system for malpractice relative value units in this year's proposed rule. We welcome and encourage the ongoing contributions of the medical community to this process, and we will continue to monitor beneficiary access to care and utilization of services as the new system is fully implemented.

We also are seeking legislation to refine the BBA's Sustainable Growth Rate for physician payment. Medicare payments for physician services are annually updated for inflation and adjusted by comparing actual physician spending to a national target for physician spending. The BBA replaced the former physician spending target rate of growth, the Medicare Volume Performance Standard, with the Sustainable Growth Rate (SGR). The SGR takes into account price changes, fee-for-service enrollment changes, real gross domestic product per capita, and changes in law or regulation affecting the baseline.

After BBA was enacted, HCFA actuaries discovered that the SGR system is unstable, and would result in unreasonable fluctuations from year to year. Also, once the SGR target is set for a year, it cannot be changed, even to correct for estimation errors or if better data on elements in the SGR formula become available. The President's fiscal 2000 budget contains a legislative proposal for a budget-neutral technical correction [The proposal would correct projection errors automatically beginning with the 2000 SGR, and make budget neutral adjustments for the 1998 and 1999 SGRs for those two years.]

CONCLUSION

The BBA made important changes to the fee-for-service Medicare program to strengthen and protect it for the future. These changes, along with a strong economy and our increased efforts to combat fraud, waste, and abuse, have extended the life of the Trust Fund until 2015. Change of the magnitude encompassed in the BBA inevitably requires adjustment and fine tuning. We welcome the opportunity to look at any new evidence regarding beneficiary access to care. We are actively gathering such data ourselves, and we are committed to making refinements to the BBA that are within our administrative authority in order to ease the burden on providers. We are also committed to working with Congress and providers to make any midcourse corrections that may be needed to protect beneficiary access to covered services.

However, it would be a mistake to backtrack on the actions behind these historic changes in the

absence of concrete, objective data that beneficiary access to care is being adversely affected.

We have a fiduciary responsibility to assure that Medicare does not overpay providers regardless of the baseline or status of the Trust Fund. ~~And surely no one would argue that the substantial~~

~~savings from successful efforts to fight fraud, waste, and abuse should go to providers rather than~~
~~taxpayers.~~

We look forward to continuing to work with this Committee to identify problems, and we will keep you up to date on the status our of implementation of the BBA. I thank you for holding this hearing, and I am happy to answer your questions.

#



Elder Health, Inc. 1001 West Pratt Street, Baltimore, MD 21223 Ph: 410/864-4460 (Corporate Office) Fx: 410/864-4467

FACSIMILE TRANSMITTAL COVER SHEET

TO:	Devore Adler
COMPANY:	
PHONE:	202 456 5707
FAX:	202 456 5557

FROM:	David Carliner-SVP of Development	Ph: 410 864 4461	Fx: (410) 864-4467
DATE:	6/7/99 4:31 PM		
RE:	Letter to Chris Jennings follows		
# of PAGES	2 (Including cover sheet)		

COMMENTS:

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...

June 3, 1999

The Honorable Christopher C. Jennings
Deputy Assistant to the President for
Health Policy Development
The White House
Old Executive Office Building – Room 216
Washington, D.C. 20502

Dear Chris:

Thank you for meeting with Bruce Yarwood and me yesterday. I appreciate your offer to work with HCFA to obtain an administrative solution to our problem.

To recap, here is the situation:

HCFA has proposed, pursuant to BBA, to implement a risk adjusted payment methodology for Medicare HMOs. They propose an interim system based only on hospital admissions. Ultimately, the system will be based on encounter data from many sites of care.

This initiative is designed to get HMOs to take sicker patients.

The interim payment system will reduce payments to HMOs by approximately 7%.

Reimbursement for institutionalized Medicare HMO members will fall by 40%+.

A handful of specialized programs, operating as subcontractors to Medicare HMOs, enhance the level of primary care in nursing homes and thus reduce the need for hospitalization.

Significant public policy objectives are met through these programs. They allow Medicare HMOs to manage a sick population in a meaningful and beneficial way. They also enable nursing homes to enhance the level of care provided to their residents.

The proposed payment methodology, if implemented, will eliminate these specialized programs. Many of the people in these programs will revert to Medicare FFS. Certainly HMOs will not grow membership of institutionalized beneficiaries.

We request that specialized programs serving institutionalized Medicare HMO members be exempted from PIP and be paid under the current payment system until the full risk adjustment system can be implemented.

The proposed exemption will add no cost to the system because the current payment system produces rates which approximate the cost for these individuals under fee-for-service. If a cost were associated with this exemption, the impact on the system would be minimal, as there are less than 20,000 beneficiaries in these programs today.

I hope that you find this information helpful. Feel free to call me at (410) 864-4461 should you have any questions.

Sincerely,

David Carliner
Senior Vice President-Development

cc: Mr. Bruce Yarwood

THE WHITE HOUSE

WASHINGTON

October 19, 1999

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

It was a pleasure to meet with you and Senator Moynihan earlier this month to discuss our mutual commitment to strengthening and modernizing Medicare. It continues to be my hope that the Congress will take action this year to, at minimum, make a down-payment on needed reforms of the program. I look forward to working with you toward that end.

In 1997, the Medicare trustees projected that Medicare would become insolvent in 2001. Working together across party lines, the Congress passed and I enacted important reforms that contributed towards extending the life of the Medicare trust fund to 2015. As with any major legislation, the Balanced Budget Act (BBA) included some policies that are flawed or have had unintended consequences that are posing immediate problems to some providers and beneficiaries. In addition, the program faces the long-term demographic and health care challenges that will inevitably result as the baby-boom generation ages into Medicare. As we worked together in 1997 to address the immediate threat to Medicare, we must work together now to address its short-term and long-term challenges.

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

You have requested a summary of the administrative actions that I plan to take to moderate the impact of the BBA. In the letter that you sent to me last Thursday, you also asked about four specific issues related to payment for hospital outpatient departments, managed care, skilled nursing facilities, and disproportionate share hospitals.

Attached is a summary of the over 25 administrative actions that my Administration is currently implementing or will take to address Medicare provider payment issues. The Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will accrue to the benefit of hospitals, nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was to not impose an additional reduction in aggregate payments for hospitals and I favor a policy that achieves this goal. The enactment of clarifying language on this subject would be useful in making clear Congressional intent with regard to this issue. I have attached a letter from Office of Management and Budget Director Jack Lew, which was sent at the request of Congressman Bill Thomas, detailing how such language would be scored by OMB.

With regards to managed care, we share your commitment to expanding choice and achieving stability in the Medicare+Choice marketplace. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support my Administration's risk adjustment plan. Consistent with this position, most policy experts believe that a further slowdown of its implementation is unwarranted. However, we remain committed to making any and all changes that improve its methodology. Moreover, as you know, any administrative and legislative changes that increase payment rates to providers in the fee-for-service program will also increase payments to managed care plans.

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. While we believe that these adjustments must be budget neutral, we are continuing to review whether we have additional administrative authority in this area.

Finally, it appears that there has been confusion about the current policy for disproportionate share hospital (DSH) payments. Hospitals across a considerable number of states have misconstrued how to calculate DSH payments. The Department of Health and Human Services (HHS) has since concluded that this resulted from unclear guidance. Thus, as reported last Friday, HHS will not recoup past overpayments and will issue new, clearer guidance as soon as possible.

We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care.

I hope and expect that our work together will lay the foundation for much broader and needed reforms to address the demographic and health care challenges confronting the program. We look forward to working with you, as well as the House Ways and Means and Commerce Committees, as we jointly strive to moderate the impact of BBA on the nation's health care provider community.

Sincerely,

A handwritten signature in black ink, appearing to read "Ben Clinton". The signature is fluid and cursive, with a long horizontal stroke at the end.

**ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

ISSUE		STATUS
	HOSPITALS: GENERAL	
✓	Capping hospital transfer policy at 10 DRGs for 2 years, through '02	Now being implemented
✓	Stop administrative recoupment of DSH payments based on unclear guidance	Now being implemented
	HOSPITALS: OUTPATIENT	
**	Eliminate the 5.7 percent payment reduction resulting from drafting problem in the Balanced Budget Act	Under review
✓	Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions	Planned for regulation early next year*
✓	Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS)	Planned for regulation early next year*
✓	Delay implementation of prospective payment system for cancer hospitals until additional data are collected	Planned for regulation early next year*
✓	Make technical refinements to the Ambulatory Payment Classification (APC) system	Planned for regulation early next year*
✓	Allow for temporary cost-based APCs for certain new technologies	Planned for regulation early next year*
✓	Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs)	Planned for regulation early next year*
✓	Create separate APCs to pay for blood and blood products	Planned for regulation early next year*
✓	Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery	Planned for regulation early next year*
✓	Eliminate use of diagnostic codes in payments for medical visits and reassess in the future	Planned for regulation early next year*
	SKILLED NURSING FACILITIES	
✓	Increase payment for high acuity patients	Will be implemented
✓	Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy	Now being implemented
	HOME HEALTH	
✓	Delay tracking patients and pro-rating payments	Now being implemented
✓	Provide for extended interim payment system repayment schedules for agencies	Now being implemented
✓	Postpone the requirement for surety bonds until October 1, 2000	Now being implemented
✓	Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues	Now being implemented

ISSUE		STATUS
✓	Eliminate the sequential billing rule	Will be implemented
✓	Phase in reporting of services in 15-minute increments	Will be implemented
PHYSICIANS		
**	Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions	Under review
RURAL PROVIDERS		
✓	Change the average wage threshold percentages so more rural hospitals can reclassify	Will be implemented
✓	Use same wage index for inpatient and outpatient PPS	Planned for regulation early next year*
✓	Provide stop-loss protection in the transition to the outpatient PPS	Planned for regulation early next year*
**	Modify Health Professional Shortage Area designations	Under review
AMBULATORY SURGICAL CENTERS		
X	Postpone implementation based on 1999 survey	
MANAGED CARE		
✓	Phase-in risk adjustment over a 5-year period	Now being implemented
✓	Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension	Now being implemented
X	Phase-in risk adjustment over a 7-year period	
✓	Improve beneficiary protections and access to information	Now being implemented
✓	Ease provider participation rules	Now being implemented

"X" indicates that this policy is not advisable, as described in the attachment.

*Federal law requires that the Administration cannot commit to changes in a proposed rule before the final publication.

**Under review.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

Dear Mr. Chairman:

I am writing to respond to your request regarding how the Administration would score the attached language clarifying Congressional intent on the outpatient prospective payment system (PPS) enacted in the Balanced Budget Act (BBA).

As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of \$7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

Jacob J. Lew
Director

SEC. ____ .INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.

**DESCRIPTION OF ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE THE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

HOSPITALS: GENERAL

Capping hospital transfer policy at 10 DRGs for 2 years, through 2002. We will postpone for two years the extension of the hospital transfer policy to additional diagnoses beyond the current set of 10 Diagnosis Related Group (DRG) categories. We also will consider whether further postponement of extension to additional diagnoses is warranted.

Stop administrative recoupment of DSH payments based on unclear guidance. We have recently determined that certain hospitals received additional disproportionate share hospital (DSH) payments because guidance on how to claim these funds was insufficiently clear. We will therefore hold harmless hospitals that have received these additional payments. We also will soon clarify guidance to hospitals and our claims processing contractors on how to claim these funds. And we will provide further clarification to State Medicaid agencies because they are the primary source of data critical to the DSH calculations. We will apply the clarified policy and hold hospitals responsible for being in compliance as of January 1, 2000.

HOSPITAL OUTPATIENT PAYMENTS

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was for this policy to be implemented in a way that is budget neutral for hospitals and the Administration favors a policy that achieves this goal. Unfortunately, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. In addition, there are a number of changes that we believe are necessary to address specific policy concerns and moderate the payment reductions in the Medicare prospective payment system (PPS) for outpatient departments. Although we are prohibited by law from committing to changes before the final rule is published, we can outline the approaches we believe are consistent with Administration policy and expect to take in the outpatient department rule. These include:

Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions. We expect to delay implementing the proposed "volume control mechanism." The statute requires the agency to develop a volume control mechanism. In the proposed rule, we suggested use of a mechanism that might lead to a downward adjustment in the payment rates as early as 2002 (to reflect volume increases in 2000). Delaying this mechanism would provide time for providers to adjust to the new system.

Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS). We expect to include a 3-year transition to the new PPS by making budget-neutral adjustments that will increase payments to hospitals that would otherwise incur large payment reductions. These hospitals would include certain rural, inner city, cancer, and teaching hospitals. Some hospitals, like cancer hospitals, are projected to experience a reduction in excess of 30 percent. This transition policy would ensure that payments do not drop below a specified threshold to protect against such reductions.

Delay implementation of prospective payment system for cancer hospitals until additional data are collected. The lack of reliable data from cancer centers makes developing a prospective payment system for them difficult. Consequently, we now expect to delay full implementation of the PPS system for the cancer hospitals and to use an interim payment system for at least 18 months from the initiation date of PPS for other hospitals. We would not end this interim system until we are ready to implement a prospective system for cancer hospitals based on full information.

Make technical refinements to the Ambulatory Payment Classification (APC) system. We plan to make changes to address the many technical comments received regarding the proposed Ambulatory Payment Classification (APC) system as part of the final rule, including the detailed comments from MedPAC. We also plan to address the many other comments, including those related to the appropriateness of the system for categories of providers, in the final rule. And we have hired another independent, outside contractor, Kathpal, to provide additional private-sector expertise as we address problems with the data we have on the cost of chemotherapeutic agents. This contractor is examining a random sample of patients who need chemotherapy and other high-cost drug costs to advise us on possible methods and data for assuring adequate payment for these drugs. We believe that further outside reviews would delay the implementation of the system and the planned reductions in beneficiary out-of-pocket expenses.

Allow for temporary cost-based APCs for certain new technologies. Concerns have been raised about the adequacy of payments in APCs for medical technologies that are new (and hence are not reflected in the data bases on which we do our estimates) and where the cost of the item is very large relative to the payment for the APC. In some instances it may be possible to accommodate new, high-cost technology items within the APCs. In others, we expect to specify in advance and use a set of cost-related APCs for some period of time while better data about actual costs are collected.

Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs). Packaging payments for certain covered drugs with the procedure or visit with which they are furnished could underpay hospitals and slow the introduction of new drugs into the system. Thus, we anticipate creating additional APCs to pay for certain drugs, particularly high-cost drugs. Where appropriate, we would permit billing for multiple APCs depending on dosages actually used. With respect to chemotherapy, we expect to substantially increase the number of APCs for chemotherapy agents to minimize the variability within groups and assure beneficiary access is not compromised. We would also create APCs for supportive and adjunctive therapies.

Create separate APCs to pay for blood and blood products. Under the proposed rule, we would pay for blood and blood products as part of the payment for a surgical procedure or blood transfusion service. As a result of concerns raised in comments, we have reconsidered our proposal and now expect to implement separate APCs to pay for blood, other blood products and anti-hemophilic factors.

Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery. Under the proposed rule, we would pay for corneal tissue acquisition costs as part of the payment for corneal transplant surgery. Given the variable rates at which hospitals acquire the tissue from eye banks, we are likely to accept the recommendation to decouple payment for tissue acquisition from that for the surgical procedure and to pay for it, at least until further experience is gained, based on acquisition cost.

Eliminate use of diagnostic codes in payments for medical visits and reassess use in future. The proposed rule based payments for medical visits to clinics and emergency departments on codes for both medical procedures and diagnosis. Because diagnostic codes are not used in payment for all other services, we now expect to revise our medical groups by eliminating the use of diagnostic codes in computing payment amounts for the present.

SKILLED NURSING FACILITIES (SNF) PAYMENTS

Increase payment for high acuity patients. We will use administrative flexibility to increase relative weights for the Resource Utilization Groups for high acuity patients under the Skilled Nursing Facility Prospective Payment System (SNF PPS). We expect to have research findings on advisable refinements completed by the end of this year and to include them in a proposed rule next Spring, for implementation in October 2000. We believe these changes should be budget neutral. However, we are continuing to review whether we have additional administrative authority.

Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy. Using the limited administrative discretion afforded by the statute, we have excluded these types of services performed in hospital outpatient departments from the SNF PPS bundle. We have done so because such services are exceptionally intensive and well beyond the scope of SNF care plans. We received a significant number of comments, both in response to last year's interim final rule, and at a national Town Hall meeting we held to solicit comments on SNF PPS. We are examining whether any additional hospital outpatient services (e.g., chemotherapy) could be carved out within the scope of our present administrative authorities, but believe that legislation is necessary to exclude these or other services (e.g., prostheses) categorically.

HOME HEALTH PAYMENTS

Delay tracking patients and pro-rating payments. Although fiscal intermediaries are responsible for tracking and pro-rating payments, we were unable to make the necessary systems changes to accomplish this due to our efforts related to Year 2000 computer systems requirements. Therefore, we are delaying implementation of the requirement until the implementation of the prospective payment system. We have developed a way to implement this proposal under the prospective payment system that will allow fiscal intermediaries and HCFA to more directly track beneficiaries. We also want to clarify that the law does not make home health agencies responsible for tracking utilization for purposes of pro-rating payments.

Provide for extended interim payment system repayment schedules for agencies. As part of our Medicare reform plan, we are allowing agencies an automatic 36 months to repay excess interim payment system (IPS) overpayments. The first year is interest-free.

Postponing the requirement for surety bonds until October 1, 2000. We are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds.

Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues. We are also following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

Eliminate the sequential billing rule. As of July 1, 1999, we eliminated the sequential billing rule. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree.

Phase in reporting of services in 15-minute increments. We are phasing in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provision. By allowing this degree of flexibility for a temporary period, we will prevent any agency cash flow problems or returned claims.

PHYSICIAN PAYMENTS

Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions. As we indicated in the *Federal Register* on October 1, 1999, at this time, we do not believe we have the ability under current law to make adjustments to revise the Sustainable Growth Rate (SGR) based on later data. We agree that there is a problem and thus have submitted, as part of the FY 2000 budget, a budget-neutral legislative proposal to require that revisions be made to correct estimation errors in calculation of the SGR and to fix other technical aspects of the SGR. However, we are continuing to review whether we have any ability administratively to address this issue.

RURAL PROVIDER PAYMENTS

Change the average wage threshold percentages so more rural hospitals can reclassify. We are implementing policies making it easier for rural hospitals, whose payments now are based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are planning to change those average wage threshold percentages in the FY 2001 hospital regulation so more hospitals can be reclassified.

Use same wage index for inpatient and outpatient PPS. In the proposed rule, we expect to help rural hospitals by using the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

Modify Health Professional Shortage Area designations. We are also working to address other concerns of rural providers, where we can, through administrative actions. The Health Care Financing Administration has formed a high-level working group on rural health to work with providers to identify both administrative and legislative issues and resolve those that we have the authority to address under current law. For example, we are working with the Health Services and Resources Administration to modify the Health Professional Shortage Area designations. We are also considering changes to policies related to Critical Access Hospitals, Graduate Medical Education payments for rural providers, and wage indices for rural providers.

AMBULATORY SURGICAL CENTER (ASC) PAYMENTS

Postpone implementation based on 1999 survey. We plan to publish the final rule on payment policy changes for ASCs next spring and implement the new system in July 2000. The current ASC rates have been in place since 1990 and are based on 1986 survey data. We appreciate the desire to incorporate more current data. However, the process of sending out and having the ASCs complete the surveys, auditing the surveys, analyzing the data, writing a proposed rule, commenting on a proposed rule, and issuing a final rule is lengthy. If we were to delay implementing payment changes until the 1999 survey data are incorporated, we would have to delay the payment policy changes planned for July 2000 for an additional three years.

MEDICARE +CHOICE PAYMENTS

Phase in risk adjustment over a 5-year period. In March, we announced a five-year transition to comprehensive risk adjustment for Medicare+Choice plans to minimize the disruption to plans. We plan to begin the transition in 2000 with a 90/10 blend of demographically and risk adjusted rates. This blend will be gradually increased over five years so that in 2004, rates will be fully risk adjusted using a comprehensive adjustment system that takes into account all care settings.

We believe that this five-year transition strikes the appropriate balance between concern for plans and our obligation to be fiscally responsible and ensure that plans are paid fairly and appropriately for the care they provide, especially to the sickest beneficiaries. Our actuaries estimate that this transition schedule will cost the Medicare Trust Funds \$4.5 billion more than full implementation of risk adjustment in 2000. Our current phase-in schedule prevents plans from experiencing more than a five to ten percent shift in rates in the first few years. For example, based on our impact analyses using 1997 and 1998 plan data, no plan would face more than a 1.85 percent reduction in 2000 and plans on average would face only a 0.7 percent reduction in 2000. Significant differences in later years would indicate that a plan's enrollees are substantially healthier than average, in which case it is appropriate to pay more to other plans that are caring for less healthy enrollees. A number of experts, including the Medicare Payment Advisory Commission, support this approach. We would like to work with Congress and other interested parties to further review technical modifications to improve Medicare+Choice risk adjustment.

Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension. For EverCare managed care plans that provide specialized services to the frail elderly, we are extending this demonstration project for an additional year through December 31, 2001. We also will continue the exemption from risk adjustment during this extension. This will provide additional time to complete our evaluation of this project. It also will allow EverCare to submit additional data on the special population it serves, which we can analyze for possible use in refinement of our risk adjustment methodology.

Improve beneficiary protections and access to administration. We also published refinements to Medicare+Choice regulation that improve beneficiary protections and access to information. For example, we clarified that any beneficiary who is enrolled in a Medicare+Choice plan that withdraws from the program is entitled to immediate enrollment in any other remaining Medicare+Choice plan serving the enrollee's area.

Ease provider participation rules. We have taken additional steps to assist plans and encourage their participation in Medicare+Choice. We worked with Congress to give plans two more months to file the information used to approve benefit and premium structures so plans are able to use more current experience when designing benefit packages and setting cost sharing levels. We also eased provider participation rules and increased flexibility for plans in coordinating care for enrollees with serious or complex conditions and in conducting initial health assessments for new enrollees.

Peter
65053



OCT 1 5 1999

The Honorable William V. Roth, Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Roth:

Knowing of your interest in Medicare's policy for determining certain hospital payment adjustments, I am writing you today to inform you of a new development in this area. The Health Care Financing Administration will hold harmless hospitals that have received certain additional Medicare disproportionate share hospital (DSH) payments because guidance on how to claim these funds was not sufficiently clear.

As you know, the DSH formula provides additional funds to hospitals that serve low income Americans. A review of the practices and policies regarding Medicare DSH determinations leads us to conclude that our guidance on the calculation of Medicare DSH, particularly with regard to the inclusion of general assistance days, was neither sufficiently clear nor well understood. The most recent guidance to hospitals on this matter was provided prior to 1998. Many hospitals, fiscal intermediaries and state Medicaid agencies have differing understandings about the particulars of the DSH calculation. We have been actively gathering facts about practices of entities involved in Medicare DSH determinations, and we now have available the information we need to resolve the confused situation we observe.

We will quickly clarify our Medicare DSH policy in guidance both to our fiscal intermediaries and to hospitals. We will also provide clarification of our policy to state Medicaid agencies to ensure that data they submit for use in making DSH determinations comport with our DSH formula. Medicaid data are critical to the DSH calculation, and the state Medicaid agencies are the primary source of the data in question. The forthcoming guidance will be effective for hospital Medicare cost reporting periods beginning on or after January 1, 2000.

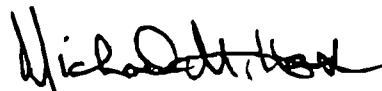
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The Honorable William V. Roth – Page 2

For hospital Medicare cost reporting periods beginning on or before December 31, 1999, our intermediaries will not disallow the portion of DSH payments claimed that reflect this misunderstanding of the DSH formula where a hospital had previously claimed and received Medicare DSH payments under the incorrect formula. This will apply to both open and closed cost reports. Where fiscal intermediaries have disallowed the portion of DSH reimbursement claimed under our insufficiently clear DSH policy, and the hospitals timely pursued their administrative remedies, the disallowances will be reversed and, where necessary, repaying the hospitals the amounts that had been recouped.

We believe the hospitals should be held harmless in light of the existing confusion. I look forward to continuing to work with you in the future on matters of mutual importance.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Hash", written in a cursive style.

Michael Hash
Deputy Administrator



OCT 15 1999

The Honorable Michael Bilirakis, Chairman
House Commerce Committee
Subcommittee on Health and Environment
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

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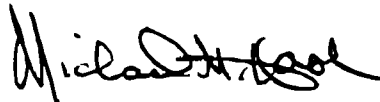
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The Honorable Michael Bilirakis – Page 2

For hospital Medicare cost reporting periods beginning on or before December 31, 1999, our intermediaries will not disallow the portion of DSH payments claimed that reflect this misunderstanding of the DSH formula where a hospital had previously claimed and received Medicare DSH payments under the incorrect formula. This will apply to both open and closed cost reports. Where fiscal intermediaries have disallowed the portion of DSH reimbursement claimed under our insufficiently clear DSH policy, and the hospitals timely pursued their administrative remedies, the disallowances will be reversed and, where necessary, repaying the hospitals the amounts that had been recouped.

We believe the hospitals should be held harmless in light of the existing confusion. I look forward to continuing to work with you in the future on matters of mutual importance.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Hash", with a stylized flourish at the end.

Michael Hash
Deputy Administrator

- I am calling to let you know that the Administration is clarifying its position regarding Medicare Disproportionate Share Hospital (DSH).
- As you know, Medicare DSH is paid by HCFA to hospitals based on a complicated statutory formula.
- We have recently determined that our guidance on how to claim Medicare DSH funds was neither sufficiently clear nor well understood.
- And, as a consequence of guidance provided to hospitals before 1998, many hospitals have claimed, and were reimbursed for, services that did not meet the criteria of the formula.
- We have been actively gathering facts about this, and we now have the information we need to resolve the situation.
- We will take two actions. First, due to the confusion that resulted from HCFA's guidance, we will hold harmless the hospitals that have been receiving these payments. This will resolve the situation for the hospitals that provide care to the most vulnerable Americans.
- Second, we will clarify our Medicare DSH policy in guidance both to our fiscal intermediaries and to hospitals.
- We will also provide clarification of our policy to state Medicaid agencies to assist them in submitting data for use in making DSH calculation. The Medicaid data is critical to the Medicare DSH calculation, and the use of this data is the primary source of the payments in question.
- After January 1, 2000, we will begin to apply the policy, and we will hold hospitals responsible for their Medicare DSH claims.

For Calls to New Jersey Members:

- We understand that at least some New Jersey hospitals had claimed funds using criteria that did not meet the formula. These claims were denied and the hospital's then appealed the decision. We have decided to allow the hospitals to receive the additional funds.

For Calls to Pennsylvania Members:

- We understand that some funds have already been recouped from at least some hospitals in Pennsylvania. These funds will be reimbursed.

Medicare DSH Policy Questions and Answers

What is being announced?

Q. What is the policy that HCFA is announcing today?

A. HCFA is announcing today that they will hold hospitals harmless that have received additional Medicare disproportionate share hospital (DSH) payments because HCFA guidance on how to claim these funds was not sufficiently clear. The DSH formula provides additional funds to hospitals that serve low-income patients. HCFA will quickly issue additional guidance and apply the policy on January 1, 2000.

Q. How will HCFA correct this problem in the future?

A. HCFA will issue additional guidance to the fiscal intermediaries (effective January 1, 2000) clearly explaining how to calculate Medicare DSH. Moreover, for the first time, we will prepare guidance that will be sent directly to the hospitals and to the State Medicaid agencies. This communication is critical because the hospitals are the ones who are directly responsible for calculating the formula. In addition, for many states, the State Medicaid Agency generates the critical Medicaid data on behalf of hospitals.

Q. Will hospitals be able to claim these additional funds if they have not claimed them previously?

A. No. We are not going to allow hospitals to receive additional funds if they had not already done so in the past. HCFA is announcing that it will hold hospitals harmless that had received additional funds under a very complicated statutory formula for the care provided to low income patients.

Q. What exactly is the confusion for the fiscal intermediaries and the hospitals regarding Medicare DSH?

Medicare DSH is calculated based on a very complicated statutory formula. The confusion centered on the number of Medicaid days counted in the Medicare DSH formula. About 35 states have a program similar to Medicaid known collectively as "General Assistance" and Medicaid waiver programs. These types of days cannot count towards the calculations. Due to insufficiently clear guidance, hospitals in a significant number of states included "General Assistance" days in the Medicare DSH formula.

Q. What is Medicare DSH? How are funds allocated?

A. Medicare provides additional funds to hospitals where a large proportion of the patients served are low-income. Funds are allocated to hospitals based on a statutory formula.

Q. What happens if a hospital was denied the ability to claim these funds by the fiscal intermediary and appealed the decision? Will those hospitals be able to claim these funds?

A. Yes. In situations where a fiscal intermediary disallowed a claim for Medicare DSH that included general assistance and a hospital filed an appeal over that decision with the government, HCFA will allow those hospitals to receive the additional funds.

Q. What does this mean exactly for the hospitals?

In technical terms, HCFA will do the following:

- For hospital Medicare cost reporting periods beginning on or before December 31, 1999, our intermediaries will not disallow the portion of DSH payments claimed that reflect this misunderstanding of the DSH formula where a hospital had previously claimed and received Medicare DSH payments under the incorrect formula. This will apply to both open and closed cost reports.
- Where fiscal intermediaries have disallowed the portion of DSH reimbursement claimed under our insufficiently clear DSH policy, and the hospitals timely pursued their administrative remedies, the disallowances will be reversed and, where necessary, repaying the hospitals the amounts that had been recouped.

What is the Impact?

Q. What does this mean for hospitals in affected States?

A. Beginning January 1, 2000, hospitals will be provided DSH funds for services provided to low-income patients based on the DSH formula with clarifying guidance from HCFA.

Q. How much money is at stake?

A. We did not initiate a comprehensive audit of the funds that may or may not be owed by hospitals in various states.

Q. What States are affected by this decision?

A. Hospitals in a significant number of states are affected by this. Due to concerns raised in a couple of states, HCFA launched a national survey effort to assess the state of the Medicare DSH program. It became obvious that the confusion regarding this issue was pervasive. Given the extent of the confusion, there was no need to complete the process, and it was terminated before final verification of the survey data. As a result, we do not want to comment on the states that may or may not be affected.

[BACKGROUND ONLY: According to the preliminary results of our survey, the states fell into the following categories.

- **Believed to have a Problem – 8 States – Hawaii, Kansas, Massachusetts, Minnesota, New York, New Jersey, Pennsylvania, and Tennessee**
- **Potential Problem, Very Likely – 4 States -- Connecticut, Rhode Island, Maryland, and Missouri**
- **Potential Problems, Some Indication – 9 States – Alabama, Delaware, Colorado, Oregon, South Dakota, Texas, Virginia, Washington, and West Virginia**
- **No Response to Questions – 1 State -- Alaska.]**

Why did this happen?

Q. You said that your guidance was unclear. What was exactly was unclear?

A. Through a national survey, it became clear that almost two-thirds of the 35 States with general assistance day programs or waiver programs (these are the only types of states that could be affected) were potentially collecting funds using criteria not allowed by the formula. Given the depth and the extent of the confusion, it became clear that our guidance on this topic was neither sufficient nor well understood.

Q. Earlier this year, HCFA stated that its guidance on this issue was clear. How could the agency now consider the same guidance to be unclear?

A. HCFA only recently received the results of a national survey regarding DSH policy. This survey showed that hospitals in a significant number of states were claiming funds not allowed under our DSH policy. Given the extensive confusion, it is now clear to us that our guidance was neither clear nor well understood. Therefore, we made our announcement today because we did not fully appreciate the confusion surrounding this policy until now.

Is this policy clarification politically motivated?

Q. When this was only a problem for Pennsylvania, HCFA said it would recoup the funds. When it was found that hospitals in New York owed funds, HCFA changed its interpretation? Is your action today politically motivated?

A. Of course not. Let's be clear on what has happened. When a problem was first identified in Pennsylvania, we believed that the fiscal intermediary and the hospitals in that state had simply misunderstood our guidance. After a similar problem was found in another state, HCFA launched a national, comprehensive effort to identify all the states where Medicare DSH issues may exist. This survey shows that hospitals in a significant number of states was not claiming DSH funds using the criteria in our policy. Therefore, HCFA decided that an argument that our guidance was clear is not supportable. We believe that holding the hospitals in these states harmless will resolve this situation.

**ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

ISSUE	STATUS	
HOSPITALS: GENERAL		
✓	Capping hospital transfer policy at 10 DRGs for 2 years, through '02	Now being implemented
✓	Stop administrative recoupment of DSH payments based on unclear guidance	Now being implemented
HOSPITALS: OUTPATIENT		
**	Eliminate the 5.7 percent payment reduction resulting from drafting problem in the Balanced Budget Act	Under review
✓	Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions	Planned for regulation early next year*
✓	Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS)	Planned for regulation early next year*
✓	Delay implementation of prospective payment system for cancer hospitals until additional data are collected	Planned for regulation early next year*
✓	Make technical refinements to the Ambulatory Payment Classification (APC) system	Planned for regulation early next year*
✓	Allow for temporary cost-based APCs for certain new technologies	Planned for regulation early next year*
✓	Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs)	Planned for regulation early next year*
✓	Create separate APCs to pay for blood and blood products	Planned for regulation early next year*
✓	Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery	Planned for regulation early next year*
✓	Eliminate use of diagnostic codes in payments for medical visits and reassess in the future	Planned for regulation early next year*
SKILLED NURSING FACILITIES		
✓	Increase payment for high acuity patients	Will be implemented
✓	Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy	Now being implemented
HOME HEALTH		
✓	Delay tracking patients and pro-rating payments	Now being implemented
✓	Provide for extended interim payment system repayment schedules for agencies	Now being implemented
✓	Postpone the requirement for surety bonds until October 1, 2000	Now being implemented
✓	Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues	Now being implemented

ISSUE		STATUS
✓	Eliminate the sequential billing rule	Will be implemented
✓	Phase in reporting of services in 15-minute increments	Will be implemented
PHYSICIANS		
**	Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions	Under review
RURAL PROVIDERS		
✓	Change the average wage threshold percentages so more rural hospitals can reclassify	Will be implemented
✓	Use same wage index for inpatient and outpatient PPS	Planned for regulation early next year*
✓	Provide stop-loss protection in the transition to the outpatient PPS	Planned for regulation early next year*
**	Modify Health Professional Shortage Area designations	Under review
AMBULATORY SURGICAL CENTERS		
X	Postpone implementation based on 1999 survey	
MANAGED CARE		
✓	Phase-in risk adjustment over a 5-year period	Now being implemented
✓	Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension	Now being implemented
X	Phase-in risk adjustment over a 7-year period	
✓	Improve beneficiary protections and access to information	Now being implemented
✓	Ease provider participation rules	Now being implemented

"X" indicates that this policy is not advisable, as described in the attachment.

*Federal law requires that the Administration cannot commit to changes in a proposed rule before the final publication.

**Under review.

**DESCRIPTION OF ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE THE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

HOSPITALS: GENERAL

Capping hospital transfer policy at 10 DRGs for 2 years, through 2002. We will postpone for two years the extension of the hospital transfer policy to additional diagnoses beyond the current set of 10 Diagnosis Related Group (DRG) categories. We also will consider whether further postponement of extension to additional diagnoses is warranted.

Stop administrative recoupment of DSH payments based on unclear guidance. We have recently determined that certain hospitals received additional disproportionate share hospital (DSH) payments because guidance on how to claim these funds was insufficiently clear. We will therefore hold harmless hospitals that have received these additional payments. We also will soon clarify guidance to hospitals and our claims processing contractors on how to claim these funds. And we will provide further clarification to State Medicaid agencies because they are the primary source of data critical to the DSH calculations. We will apply the clarified policy and hold hospitals responsible for being in compliance as of January 1, 2000.

HOSPITAL OUTPATIENT PAYMENTS

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was for this policy to be implemented in a way that is budget neutral for hospitals and the Administration favors a policy that achieves this goal. Unfortunately, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. In addition, there are a number of changes that we believe are necessary to address specific policy concerns and moderate the payment reductions in the Medicare prospective payment system (PPS) for outpatient departments. Although we are prohibited by law from committing to changes before the final rule is published, we can outline the approaches we believe are consistent with Administration policy and expect to take in the outpatient department rule. These include:

Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions. We expect to delay implementing the proposed "volume control mechanism." The statute requires the agency to develop a volume control mechanism. In the proposed rule, we suggested use of a mechanism that might lead to a downward adjustment in the payment rates as early as 2002 (to reflect volume increases in 2000). Delaying this mechanism would provide time for providers to adjust to the new system.

Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS). We expect to include a 3-year transition to the new PPS by making budget-neutral adjustments that will increase payments to hospitals that would otherwise incur large payment reductions. These hospitals would include certain rural, inner city, cancer, and teaching hospitals. Some hospitals, like cancer hospitals, are projected to experience a reduction in excess of 30 percent. This transition policy would ensure that payments do not drop below a specified threshold to protect against such reductions.

Delay implementation of prospective payment system for cancer hospitals until additional data are collected. The lack of reliable data from cancer centers makes developing a prospective payment system for them difficult. Consequently, we now expect to delay full implementation of the PPS system for the cancer hospitals and to use an interim payment system for at least 18 months from the initiation date of PPS for other hospitals. We would not end this interim system until we are ready to implement a prospective system for cancer hospitals based on full information.

Make technical refinements to the Ambulatory Payment Classification (APC) system. We plan to make changes to address the many technical comments received regarding the proposed Ambulatory Payment Classification (APC) system as part of the final rule, including the detailed comments from MedPAC. We also plan to address the many other comments, including those related to the appropriateness of the system for categories of providers, in the final rule. And we have hired another independent, outside contractor, Kathpal, to provide additional private-sector expertise as we address problems with the data we have on the cost of chemotherapeutic agents. This contractor is examining a random sample of patients who need chemotherapy and other high-cost drug costs to advise us on possible methods and data for assuring adequate payment for these drugs. We believe that further outside reviews would delay the implementation of the system and the planned reductions in beneficiary out-of-pocket expenses.

Allow for temporary cost-based APCs for certain new technologies. Concerns have been raised about the adequacy of payments in APCs for medical technologies that are new (and hence are not reflected in the data bases on which we do our estimates) and where the cost of the item is very large relative to the payment for the APC. In some instances it may be possible to accommodate new, high-cost technology items within the APCs. In others, we expect to specify in advance and use a set of cost-related APCs for some period of time while better data about actual costs are collected.

Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs). Packaging payments for certain covered drugs with the procedure or visit with which they are furnished could underpay hospitals and slow the introduction of new drugs into the system. Thus, we anticipate creating additional APCs to pay for certain drugs, particularly high-cost drugs. Where appropriate, we would permit billing for multiple APCs depending on dosages actually used. With respect to chemotherapy, we expect to substantially increase the number of APCs for chemotherapy agents to minimize the variability within groups and assure beneficiary access is not compromised. We would also create APCs for supportive and adjunctive therapies.

Create separate APCs to pay for blood and blood products. Under the proposed rule, we would pay for blood and blood products as part of the payment for a surgical procedure or blood transfusion service. As a result of concerns raised in comments, we have reconsidered our proposal and now expect to implement separate APCs to pay for blood, other blood products and anti-hemophilic factors.

Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery. Under the proposed rule, we would pay for corneal tissue acquisition costs as part of the payment for corneal transplant surgery. Given the variable rates at which hospitals acquire the tissue from eye banks, we are likely to accept the recommendation to decouple payment for tissue acquisition from that for the surgical procedure and to pay for it, at least until further experience is gained, based on acquisition cost.

Eliminate use of diagnostic codes in payments for medical visits and reassess use in future. The proposed rule based payments for medical visits to clinics and emergency departments on codes for both medical procedures and diagnosis. Because diagnostic codes are not used in payment for all other services, we now expect to revise our medical groups by eliminating the use of diagnostic codes in computing payment amounts for the present.

SKILLED NURSING FACILITIES (SNF) PAYMENTS

Increase payment for high acuity patients. We will use administrative flexibility to increase relative weights for the Resource Utilization Groups for high acuity patients under the Skilled Nursing Facility Prospective Payment System (SNF PPS). We expect to have research findings on advisable refinements completed by the end of this year and to include them in a proposed rule next Spring, for implementation in October 2000. We believe these changes should be budget neutral. However, we are continuing to review whether we have additional administrative authority.

Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy. Using the limited administrative discretion afforded by the statute, we have excluded these types of services performed in hospital outpatient departments from the SNF PPS bundle. We have done so because such services are exceptionally intensive and well beyond the scope of SNF care plans. We received a significant number of comments, both in response to last year's interim final rule, and at a national Town Hall meeting we held to solicit comments on SNF PPS. We are examining whether any additional hospital outpatient services (e.g., chemotherapy) could be carved out within the scope of our present administrative authorities, but believe that legislation is necessary to exclude these or other services (e.g., prostheses) categorically.

HOME HEALTH PAYMENTS

Delay tracking patients and pro-rating payments. Although fiscal intermediaries are responsible for tracking and pro-rating payments, we were unable to make the necessary systems changes to accomplish this due to our efforts related to Year 2000 computer systems requirements. Therefore, we are delaying implementation of the requirement until the implementation of the prospective payment system. We have developed a way to implement this proposal under the prospective payment system that will allow fiscal intermediaries and HCFA to more directly track beneficiaries. We also want to clarify that the law does not make home health agencies responsible for tracking utilization for purposes of pro-rating payments.

Provide for extended interim payment system repayment schedules for agencies. As part of our Medicare reform plan, we are allowing agencies an automatic 36 months to repay excess interim payment system (IPS) overpayments. The first year is interest-free.

Postponing the requirement for surety bonds until October 1, 2000. We are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds.

Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues. We are also following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

Eliminate the sequential billing rule. As of July 1, 1999, we eliminated the sequential billing rule. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree.

Phase in reporting of services in 15-minute increments. We are phasing in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provision. By allowing this degree of flexibility for a temporary period, we will prevent any agency cash flow problems or returned claims.

PHYSICIAN PAYMENTS

Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions. As we indicated in the *Federal Register* on October 1, 1999, at this time, we do not believe we have the ability under current law to make adjustments to revise the Sustainable Growth Rate (SGR) based on later data. We agree that there is a problem and thus have submitted, as part of the FY 2000 budget, a budget-neutral legislative proposal to require that revisions be made to correct estimation errors in calculation of the SGR and to fix other technical aspects of the SGR. However, we are continuing to review whether we have any ability administratively to address this issue.

RURAL PROVIDER PAYMENTS

Change the average wage threshold percentages so more rural hospitals can reclassify. We are implementing policies making it easier for rural hospitals, whose payments now are based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are planning to change those average wage threshold percentages in the FY 2001 hospital regulation so more hospitals can be reclassified.

Use same wage index for inpatient and outpatient PPS. In the proposed rule, we expect to help rural hospitals by using the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

Modify Health Professional Shortage Area designations. We are also working to address other concerns of rural providers, where we can, through administrative actions. The Health Care Financing Administration has formed a high-level working group on rural health to work with providers to identify both administrative and legislative issues and resolve those that we have the authority to address under current law. For example, we are working with the Health Services and Resources Administration to modify the Health Professional Shortage Area designations. We are also considering changes to policies related to Critical Access Hospitals, Graduate Medical Education payments for rural providers, and wage indices for rural providers.

AMBULATORY SURGICAL CENTER (ASC) PAYMENTS

Postpone implementation based on 1999 survey. We plan to publish the final rule on payment policy changes for ASCs next spring and implement the new system in July 2000. The current ASC rates have been in place since 1990 and are based on 1986 survey data. We appreciate the desire to incorporate more current data. However, the process of sending out and having the ASCs complete the surveys, auditing the surveys, analyzing the data, writing a proposed rule, commenting on a proposed rule, and issuing a final rule is lengthy. If we were to delay implementing payment changes until the 1999 survey data are incorporated, we would have to delay the payment policy changes planned for July 2000 for an additional three years.

MEDICARE +CHOICE PAYMENTS

Phase in risk adjustment over a 5-year period. In March, we announced a five-year transition to comprehensive risk adjustment for Medicare+Choice plans to minimize the disruption to plans. We plan to begin the transition in 2000 with a 90/10 blend of demographically and risk adjusted rates. This blend will be gradually increased over five years so that in 2004, rates will be fully risk adjusted using a comprehensive adjustment system that takes into account all care settings.

We believe that this five-year transition strikes the appropriate balance between concern for plans and our obligation to be fiscally responsible and ensure that plans are paid fairly and appropriately for the care they provide, especially to the sickest beneficiaries. Our actuaries estimate that this transition schedule will cost the Medicare Trust Funds \$4.5 billion more than full implementation of risk adjustment in 2000. Our current phase-in schedule prevents plans from experiencing more than a five to ten percent shift in rates in the first few years. For example, based on our impact analyses using 1997 and 1998 plan data, no plan would face more than a 1.85 percent reduction in 2000 and plans on average would face only a 0.7 percent reduction in 2000. Significant differences in later years would indicate that a plan's enrollees are substantially healthier than average, in which case it is appropriate to pay more to other plans that are caring for less healthy enrollees. A number of experts, including the Medicare Payment Advisory Commission, support this approach. We would like to work with Congress and other interested parties to further review technical modifications to improve Medicare+Choice risk adjustment.

Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension. For EverCare managed care plans that provide specialized services to the frail elderly, we are extending this demonstration project for an additional year through December 31, 2001. We also will continue the exemption from risk adjustment during this extension. This will provide additional time to complete our evaluation of this project. It also will allow EverCare to submit additional data on the special population it serves, which we can analyze for possible use in refinement of our risk adjustment methodology.

Improve beneficiary protections and access to administration. We also published refinements to Medicare+Choice regulation that improve beneficiary protections and access to information. For example, we clarified that any beneficiary who is enrolled in a Medicare+Choice plan that withdraws from the program is entitled to immediate enrollment in any other remaining Medicare+Choice plan serving the enrollee's area.

Ease provider participation rules. We have taken additional steps to assist plans and encourage their participation in Medicare+Choice. We worked with Congress to give plans two more months to file the information used to approve benefit and premium structures so plans are able to use more current experience when designing benefit packages and setting cost sharing levels. We also eased provider participation rules and increased flexibility for plans in coordinating care for enrollees with serious or complex conditions and in conducting initial health assessments for new enrollees.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D. C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

Dear Mr. Chairman:

I am writing to respond to your request regarding how the Administration would score the attached language clarifying Congressional intent on the outpatient prospective payment system (PPS) enacted in the Balanced Budget Act (BBA).

As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of \$7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

A handwritten signature in black ink, appearing to read "Jacob J. Lew".

Jacob J. Lew
Director

SEC. ____. INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

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Sincerely,

A handwritten signature in black ink, appearing to read "Jacob J. Lew", is written over a horizontal line.

Jacob J. Lew
Director

SEC. ____.INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.

American Medical Association

Physicians dedicated to the health of America



1101 Vermont Avenue, NW
Washington, DC 20005

Time Sensitive

FAX TRANSMISSION SHEET

Date: 10/19/99

To: Barbara Woolley
Chris Jennings

From: Richard A. Deem
Vice President
Government Affairs
Tel: (202)789-7413

Message:

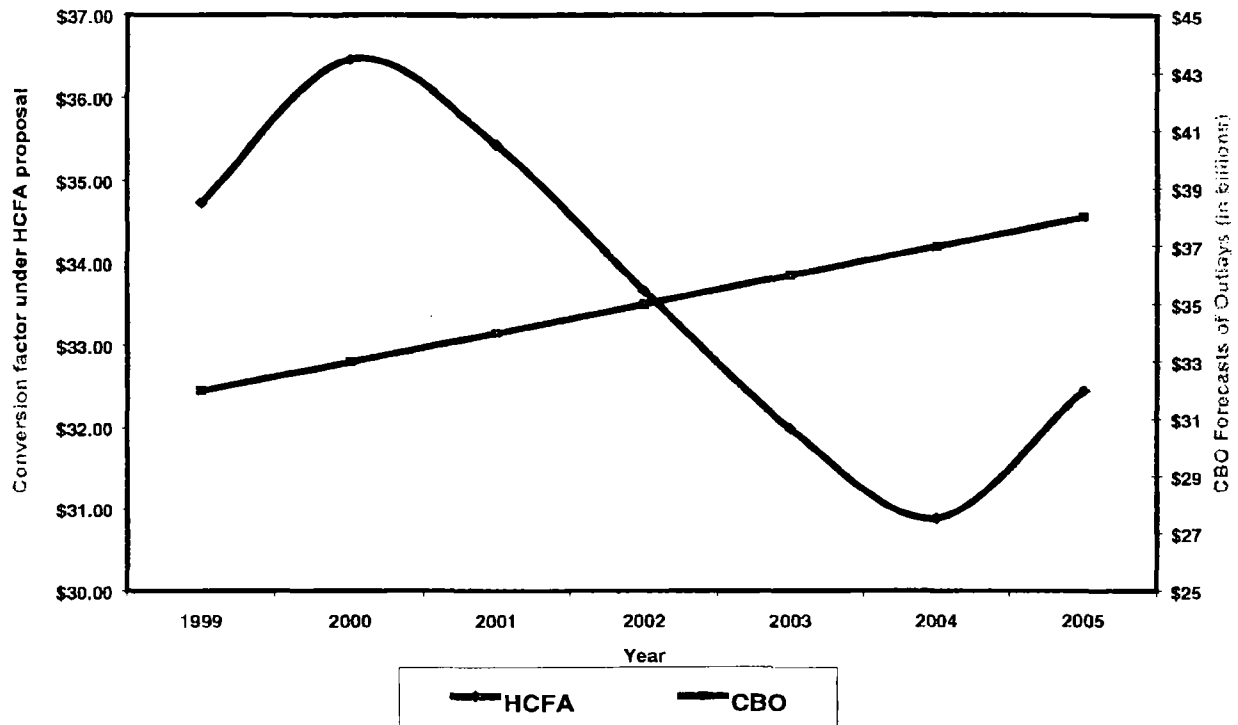
for 11a.m. Conference call.

Total Pages (including cover sheet):

2

Reply Fax Number: (202)789-4692
Government Affairs

Comparison of Medicare Payment Levels Under HCFA SGR Proposal and CBO Forecasts of Outlays for MD Services



Fax Transmission Cover Sheet

Date: 10/19/99 Time: _____

Page #1 of 2

TO: Att: Chris Greening

COMPANY NAME: White House

FAX NUMBER: 202-456-5557

FROM: CHICOT MEMORIAL HOSPITAL
LAKE VILLAGE, ARKANSAS

FAX # 870-265-2123

Document(s) being sent:

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Message:

Transmitted By:

**IF THERE IS ANY PROBLEM WITH THIS
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**RESOLUTION CALLING ON CONGRESS AND THE
ADMINISTRATION TO PROVIDE BBA RELIEF NOW
TO AMERICA'S HOSPITALS**

Whereas Congress and the Clinton Administration, in order to achieve a balanced federal budget, made massive cuts in Medicare spending from 1998 – 2002 as part of the Balanced Budget Act of 1997 (BBA); and

Whereas these cuts were originally estimated to reduce Medicare payments to hospitals and health systems by approximately \$53 billion over those five years; and

Whereas reliable, independent estimates now project that these reductions actually will cost hospitals and health systems as much as \$71 billion over those five years; and

Whereas BBA Medicare cuts have significantly reduced the availability of vital health care services for all patients; and

Whereas access to these and other services will be further reduced as the most severe Medicare reductions take effect in 2000, 2001 and 2002; and

Whereas there is a growing federal budget surplus that can and should be used to repair these unintended consequences of the Balanced Budget Act;

Therefore, be it resolved that the Governing Board of (Healthcare Organization) calls on Congress and the Clinton Administration to

1. Restore Medicare funding for America's hospitals and health systems before completing business and recessing this year; and
2. Commit a minimum of \$25 billion in additional Medicare funding for hospitals and health systems to repair the unintended consequences of the BBA's Medicare cuts.

Members of the Board:

W. C. Mence
Dennis J. Huggins
Bruce

Debra Berkemeyer
Jimmy L. Parkerson
Mark Gelan



re - but
Theresa
Jones

Mary Suther
Chair of the Board
Val J. Halamandaris
President

NATIONAL ASSOCIATION FOR HOME CARE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-6137 fax

Honorable Frank E. Moss
Senior Counsel
Stanley M. Brand
General Counsel

Facsimile Cover Letter

Oct 19 1999
Date

Please deliver the following pages to:

Chris Jennings
Name

The White House
Firm

202 456-5560
Telephone number

202 456-5557
Telecopy number

From VAL J. HALAMANDARIS

(3) See my letter and
Please re fax the President's
Comments

Oct 19 letter. We only got
part of it. We did not
get any addendum or
specific list of issues.
Thanks

If you have any questions, please call 202/547-7424.
Our direct fax number is 202/547-5009.

The only limit of our
realization of tomorrow
will be our doubts of today.
Let us move forward with a
strong and active faith.

Franklin D. Roosevelt
(1882-1945)

NAHC's Upcoming Meetings

18th Annual Meeting and HOMECARE Expo
October 9-13, 1999
San Diego, California

National Policy Conference/
Legal Symposium/IS Expo
April 2-5, 2000
Washington, DC

National Clinical Directors
Conference & Expo
May 3-5, 2000
Dallas, Texas

New Business Development/
Home Care Aide Conference
May 7-10, 2000
Arlington, Virginia

Financial Management Conference
July 12-14, 2000
Hilton Head, South Carolina

For more information, log on to
www.nahc.org or call NAHC's
Meeting Department at 202/547-5050.

For information on the benefits of
NAHC membership, call 202/547-7424
or fax 202/547-3540.



Mary Suther
Chairman of the Board
Val J. Halumandaris
President

NATIONAL ASSOCIATION FOR HOME CARE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Honorable Frank E. Moss
Senior Counsel
Stanley M. Brand
General Counsel

October 19, 1999

Chris Jennings
Deputy Assistant to the President for
Health Policy
Old Executive Building
Room 216
Washington, DC 20503
White House

Re: Interpretation of Balanced Budget Act by HCFA

Dear Chris:

It was great to speak with you a short while ago. We received the President's letter of October 19 to Chairman Roth, and found it to be of great interest. Unfortunately, we did not receive a copy of the addendum in which the more than 25 items the Administration has assured the Finance Committee that it intends to implement with respect to the Balanced Budget Act of 1997 (BBA). I would appreciate it if you could forward that on to me by fax.

Chris, we are very appreciative of the Administration's efforts to alleviate some of the burdens that have been imposed upon home health agencies over the last few years. Allowances for extended repayment plans on Medicare overpayments, modifications in the surety bond standards, elimination of sequential billing, and other changes have gone a long way toward stabilizing the delivery of home health services to Medicare beneficiaries. I would strongly encourage the Administration to consider an additional adjustment relating to the implementation of the interim payment system limits under the BBA.

We firmly believe that the Health Care Financing Administration (HCFA) went beyond the intent of Congress, further reducing the per beneficiary payment limits by excluding inflation updates for 1995 and 1996 from its calculation of the limits. HCFA has stated its authority for eliminating the inflation update is a provision in the BBA that was intended to recapture savings from an earlier freeze on per visit cost limits. However, there was no reason to apply this

Chris Jennings
October 19, 1999
Page 2



"recapture" provision to the per beneficiary limits as well since that limit did not exist during the two year cost limit freeze period of 1995 and 1996. All of the necessary savings to recapture can occur through the per visit cost limits.

The unintended depth of the Medicare home health care cuts is illustrated in the most recent data supplied by the HCFA Office of the Actuary. This data shows that Medicare home health care expenditures have been reduced from \$16.7 billion in 1997 to \$10.6 billion in 1998. The purpose of the BBA was to restrain the growth in home health services, not to impose more than a one-third cut in expenditures in one year alone. A significant reason for the extreme cut in expenditures is HCFA's method for calculating the per beneficiary limit, which excluded full inflation updates.

In consideration of administrative actions that could alleviate the unintended impact of the BBA changes, we strongly urge that the Administration instruct HCFA to adjust the per beneficiary limits to include full inflation updates. The result would be to reduce the current "overpayments" made to agencies that provided Medicare coverage services beyond the level payable through the aggregate payment limits. It would also provide a more reasonable payment limit, which would allow home health agencies to improve access to care to those higher cost Medicare beneficiaries. Finally, it would create a more sensible base from which to implement a prospective payment system in October, 2000.

Thank you again for your efforts on behalf of home care.

Sincerely,

Val J. Halamandaris



FAX COVER SHEET



OFFICE OF LEGISLATION

Number of Pages: _____

Date: _____

To: Chris Jeanne

From: Bonnie IIRA

Fax: _____

Fax: 202-690-8168 or 205-5157

Phone: _____

Phone: _____

REMARKS: Have a draft paper on physician
SCR numbers. Ganske asked for this at
the hearing & we feel we need to
get back to him before Commerce
works up, but are concerned about the
costs + the implication for the AMA.
Please call to discuss.

HEALTH CARE FINANCING ADMINISTRATION

200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

Physician Updates and the Sustainable Growth Rates (SGRs)**The 2000 Update**

- o The 2000 update for physicians' services will be a 5.5 percent increase, which includes a 3.0 percentage point adjustment for performance under the sustainable growth rate (SGR), the maximum annual performance bonus. A performance bonus of this size is a result of SGR problems: physicians will receive a 2000 bonus (3.0 percent) that is much larger than the amount that expenditures are under target (0.4 percent).
- o Physicians received updates of 3.4 percent in 1998 and 2.3 percent in 1999. Cumulatively, since BBA (i.e., 1998, 1999 and 2000), physicians will have received updates of 11.6 percent. (Of the 11.6 percent, 7.1 percentage points are for the MEI and 4.2 percentage points are for performance bonuses.)

The Sustainable Growth Rate (SGR) Legislative Proposal

- o The Administration submitted a budget-neutral legislative proposal in February 1999 to correct the SGR technical problems and also require that the SGR's be revised, after they are set, to reflect later data.
 - + The SGR is equal to the sum of four factors: (1) the estimated percent change in prices for the next year, (2) the estimated percent change in fee-for-service enrollment for the next year, (3) the estimated percent change in real GDP per capita for the next year, and (4) the estimated changes in law or regulation for the next year.
- o The legislative proposal would reduce the instability of the system and require revision of the SGR to reflect later data.
- o The Administration's legislative proposal is budget-neutral. The technical aspects of the SGR changes result in some savings which are exceeded by the costs of revision of the FY 1998 and FY 1999 SGR's. Without a budget-neutrality adjustment, the legislative proposal would have net Federal budget costs.
 - + There is not a one-to-one relationship between the SGR and physician updates in a particular year for several reasons. However, if the technical problems with the SGR were fixed, and if the SGR were revised based on later data, then physician updates would be higher.
 - * If only the portion of the legislative proposal dealing with revising the SGR based on later data were done, then physicians' fees would eventually be cumulatively 7.1 percent higher.

-2-

- * The legislative proposal gives back to physicians 2.3 percentage points (of the 7.1 percent, i.e., gives back 32 percent), the amount of the savings from the technical restructuring aspect of the legislative proposal (e.g., moving to 1996 as the base year).
- + The legislative proposal has a budget neutrality adjustment of 4.7 percent.
 - * If there were no limit on the update, and if the legislative proposal was not budget neutral, the 2000 physician update would be 10.5 percent.
 - * Without a budget-neutrality adjustment, the legislative proposal would cost \$8 billion over 5 years.
- + The legislative proposal also has a separate budget neutrality adjustment to offset the costs associated with reducing SGR oscillation by blending 75 percent of the year-to-year change and 33 percent of the cumulative change. Without these special budget neutrality adjustments, which apply only during 2001 through 2006, there would be costs of about \$1.5 billion over 5 years.
- + The 4.7 percent overall budget neutrality adjustment is partially offset by MVPS projection error which was in the favor of physicians. That is, current physician payment levels are 1.9 percent higher than they would otherwise be if projection error under the MVPS had been corrected. That would leave a net budget-neutrality adjustment of 2.7 percent. Removing this 2.7 percent adjustment would cost about \$4.5 billion over 5 years.
- + The net budget-neutrality adjustment of 2.7 percent can be compared to the 3.9 percent projection error for the FY 1998 and FY 1999 SGRs due to performance of the economy. That is, the performance of the economy substantially in excess of projections more than offsets the net budget neutrality adjustment.

The White House
Office of Legislative Affairs
Congressional Correspondence
Interim Tracking Sheet

To: Devorah

Member: SEN. FEINSTEIN Date: 10-20-99

Tasked To: HHS

Copied To: Joanna, Medicare file, NEC,



402255

COPY

United States Senate

WASHINGTON, DC 20510-0504

October 12, 1999

The Honorable William Jefferson Clinton
President of the United States
The White House
1600 Pennsylvania Avenue N.W.
Washington, D.C. 20500

Dear Mr. President:

I write to urge you to assist me in addressing the way Medicare pays physicians. The Balanced Budget Act of 1997 (BBA) made some changes for annually updating Medicare physician payment rates, including the new sustainable growth rate (SGR). The SGR has resulted in the loss of billions of dollars to physicians.

In the first two years of utilizing the SGR, it appears that the Health Care Financing Administration (HCFA) made some errors in its calculations because they used projections to determine the rate rather than actual data. For example, HCFA underestimated by one million beneficiaries the number of elderly and disabled patients enrolling in the Medicare fee-for-service program rather than managed care. As a result of these errors, physicians are caring for one million more patients than Medicare anticipated, at a cost of \$3 billion according to the American Medical Association. In addition, California was one of the States where several health plans pulled out of Medicare in 1999. HCFA did not account for these plan withdrawals in the SGR, hence California physicians have lost \$270 million or approximately \$2,800 per physician in the State. California's doctors have made a compelling case that these errors have caused unintended reductions in payments to physicians.

It is my understanding that HCFA can correct the errors in the sustainable growth rate (SGR) calculation without any new legislation. I urge you to direct the Department of Health and Human Services (HHS) to address these concerns. I am enclosing some materials from the California Medical Association which further describes the problem and proposed solutions.

I greatly appreciate consideration of these suggestions and I look forward to working closely with you and Administration officials to bring stability to California's health care system.

Sincerely,

MEDICARE SUSTAINABLE GROWTH RATE

BRIEF DESCRIPTION

The Sustainable Growth Rate is a component of the formula used to update Medicare physician fee-for-service reimbursement rates.

The Sustainable Growth Rate (SGR) system, enacted under the Balanced Budget Act of 1997, sets a target rate of spending growth based on four factors: inflation in physicians' practice costs; changes in Medicare fee-for-service enrollment; changes in real per capita gross domestic product (GDP); and an allowance for legislative and regulatory factors affecting physician expenditures. Growth in real per capita GDP represents the formula's allowance for growth in the utilization of physician services. The SGR target is calculated each year and is designed to hold annual growth in utilization of services per beneficiary to the same level as annual GDP.

Physician payment updates depend on whether utilization growth exceeds or falls short of the target rate. If utilization growth exceeds GDP, then payment updates are less than inflation. If utilization is less than GDP, payment updates are above inflation.

Because of the serious problems with the SGR system, four improvements must be included in legislation to fix the SGR:

1. HCFA must be required to correct its projection errors and restore the \$3 billion SGR shortfall resulting from these errors;
2. The SGR must be increased to account for physician costs due to technological advances and an aging population;
3. Measures must be implemented to curtail volatility in physician payment rates; and
4. HCFA must be required to provide information and data on payment updates for Medicare Payment Advisory Commission review.



California Medical Association

221 Main Street, P.O. Box 7690, San Francisco, CA 94120-7690 • (415) 541-0900

Physicians dedicated to the health of Californians

October 7, 1999

The Honorable Dianne Feinstein
United States Senate
331 Senate Hart Office Building
Washington, DC 20510-0504

Dear Senator Feinstein:

Thank you for meeting with us yesterday to discuss needed improvements in the Medicare sustainable growth rate (SGR) which is a component of the Medicare funding formula used to reimburse fee-for-service physician services. On behalf of the California Medical Association (CMA), I want to thank you for agreeing to support both administrative actions and legislation needed to correct serious problems in the SGR system. As promised, I am sending a brief summary of the issues.

It is our understanding that Senator Roth has written to the President and pointed out that legislation is not necessarily needed for the Administration to fix errors that the Health Care Financing Administration (HCFA) has made in its calculations of the 1998 and 1999 SGR. Therefore, we recommend the first step in your efforts be to join Senator Roth in immediately urging the Administration to take swift action to replace its erroneous estimates with accurate data. The HCFA errors have already shortchanged physicians by \$3 billion. A suggested letter to the President is attached, for your convenience.

Further, we appreciate your generous support for including the SGR refinements described below in the Senate's legislation to address unintended consequences of the Balanced Budget Act (BBA) of 1997. Because of the complexity of the issue, I have attached a brief description of SGR. Please be aware that our recommendations are compatible with those made by the Medicare Payment Advisory Commission (MedPAC) in its March 1999 Report to Congress.

1. Physician Payment Updates Must Be Based on Actual Data, Not Erroneous Estimates

Problem: The erroneous administrative projections used to set the SGR each year must be adjusted in order to avoid inappropriate payment reductions to physicians. Among several errors that HCFA has made in just the first two years of the SGR, the most serious was to underestimate by 1,000,000 beneficiaries the number of elderly and disabled patients enrolling in the Medicare fee-for-service program rather than managed care. For example, California was one of the States where health plans abandoned Medicare in 1999, leaving fee-for-service as the major option available for many patients. HCFA did not account for these plan withdrawals in the SGR; however, shortchanging California physicians by \$270 million, or about \$2,800 for each physician in the State.

Recommendation: We recommend that the legislation direct HCFA to replace its estimates with actual data for 2000 and each year thereafter. We further recommend that the Senate include report language expressing its concern about the erroneous projections in the 1998 and 1999 SGR and directing that they be corrected.

2. The SGR Must Be Increased to Gross Domestic Product (GDP) +2 to Allow for Technological Advances and an Aging Population

Problem: The original design of the SGR system would have set the SGR factor for gross domestic product (GDP) growth at GDP plus two percentage points, but the BBA of 1997 set this factor at GDP alone.

Recommendation: We recommend that the GDP growth factor be increased to GDP+2 in 2003, which means there are no costs associated with this proposal for the first three years of the budget cycle.

MedPAC recommends increasing the GDP factor to allow for "cost increases due to improvements in medical capabilities and advancements in scientific technology." A MedPAC analysis also has found that the proportion of patients in older age groups is increasing relative to the younger age group. Thus, MedPAC recommends revising the SGR to "include measures of changes in the composition of Medicare fee-for-service enrollment."

These two factors—technological advances and an aging patient population—have always led to increased utilization of health care services. The Medicare Trustees report that utilization growth will outstrip Congressional Budget Office forecasts of GDP growth over the next decade. Thus, no matter how cost-effective physicians are in caring for their Medicare patients, Medicare physician payment rates are virtually guaranteed to decline relative to inflation in their costs of practice. The SGR must be increased if physicians are to continue to be able to offer their Medicare patients the finest medical care in the world.

3. Steps Must Be Taken to Stabilize Future Payment Updates

Problem: As a result of design flaws in the SGR system, updates will alternate between steep increases and steep decreases, which virtually guarantees 5% physician payment cuts each year for several years.

Recommendation: We recommend several measures to prevent this volatility:

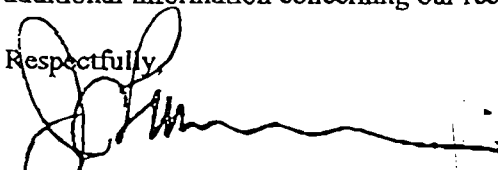
- narrow the range of allowable payment updates to inflation +/- 2%;
- synchronize the current mismatch in time periods into a calendar year system; and
- reduce the effect of yearly GDP fluctuation by using 5-year average GDP growth.

4. HCFA Should Be Required to Provide Payment Previews for MedPAC's Review

The problems with the SGR system are augmented by the lack of timely, reliable information. HCFA should be required to provide previews for the Medicare Payment Advisory Commission's (MedPAC's) review of forthcoming payment updates and to share information on quarterly expenditures and changes in projections, as recommended by MedPAC.

Thank you for your consideration, Senator Feinstein. We look forward to working with you to improve the SGR in Medicare. Please feel free to contact me at 415-265-4975, or Richard Deem at the American Medical Association (202-789-7413) who has been helpful to me. He has additional information concerning our recommendations.

Respectfully,


Jack Lewin, MD
EVP/CEO

Suggested [REDACTED] Language:

The Committee is concerned that HCFA made several serious errors in its estimates of the factors used to establish the 1998 and 1999 sustainable growth rate (SGR) for the Medicare physician fee schedule. The Committee is aware that HCFA underestimated by more than 1,000,000 beneficiaries the number of Medicare beneficiaries that would be enrolled in the Medicare fee-for-service program in 1999. The Committee remains concerned that HCFA stated in a 1997 regulation that the errors would be corrected in future years, but then reneged on this commitment in a 1998 regulation, so that the sustainable growth rate and annual physician payment updates continue to be based on inaccurate data. The growth rate factor for changes due to law and regulation provides HCFA with the ability to correct its SGR estimation errors in subsequent years when actual data become available.

The Committee directs HCFA to correct the SGR for projection errors for 1998 and 1999 to reflect actual data on changes in these factors. The Committee further directs HCFA to correct allowed expenditures for projection errors in 1998 and 1999 to reflect actual data on changes in these factors. HCFA is to make no retroactive corrections to the payment updates for calendar years 1998 and 1999, but the Committee directs that calculations of the update adjustment factor and payment updates for 2000 and years thereafter are to be based on correct growth rate data for 1998 and 1999.

A BILL

To amend Title XVIII of the Social Security Act to stabilize and ensure appropriate payment for physician services.

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

SEC. 101. ADJUSTMENTS TO SGR.

(a) IN GENERAL—Section 1848 of Title XVIII of the Social Security Act, 42 U.S.C. § 1395w-4, is amended as follows:

- (1) Delete subsections 1848(d)(3)(B)(C) and (D), and replace them with the following new subsections (d)(3)(B) through (E):

“(B) Update adjustment factor. For purposes of subparagraph (A)(ii), the “update adjustment factor” for a year is equal (as estimated by the Secretary) to—

“(i) the difference between (I) allowed expenditures for physicians’ services (as determined under subparagraph (C), and as revised under subsection (d)(3)(D)) for the period beginning April 1, 1997, and ending on December 31 of the year involved, and (II) actual expenditures for physicians’ services furnished during the period beginning April 1, 1997, and ending on December 31 of the preceding year, divided by

“(ii) the actual expenditures for physicians’ services for the preceding calendar year, increased by the sustainable growth rate under subsection (f) for the calendar year involved. * :

“(C) Determination of allowed expenditures. For purposes of this paragraph, the initial estimate of allowed expenditures for physicians’ services—

“(i) for April 1, 1999 through December 31, 1999 is equal to the actual expenditures for physicians’ services furnished during such period, as estimated by the Secretary; or

“(ii) beginning with the year 2000, and for each year thereafter, is equal to the allowed expenditures for physicians’ services for the preceding calendar year, increased by the sustainable growth rate under subsection (f)(3) for the calendar year involved, as corrected under subsection (f)(4).

~~“(D) Correction of allowed expenditures for projection errors in 1998 and 1999. Errors in the estimate of allowed expenditures previously published by the Secretary for the 12-month periods beginning on April 1, 1997 and ending on March 31, 1998 and beginning on April 1, 1998 and ending on March 31, 1999 shall be corrected by the Secretary to reflect actual data, as described under subsection (f)(2)(B) through (D), upon the date of enactment of this Act, and, with respect to fiscal year 1999, by no later than November 1, 2000, as the sustainable growth rate for these periods is revised under subsection (f)(4).~~

~~“(E) Correction of allowed expenditures for projection errors for April 1, 1999 through December 31, 1999. Errors in the estimate of allowed expenditures determined under subsection (d)(3)(C)(i) for the 9-month period beginning on April 1, 1999 and ending on December 31, 1999 shall be corrected by the Secretary to reflect actual data by no later than November 1, 2000~~

“(D) Correction of allowed expenditures for projection errors. ~~After correcting for errors in the estimate of allowed expenditures for 1998 and 1999 and for the 9-month period beginning on April 1, 1999 and ending on December 31, 1999, under subsections (d)(3)(D) and (E), respectively,~~ Beginning with calendar year 2000, errors in the estimate of allowed expenditures determined under subsection (d)(3)(C)(ii) shall be corrected by the Secretary in subsequent years to reflect actual data; the estimate of allowed expenditures for a given year shall be revised by no later than November 1 of the following year, and shall again be revised by no later than November 1 of the year subsequent to that, as the data becomes available, and as the sustainable growth rate for that period, and any prior periods, is revised under subsection (f)(4).

“(E) Restriction on variation from Medicare economic index. Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

“(i) greater than 100 times the following amount: $(1.02 + (\text{MEI percentage}/100)) - 1$; or

“(ii) less than 100 times the following amount: $(0.98 + (\text{MEI percentage}/100)) - 1$,

“where “MEI percentage” means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.”

- (2) Delete subsection 1848(f), and replace it with the following new subsection (f):

“(f) Sustainable growth rate.

“(1) Publication of conversion factor, sustainable growth rate and expenditure data.—(A) Publication of conversion factor and sustainable growth rate. The Secretary shall cause to have published in the Federal Register, by no later than November 1 before each calendar year, the conversion factor update and an estimate of the sustainable growth rate, including any revisions thereto under subsections (d)(3)(D) and (f)(4), and data on which these estimates are based; publication of data under this subsection shall include but shall not be not limited to—

“(i) the determinants of the sustainable growth rate, including an itemized list of factors within the law and regulation component that affect allowed expenditures by more than \$100 million in a given year, for ~~fiscal years 1998 through 1999~~ and calendar years 2000 through the most recent year that such target growth rates have been determined;

“(ii) allowed expenditures and the Secretary’s estimate of actual expenditures for ~~the years ending March 31, 1998 and March 31, 1999; for the nine month period ending December 31, 1999; and for all~~ calendar years 2000 through thereafter through the most recent year that allowed expenditures has been determined;

“(iii) a summary of revisions to the sustainable growth rate targets and allowed expenditures as required under subsections (d)(3)(D) and (f)(4) for all years affected, and the rationale for such revisions; and

“(iv) a description of the methodology used to calculate the estimate of actual expenditures for the year ending December 31 of the year prior to the update.

“(B) Publication of data on expenditures. The Secretary shall make available to the Medicare Payment Advisory Commission (in this section referred to as “MedPAC”), the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate, and organizations representing physicians by not later than April 15 before each calendar year beginning with April 15, 2000, and each year thereafter, an estimate of the conversion factor for the next calendar year, including an estimate of the impact on such conversion factor from the factors described under (f)(3)(A) through (D) and all underlying assumptions used to make such

estimates, and including actual physician expenditures for both the preceding year and the current year to the extent that such actual data is available for the current year, with quarterly data on such actual expenditures.

“(C) MedPAC review. MedPAC shall review the estimates and data published under subsection (B), and shall submit written comments by not later than June 30 before each calendar year containing the results of such review, including such recommendations as MedPAC deems appropriate, to the Secretary and to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

“(2) Specification of growth rate for 1998 through 2002. The sustainable growth rate for all physicians' services for fiscal years 1998 and 1999 and calendar years 2000, 2001, and 2002 shall be equal to the product of—

“(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the year involved,

“(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the preceding year to the year involved,

“(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the preceding year to the year involved, and

“(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the year (compared with the preceding year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B),

“minus 1 and multiplied by 100.

“(3) Specification of growth rate. The sustainable growth rate for all physicians' services for a calendar year (beginning with calendar year 2003) shall be equal to the product of—

“(A) 1 plus the Secretary’s estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians’ services in the calendar year involved,

“(B) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the preceding calendar year to the calendar year involved,

“(C) 1 plus the average annual change in real gross domestic product per capita over the preceding five calendar years up to and including the year involved (divided by 100), plus 2 percentage points; for years during this 5-year period for which projections of real gross domestic product and population growth are required, the Secretary shall use the most recent published estimates available from the Congressional Budget Office and the Census Bureau, respectively, and

“(D) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in expenditures for all physicians’ services in the calendar year (compared with the preceding calendar year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B),

“minus 1 and multiplied by 100.

~~“(4) Correction of growth rate for projection errors for 1998 and 1999. The Secretary shall correct errors in the estimate of the sustainable growth rate for fiscal years 1998 and 1999; estimates of changes in the factors described under subsections (f)(2)(A) through (D) for fiscal years 1998 and 1999 shall be revised upon the date of enactment of this Act, and, with respect to fiscal year 1999, by no later than November 1, 2000, to reflect actual data on changes in these factors.~~

“(4) Correction of growth rate for projection errors. The Secretary shall correct errors in the estimate of the sustainable growth rate, beginning with the year 2000 and each year thereafter, specified under subsection (f)(3), to reflect actual data; estimates of changes in the factors described under subsections (f)(3)(A) through (D) for a particular year shall be revised by no later than November 1 of the year following the initial publication of the sustainable growth rate, and shall again be revised by no later than November 1 of the year subsequent to that, to reflect actual data on changes in these factors as it becomes available.

“(5) Definitions. In this subsection:

“(A) Services included in physicians’ services. The term “physicians’ services” includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician’s office, but does not include services furnished to a Medicare+Choice plan enrollee.

“(B) Medicare+Choice plan enrollee. The term “Medicare+Choice plan enrollee” means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.

“(C) The year involved. The term “the year involved” means the year to which an update adjustment factor or sustainable growth rate factor applies.”

- (3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply upon date of enactment of this Act, and shall apply to the update adjustment factor for years beginning with calendar year 2000, except as otherwise provided in this section.

(b) **STUDY**—The Secretary of the Department of Health and Human Services shall request the Agency for Health Care Policy and Research (in the section referred to as “AHCPR”) to analyze various methods for accurately estimating the economic impact on expenditures for physician services under Title XVIII of the Social Security Act resulting from improvements in medical capabilities and advancements in scientific technology, changes in the composition of enrollment of beneficiaries under the fee-for-service Medicare program under Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and shifts in usage of sites-of-service.

- (1) **AHCPR report.** Not later than 3 years after the date of enactment of this Act, the Secretary shall submit a report to the Commission for analysis and evaluation. Such report shall provide a description and evaluation of the methods studied under subsection (b) and shall make recommendations concerning such methods.
- (2) **MedPAC report.** Upon receiving the report under subsection (b)(1) from the Agency for Health Care Policy and Research, MedPAC shall analyze and evaluate the report, and not later than March 30 of the calendar year following receipt of such report, MedPAC shall submit recommendations based on the report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

- (3) Contents with respect to composition of enrollment. When reviewing methods for accurately estimating the economic impact on physician payments resulting from changes in the composition of enrollment of beneficiaries under the fee-for-service Medicare program under Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as required under subsection (b), AHCPR shall analyze methods to estimate various factors, including, but not be limited to:
- (A) Growth in age groups under fee-for-service enrollment under the Medicare program, including beneficiaries in the age groups between 65-74, 75-84 and 85 and over, and disabled beneficiaries under the age of 65; and
 - (B) Other factors that may be reliable predictors of beneficiary utilization of physician services.
- (4) Funding. From funds appropriated to the Department of Health and Human Services for fiscal years 2000 through 2002, the Secretary shall provide for such funding as the Secretary determines necessary for AHCPR to conduct the study under this subsection.

* Suggested conference report language relating to provisions under section 1848(d)(3)(B)(ii) of the Social Security Act is as follows:

"The Secretary's estimate of actual expenditures for the preceding calendar year under this subsection (d)(3)(B)(ii) shall be made based on: (i) actual data on expenditures for as much of the preceding year as is available (at least the first 6 months of the year) with a commensurate increase to account for average delays in claims submission and processing; and (ii) a projection of expenditures for the remainder of the year that is based on expenditures for the year-to-date and estimated changes of enrollment and utilization per enrollee for the remainder of the calendar year."

THE WHITE HOUSE
WASHINGTON

Copied
Jennings
Padeste

October 19, 1999

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

It was a pleasure to meet with you and Senator Moynihan earlier this month to discuss our mutual commitment to strengthening and modernizing Medicare. It continues to be my hope that the Congress will take action this year to, at minimum, make a down-payment on needed reforms of the program. I look forward to working with you toward that end.

In 1997, the Medicare trustees projected that Medicare would become insolvent in 2001. Working together across party lines, the Congress passed and I enacted important reforms that contributed towards extending the life of the Medicare trust fund to 2015. As with any major legislation, the Balanced Budget Act (BBA) included some policies that are flawed or have had unintended consequences that are posing immediate problems to some providers and beneficiaries. In addition, the program faces the long-term demographic and health care challenges that will inevitably result as the baby-boom generation ages into Medicare. As we worked together in 1997 to address the immediate threat to Medicare, we must work together now to address its short-term and long-term challenges.

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

You have requested a summary of the administrative actions that I plan to take to moderate the impact of the BBA. In the letter that you sent to me last Thursday, you also asked about four specific issues related to payment for hospital outpatient departments, managed care, skilled nursing facilities, and disproportionate share hospitals.

Attached is a summary of the over 25 administrative actions that my Administration is currently implementing or will take to address Medicare provider payment issues. The Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will accrue to the benefit of hospitals, nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was to not impose an additional reduction in aggregate payments for hospitals and I favor a policy that achieves this goal. The enactment of clarifying language on this subject would be useful in making clear Congressional intent with regard to this issue. I have attached a letter from Office of Management and Budget Director Jack Lew, which was sent at the request of Congressman Bill Thomas, detailing how such language would be scored by OMB.

With regards to managed care, we share your commitment to expanding choice and achieving stability in the Medicare+Choice marketplace. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support my Administration's risk adjustment plan. Consistent with this position, most policy experts believe that a further slowdown of its implementation is unwarranted. However, we remain committed to making any and all changes that improve its methodology. Moreover, as you know, any administrative and legislative changes that increase payment rates to providers in the fee-for-service program will also increase payments to managed care plans.

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. While we believe that these adjustments must be budget neutral, we are continuing to review whether we have additional administrative authority in this area.

Finally, it appears that there has been confusion about the current policy for disproportionate share hospital (DSH) payments. Hospitals across a considerable number of states have misconstrued how to calculate DSH payments. The Department of Health and Human Services (HHS) has since concluded that this resulted from unclear guidance. Thus, as reported last Friday, HHS will not recoup past overpayments and will issue new, clearer guidance as soon as possible.

We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care.

I hope and expect that our work together will lay the foundation for much broader and needed reforms to address the demographic and health care challenges confronting the program. We look forward to working with you, as well as the House Ways and Means and Commerce Committees, as we jointly strive to moderate the impact of BBA on the nation's health care provider community.

Sincerely,

A handwritten signature in black ink, reading "Bill Clinton". The signature is written in a cursive, flowing style with a long horizontal line extending from the end.

**ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

ISSUE	STATUS
HOSPITALS: GENERAL	
✓ Capping hospital transfer policy at 10 DRGs for 2 years, through '02	Now being implemented
✓ Stop administrative recoupment of DSH payments based on unclear guidance	Now being implemented
HOSPITALS: OUTPATIENT	
** Eliminate the 5.7 percent payment reduction resulting from drafting problem in the Balanced Budget Act	Under review
✓ Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions	Planned for regulation early next year*
✓ Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS)	Planned for regulation early next year*
✓ Delay implementation of prospective payment system for cancer hospitals until additional data are collected	Planned for regulation early next year*
✓ Make technical refinements to the Ambulatory Payment Classification (APC) system	Planned for regulation early next year*
✓ Allow for temporary cost-based APCs for certain new technologies	Planned for regulation early next year*
✓ Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs)	Planned for regulation early next year*
✓ Create separate APCs to pay for blood and blood products	Planned for regulation early next year*
✓ Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery	Planned for regulation early next year*
✓ Eliminate use of diagnostic codes in payments for medical visits and reassess in the future	Planned for regulation early next year*
SKILLED NURSING FACILITIES	
✓ Increase payment for high acuity patients	Will be implemented
✓ Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy	Now being implemented
HOME HEALTH	
✓ Delay tracking patients and pro-rating payments	Now being implemented
✓ Provide for extended interim payment system repayment schedules for agencies	Now being implemented
✓ Postpone the requirement for surety bonds until October 1, 2000	Now being implemented
✓ Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues	Now being implemented

✓	ISSUE	STATUS
✓	Eliminate the sequential billing rule	Will be implemented
✓	Phase in reporting of services in 15-minute increments	Will be implemented
	PHYSICIANS	
**	Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions	Under review
	RURAL PROVIDERS	
✓	Change the average wage threshold percentages so more rural hospitals can reclassify	Will be implemented
✓	Use same wage index for inpatient and outpatient PPS	Planned for regulation early next year*
✓	Provide stop-loss protection in the transition to the outpatient PPS	Planned for regulation early next year*
**	Modify Health Professional Shortage Area designations	Under review
	AMBULATORY SURGICAL CENTERS	
X	Postpone implementation based on 1999 survey	
	MANAGED CARE	
✓	Phase-in risk adjustment over a 5-year period	Now being implemented
✓	Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension	Now being implemented
X	Phase-in risk adjustment over a 7-year period	
✓	Improve beneficiary protections and access to information	Now being implemented
✓	Ease provider participation rules	Now being implemented

"X" indicates that this policy is not advisable, as described in the attachment.

*Federal law requires that the Administration cannot commit to changes in a proposed rule before the final publication.

**Under review.

**DESCRIPTION OF ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE THE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

HOSPITALS: GENERAL

Capping hospital transfer policy at 10 DRGs for 2 years, through 2002. We will postpone for two years the extension of the hospital transfer policy to additional diagnoses beyond the current set of 10 Diagnosis Related Group (DRG) categories. We also will consider whether further postponement of extension to additional diagnoses is warranted.

Stop administrative recoupment of DSH payments based on unclear guidance. We have recently determined that certain hospitals received additional disproportionate share hospital (DSH) payments because guidance on how to claim these funds was insufficiently clear. We will therefore hold harmless hospitals that have received these additional payments. We also will soon clarify guidance to hospitals and our claims processing contractors on how to claim these funds. And we will provide further clarification to State Medicaid agencies because they are the primary source of data critical to the DSH calculations. We will apply the clarified policy and hold hospitals responsible for being in compliance as of January 1, 2000.

HOSPITAL OUTPATIENT PAYMENTS

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was for this policy to be implemented in a way that is budget neutral for hospitals and the Administration favors a policy that achieves this goal. Unfortunately, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. In addition, there are a number of changes that we believe are necessary to address specific policy concerns and moderate the payment reductions in the Medicare prospective payment system (PPS) for outpatient departments. Although we are prohibited by law from committing to changes before the final rule is published, we can outline the approaches we believe are consistent with Administration policy and expect to take in the outpatient department rule. These include:

Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions. We expect to delay implementing the proposed "volume control mechanism." The statute requires the agency to develop a volume control mechanism. In the proposed rule, we suggested use of a mechanism that might lead to a downward adjustment in the payment rates as early as 2002 (to reflect volume increases in 2000). Delaying this mechanism would provide time for providers to adjust to the new system.

Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS). We expect to include a 3-year transition to the new PPS by making budget-neutral adjustments that will increase payments to hospitals that would otherwise incur large payment reductions. These hospitals would include certain rural, inner city, cancer, and teaching hospitals. Some hospitals, like cancer hospitals, are projected to experience a reduction in excess of 30 percent. This transition policy would ensure that payments do not drop below a specified threshold to protect against such reductions.

Delay implementation of prospective payment system for cancer hospitals until additional data are collected. The lack of reliable data from cancer centers makes developing a prospective payment system for them difficult. Consequently, we now expect to delay full implementation of the PPS system for the cancer hospitals and to use an interim payment system for at least 18 months from the initiation date of PPS for other hospitals. We would not end this interim system until we are ready to implement a prospective system for cancer hospitals based on full information.

Make technical refinements to the Ambulatory Payment Classification (APC) system. We plan to make changes to address the many technical comments received regarding the proposed Ambulatory Payment Classification (APC) system as part of the final rule, including the detailed comments from MedPAC. We also plan to address the many other comments, including those related to the appropriateness of the system for categories of providers, in the final rule. And we have hired another independent, outside contractor, Kathpal, to provide additional private-sector expertise as we address problems with the data we have on the cost of chemotherapeutic agents. This contractor is examining a random sample of patients who need chemotherapy and other high-cost drug costs to advise us on possible methods and data for assuring adequate payment for these drugs. We believe that further outside reviews would delay the implementation of the system and the planned reductions in beneficiary out-of-pocket expenses.

Allow for temporary cost-based APCs for certain new technologies. Concerns have been raised about the adequacy of payments in APCs for medical technologies that are new (and hence are not reflected in the data bases on which we do our estimates) and where the cost of the item is very large relative to the payment for the APC. In some instances it may be possible to accommodate new, high-cost technology items within the APCs. In others, we expect to specify in advance and use a set of cost-related APCs for some period of time while better data about actual costs are collected.

Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs). Packaging payments for certain covered drugs with the procedure or visit with which they are furnished could underpay hospitals and slow the introduction of new drugs into the system. Thus, we anticipate creating additional APCs to pay for certain drugs, particularly high-cost drugs. Where appropriate, we would permit billing for multiple APCs depending on dosages actually used. With respect to chemotherapy, we expect to substantially increase the number of APCs for chemotherapy agents to minimize the variability within groups and assure beneficiary access is not compromised. We would also create APCs for supportive and adjunctive therapies.

Create separate APCs to pay for blood and blood products. Under the proposed rule, we would pay for blood and blood products as part of the payment for a surgical procedure or blood transfusion service. As a result of concerns raised in comments, we have reconsidered our proposal and now expect to implement separate APCs to pay for blood, other blood products and anti-hemophilic factors.

Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery. Under the proposed rule, we would pay for corneal tissue acquisition costs as part of the payment for corneal transplant surgery. Given the variable rates at which hospitals acquire the tissue from eye banks, we are likely to accept the recommendation to decouple payment for tissue acquisition from that for the surgical procedure and to pay for it, at least until further experience is gained, based on acquisition cost.

Eliminate use of diagnostic codes in payments for medical visits and reassess use in future. The proposed rule based payments for medical visits to clinics and emergency departments on codes for both medical procedures and diagnosis. Because diagnostic codes are not used in payment for all other services, we now expect to revise our medical groups by eliminating the use of diagnostic codes in computing payment amounts for the present.

SKILLED NURSING FACILITIES (SNF) PAYMENTS

Increase payment for high acuity patients. We will use administrative flexibility to increase relative weights for the Resource Utilization Groups for high acuity patients under the Skilled Nursing Facility Prospective Payment System (SNF PPS). We expect to have research findings on advisable refinements completed by the end of this year and to include them in a proposed rule next Spring, for implementation in October 2000. We believe these changes should be budget neutral. However, we are continuing to review whether we have additional administrative authority.

Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy. Using the limited administrative discretion afforded by the statute, we have excluded these types of services performed in hospital outpatient departments from the SNF PPS bundle. We have done so because such services are exceptionally intensive and well beyond the scope of SNF care plans. We received a significant number of comments, both in response to last year's interim final rule, and at a national Town Hall meeting we held to solicit comments on SNF PPS. We are examining whether any additional hospital outpatient services (e.g., chemotherapy) could be carved out within the scope of our present administrative authorities, but believe that legislation is necessary to exclude these or other services (e.g., prostheses) categorically.

HOME HEALTH PAYMENTS

Delay tracking patients and pro-rating payments. Although fiscal intermediaries are responsible for tracking and pro-rating payments, we were unable to make the necessary systems changes to accomplish this due to our efforts related to Year 2000 computer systems requirements. Therefore, we are delaying implementation of the requirement until the implementation of the prospective payment system. We have developed a way to implement this proposal under the prospective payment system that will allow fiscal intermediaries and HCFA to more directly track beneficiaries. We also want to clarify that the law does not make home health agencies responsible for tracking utilization for purposes of pro-rating payments.

Provide for extended interim payment system repayment schedules for agencies. As part of our Medicare reform plan, we are allowing agencies an automatic 36 months to repay excess interim payment system (IPS) overpayments. The first year is interest-free.

Postponing the requirement for surety bonds until October 1, 2000. We are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds.

Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues. We are also following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

Eliminate the sequential billing rule. As of July 1, 1999, we eliminated the sequential billing rule. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree.

Phase in reporting of services in 15-minute increments. We are phasing in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provision. By allowing this degree of flexibility for a temporary period, we will prevent any agency cash flow problems or returned claims.

PHYSICIAN PAYMENTS

Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions. As we indicated in the *Federal Register* on October 1, 1999, at this time, we do not believe we have the ability under current law to make adjustments to revise the Sustainable Growth Rate (SGR) based on later data. We agree that there is a problem and thus have submitted, as part of the FY 2000 budget, a budget-neutral legislative proposal to require that revisions be made to correct estimation errors in calculation of the SGR and to fix other technical aspects of the SGR. However, we are continuing to review whether we have any ability administratively to address this issue.

RURAL PROVIDER PAYMENTS

Change the average wage threshold percentages so more rural hospitals can reclassify. We are implementing policies making it easier for rural hospitals, whose payments now are based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are planning to change those average wage threshold percentages in the FY 2001 hospital regulation so more hospitals can be reclassified.

Use same wage index for inpatient and outpatient PPS. In the proposed rule, we expect to help rural hospitals by using the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

Modify Health Professional Shortage Area designations. We are also working to address other concerns of rural providers, where we can, through administrative actions. The Health Care Financing Administration has formed a high-level working group on rural health to work with providers to identify both administrative and legislative issues and resolve those that we have the authority to address under current law. For example, we are working with the Health Services and Resources Administration to modify the Health Professional Shortage Area designations. We are also considering changes to policies related to Critical Access Hospitals, Graduate Medical Education payments for rural providers, and wage indices for rural providers.

AMBULATORY SURGICAL CENTER (ASC) PAYMENTS

Postpone implementation based on 1999 survey. We plan to publish the final rule on payment policy changes for ASCs next spring and implement the new system in July 2000. The current ASC rates have been in place since 1990 and are based on 1986 survey data. We appreciate the desire to incorporate more current data. However, the process of sending out and having the ASCs complete the surveys, auditing the surveys, analyzing the data, writing a proposed rule, commenting on a proposed rule, and issuing a final rule is lengthy. If we were to delay implementing payment changes until the 1999 survey data are incorporated, we would have to delay the payment policy changes planned for July 2000 for an additional three years.

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We believe that this five-year transition strikes the appropriate balance between concern for plans and our obligation to be fiscally responsible and ensure that plans are paid fairly and appropriately for the care they provide, especially to the sickest beneficiaries. Our actuaries estimate that this transition schedule will cost the Medicare Trust Funds \$4.5 billion more than full implementation of risk adjustment in 2000. Our current phase-in schedule prevents plans from experiencing more than a five to ten percent shift in rates in the first few years. For example, based on our impact analyses using 1997 and 1998 plan data, no plan would face more than a 1.85 percent reduction in 2000 and plans on average would face only a 0.7 percent reduction in 2000. Significant differences in later years would indicate that a plan's enrollees are substantially healthier than average, in which case it is appropriate to pay more to other plans that are caring for less healthy enrollees. A number of experts, including the Medicare Payment Advisory Commission, support this approach. We would like to work with Congress and other interested parties to further review technical modifications to improve Medicare+Choice risk adjustment.

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

Dear Mr. Chairman:

I am writing to respond to your request regarding how the Administration would score the attached language clarifying Congressional intent on the outpatient prospective payment system (PPS) enacted in the Balanced Budget Act (BBA).

As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of \$7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

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Jacob J. Lew
Director

SEC. ____. INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.

October 20, 1999

✓
MR. PRESIDENT:

On your behalf, we executed the
attached letter on Medicare to
Members of Congress.

FYI

Sean Maloney 

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THE WHITE HOUSE
WASHINGTON

Copied
Jennings
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October 19, 1999

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

It was a pleasure to meet with you and Senator Moynihan earlier this month to discuss our mutual commitment to strengthening and modernizing Medicare. It continues to be my hope that the Congress will take action this year to, at minimum, make a down-payment on needed reforms of the program. I look forward to working with you toward that end.

In 1997, the Medicare trustees projected that Medicare would become insolvent in 2001. Working together across party lines, the Congress passed and I enacted important reforms that contributed towards extending the life of the Medicare trust fund to 2015. As with any major legislation, the Balanced Budget Act (BBA) included some policies that are flawed or have had unintended consequences that are posing immediate problems to some providers and beneficiaries. In addition, the program faces the long-term demographic and health care challenges that will inevitably result as the baby-boom generation ages into Medicare. As we worked together in 1997 to address the immediate threat to Medicare, we must work together now to address its short-term and long-term challenges.

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

You have requested a summary of the administrative actions that I plan to take to moderate the impact of the BBA. In the letter that you sent to me last Thursday, you also asked about four specific issues related to payment for hospital outpatient departments, managed care, skilled nursing facilities, and disproportionate share hospitals.

Attached is a summary of the over 25 administrative actions that my Administration is currently implementing or will take to address Medicare provider payment issues. The Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will accrue to the benefit of hospitals, nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was to not impose an additional reduction in aggregate payments for hospitals and I favor a policy that achieves this goal. The enactment of clarifying language on this subject would be useful in making clear Congressional intent with regard to this issue. I have attached a letter from Office of Management and Budget Director Jack Lew, which was sent at the request of Congressman Bill Thomas, detailing how such language would be scored by OMB.

With regards to managed care, we share your commitment to expanding choice and achieving stability in the Medicare+Choice marketplace. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support my Administration's risk adjustment plan. Consistent with this position, most policy experts believe that a further slowdown of its implementation is unwarranted. However, we remain committed to making any and all changes that improve its methodology. Moreover, as you know, any administrative and legislative changes that increase payment rates to providers in the fee-for-service program will also increase payments to managed care plans.

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. While we believe that these adjustments must be budget neutral, we are continuing to review whether we have additional administrative authority in this area.

Finally, it appears that there has been confusion about the current policy for disproportionate share hospital (DSH) payments. Hospitals across a considerable number of states have misconstrued how to calculate DSH payments. The Department of Health and Human Services (HHS) has since concluded that this resulted from unclear guidance. Thus, as reported last Friday, HHS will not recoup past overpayments and will issue new, clearer guidance as soon as possible.

We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care.

I hope and expect that our work together will lay the foundation for much broader and needed reforms to address the demographic and health care challenges confronting the program. We look forward to working with you, as well as the House Ways and Means and Commerce Committees, as we jointly strive to moderate the impact of BBA on the nation's health care provider community.

Sincerely,

A handwritten signature in black ink, reading "Bill Clinton". The signature is written in a cursive, flowing style with a long horizontal line extending from the end.

**ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

ISSUE	STATUS
HOSPITALS: GENERAL	
✓ Capping hospital transfer policy at 10 DRGs for 2 years, through '02	Now being implemented
✓ Stop administrative recoupment of DSH payments based on unclear guidance	Now being implemented
HOSPITALS: OUTPATIENT	
** Eliminate the 5.7 percent payment reduction resulting from drafting problem in the Balanced Budget Act	Under review
✓ Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions	Planned for regulation early next year*
✓ Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS)	Planned for regulation early next year*
✓ Delay implementation of prospective payment system for cancer hospitals until additional data are collected	Planned for regulation early next year*
✓ Make technical refinements to the Ambulatory Payment Classification (APC) system	Planned for regulation early next year*
✓ Allow for temporary cost-based APCs for certain new technologies	Planned for regulation early next year*
✓ Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs)	Planned for regulation early next year*
✓ Create separate APCs to pay for blood and blood products	Planned for regulation early next year*
✓ Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery	Planned for regulation early next year*
✓ Eliminate use of diagnostic codes in payments for medical visits and reassess in the future	Planned for regulation early next year*
SKILLED NURSING FACILITIES	
✓ Increase payment for high acuity patients	Will be implemented
✓ Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy	Now being implemented
HOME HEALTH	
✓ Delay tracking patients and pro-rating payments	Now being implemented
✓ Provide for extended interim payment system repayment schedules for agencies	Now being implemented
✓ Postpone the requirement for surety bonds until October 1, 2000	Now being implemented
✓ Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues	Now being implemented

ISSUE		STATUS
✓	Eliminate the sequential billing rule	Will be implemented
✓	Phase in reporting of services in 15-minute increments	Will be implemented
PHYSICIANS		
**	Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions	Under review
RURAL PROVIDERS		
✓	Change the average wage threshold percentages so more rural hospitals can reclassify	Will be implemented
✓	Use same wage index for inpatient and outpatient PPS	Planned for regulation early next year*
✓	Provide stop-loss protection in the transition to the outpatient PPS	Planned for regulation early next year*
**	Modify Health Professional Shortage Area designations	Under review
AMBULATORY SURGICAL CENTERS		
X	Postpone implementation based on 1999 survey	
MANAGED CARE		
✓	Phase-in risk adjustment over a 5-year period	Now being implemented
✓	Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension	Now being implemented
X	Phase-in risk adjustment over a 7-year period	
✓	Improve beneficiary protections and access to information	Now being implemented
✓	Ease provider participation rules	Now being implemented

"X" indicates that this policy is not advisable, as described in the attachment.

*Federal law requires that the Administration cannot commit to changes in a proposed rule before the final publication.

**Under review.

**DESCRIPTION OF ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE THE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

HOSPITALS: GENERAL

Capping hospital transfer policy at 10 DRGs for 2 years, through 2002. We will postpone for two years the extension of the hospital transfer policy to additional diagnoses beyond the current set of 10 Diagnosis Related Group (DRG) categories. We also will consider whether further postponement of extension to additional diagnoses is warranted.

Stop administrative recoupment of DSH payments based on unclear guidance. We have recently determined that certain hospitals received additional disproportionate share hospital (DSH) payments because guidance on how to claim these funds was insufficiently clear. We will therefore hold harmless hospitals that have received these additional payments. We also will soon clarify guidance to hospitals and our claims processing contractors on how to claim these funds. And we will provide further clarification to State Medicaid agencies because they are the primary source of data critical to the DSH calculations. We will apply the clarified policy and hold hospitals responsible for being in compliance as of January 1, 2000.

HOSPITAL OUTPATIENT PAYMENTS

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was for this policy to be implemented in a way that is budget neutral for hospitals and the Administration favors a policy that achieves this goal. Unfortunately, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. In addition, there are a number of changes that we believe are necessary to address specific policy concerns and moderate the payment reductions in the Medicare prospective payment system (PPS) for outpatient departments. Although we are prohibited by law from committing to changes before the final rule is published, we can outline the approaches we believe are consistent with Administration policy and expect to take in the outpatient department rule. These include:

Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions. We expect to delay implementing the proposed "volume control mechanism." The statute requires the agency to develop a volume control mechanism. In the proposed rule, we suggested use of a mechanism that might lead to a downward adjustment in the payment rates as early as 2002 (to reflect volume increases in 2000). Delaying this mechanism would provide time for providers to adjust to the new system.

Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS). We expect to include a 3-year transition to the new PPS by making budget-neutral adjustments that will increase payments to hospitals that would otherwise incur large payment reductions. These hospitals would include certain rural, inner city, cancer, and teaching hospitals. Some hospitals, like cancer hospitals, are projected to experience a reduction in excess of 30 percent. This transition policy would ensure that payments do not drop below a specified threshold to protect against such reductions.

Delay implementation of prospective payment system for cancer hospitals until additional data are collected. The lack of reliable data from cancer centers makes developing a prospective payment system for them difficult. Consequently, we now expect to delay full implementation of the PPS system for the cancer hospitals and to use an interim payment system for at least 18 months from the initiation date of PPS for other hospitals. We would not end this interim system until we are ready to implement a prospective system for cancer hospitals based on full information.

Make technical refinements to the Ambulatory Payment Classification (APC) system. We plan to make changes to address the many technical comments received regarding the proposed Ambulatory Payment Classification (APC) system as part of the final rule, including the detailed comments from MedPAC. We also plan to address the many other comments, including those related to the appropriateness of the system for categories of providers, in the final rule. And we have hired another independent, outside contractor, Kathpal, to provide additional private-sector expertise as we address problems with the data we have on the cost of chemotherapeutic agents. This contractor is examining a random sample of patients who need chemotherapy and other high-cost drug costs to advise us on possible methods and data for assuring adequate payment for these drugs. We believe that further outside reviews would delay the implementation of the system and the planned reductions in beneficiary out-of-pocket expenses.

Allow for temporary cost-based APCs for certain new technologies. Concerns have been raised about the adequacy of payments in APCs for medical technologies that are new (and hence are not reflected in the data bases on which we do our estimates) and where the cost of the item is very large relative to the payment for the APC. In some instances it may be possible to accommodate new, high-cost technology items within the APCs. In others, we expect to specify in advance and use a set of cost-related APCs for some period of time while better data about actual costs are collected.

Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs). Packaging payments for certain covered drugs with the procedure or visit with which they are furnished could underpay hospitals and slow the introduction of new drugs into the system. Thus, we anticipate creating additional APCs to pay for certain drugs, particularly high-cost drugs. Where appropriate, we would permit billing for multiple APCs depending on dosages actually used. With respect to chemotherapy, we expect to substantially increase the number of APCs for chemotherapy agents to minimize the variability within groups and assure beneficiary access is not compromised. We would also create APCs for supportive and adjunctive therapies.

Create separate APCs to pay for blood and blood products. Under the proposed rule, we would pay for blood and blood products as part of the payment for a surgical procedure or blood transfusion service. As a result of concerns raised in comments, we have reconsidered our proposal and now expect to implement separate APCs to pay for blood, other blood products and anti-hemophilic factors.

Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery. Under the proposed rule, we would pay for corneal tissue acquisition costs as part of the payment for corneal transplant surgery. Given the variable rates at which hospitals acquire the tissue from eye banks, we are likely to accept the recommendation to decouple payment for tissue acquisition from that for the surgical procedure and to pay for it, at least until further experience is gained, based on acquisition cost.

Eliminate use of diagnostic codes in payments for medical visits and reassess use in future. The proposed rule based payments for medical visits to clinics and emergency departments on codes for both medical procedures and diagnosis. Because diagnostic codes are not used in payment for all other services, we now expect to revise our medical groups by eliminating the use of diagnostic codes in computing payment amounts for the present.

SKILLED NURSING FACILITIES (SNF) PAYMENTS

Increase payment for high acuity patients. We will use administrative flexibility to increase relative weights for the Resource Utilization Groups for high acuity patients under the Skilled Nursing Facility Prospective Payment System (SNF PPS). We expect to have research findings on advisable refinements completed by the end of this year and to include them in a proposed rule next Spring, for implementation in October 2000. We believe these changes should be budget neutral. However, we are continuing to review whether we have additional administrative authority.

Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy. Using the limited administrative discretion afforded by the statute, we have excluded these types of services performed in hospital outpatient departments from the SNF PPS bundle. We have done so because such services are exceptionally intensive and well beyond the scope of SNF care plans. We received a significant number of comments, both in response to last year's interim final rule, and at a national Town Hall meeting we held to solicit comments on SNF PPS. We are examining whether any additional hospital outpatient services (e.g., chemotherapy) could be carved out within the scope of our present administrative authorities, but believe that legislation is necessary to exclude these or other services (e.g., prostheses) categorically.

HOME HEALTH PAYMENTS

Delay tracking patients and pro-rating payments. Although fiscal intermediaries are responsible for tracking and pro-rating payments, we were unable to make the necessary systems changes to accomplish this due to our efforts related to Year 2000 computer systems requirements. Therefore, we are delaying implementation of the requirement until the implementation of the prospective payment system. We have developed a way to implement this proposal under the prospective payment system that will allow fiscal intermediaries and HCFA to more directly track beneficiaries. We also want to clarify that the law does not make home health agencies responsible for tracking utilization for purposes of pro-rating payments.

Provide for extended interim payment system repayment schedules for agencies. As part of our Medicare reform plan, we are allowing agencies an automatic 36 months to repay excess interim payment system (IPS) overpayments. The first year is interest-free.

Postponing the requirement for surety bonds until October 1, 2000. We are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds.

Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues. We are also following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

Eliminate the sequential billing rule. As of July 1, 1999, we eliminated the sequential billing rule. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree.

Phase in reporting of services in 15-minute increments. We are phasing in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provision. By allowing this degree of flexibility for a temporary period, we will prevent any agency cash flow problems or returned claims.

PHYSICIAN PAYMENTS

Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions. As we indicated in the *Federal Register* on October 1, 1999, at this time, we do not believe we have the ability under current law to make adjustments to revise the Sustainable Growth Rate (SGR) based on later data. We agree that there is a problem and thus have submitted, as part of the FY 2000 budget, a budget-neutral legislative proposal to require that revisions be made to correct estimation errors in calculation of the SGR and to fix other technical aspects of the SGR. However, we are continuing to review whether we have any ability administratively to address this issue.

RURAL PROVIDER PAYMENTS

Change the average wage threshold percentages so more rural hospitals can reclassify. We are implementing policies making it easier for rural hospitals, whose payments now are based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are planning to change those average wage threshold percentages in the FY 2001 hospital regulation so more hospitals can be reclassified.

Use same wage index for inpatient and outpatient PPS. In the proposed rule, we expect to help rural hospitals by using the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

Modify Health Professional Shortage Area designations. We are also working to address other concerns of rural providers, where we can, through administrative actions. The Health Care Financing Administration has formed a high-level working group on rural health to work with providers to identify both administrative and legislative issues and resolve those that we have the authority to address under current law. For example, we are working with the Health Services and Resources Administration to modify the Health Professional Shortage Area designations. We are also considering changes to policies related to Critical Access Hospitals, Graduate Medical Education payments for rural providers, and wage indices for rural providers.

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We believe that this five-year transition strikes the appropriate balance between concern for plans and our obligation to be fiscally responsible and ensure that plans are paid fairly and appropriately for the care they provide, especially to the sickest beneficiaries. Our actuaries estimate that this transition schedule will cost the Medicare Trust Funds \$4.5 billion more than full implementation of risk adjustment in 2000. Our current phase-in schedule prevents plans from experiencing more than a five to ten percent shift in rates in the first few years. For example, based on our impact analyses using 1997 and 1998 plan data, no plan would face more than a 1.85 percent reduction in 2000 and plans on average would face only a 0.7 percent reduction in 2000. Significant differences in later years would indicate that a plan's enrollees are substantially healthier than average, in which case it is appropriate to pay more to other plans that are caring for less healthy enrollees. A number of experts, including the Medicare Payment Advisory Commission, support this approach. We would like to work with Congress and other interested parties to further review technical modifications to improve Medicare+Choice risk adjustment.

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Ease provider participation rules. We have taken additional steps to assist plans and encourage their participation in Medicare+Choice. We worked with Congress to give plans two more months to file the information used to approve benefit and premium structures so plans are able to use more current experience when designing benefit packages and setting cost sharing levels. We also eased provider participation rules and increased flexibility for plans in coordinating care for enrollees with serious or complex conditions and in conducting initial health assessments for new enrollees.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

Dear Mr. Chairman:

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As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of \$7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

A handwritten signature in black ink, appearing to read "Jacob J. Lew".

Jacob J. Lew
Director

SEC. ____ .INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.

WHITE HOUSE
WASHINGTON

10-20-99

October 20, 1999

✓
MR. PRESIDENT:

On your behalf, we executed the
attached letter on Medicare to
Members of Congress.

FYI

Sean Maloney 

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