HELMSIN & YARWOOD ASSOCIATES

June 02, 1999

Mr. Christopher Jennings
Deputy Assistant to the President
Health Policy
OEOB, #216
1700 Pennsylvania Avenue
Washington, DC 20502

Dear Chris:

I represent a consortium of health care organizations who provide intensive health care services to our nation's frail elderly population through a special reimbursement program. This program is currently being threatened by the introduction of an insufficient Medicare reimbursement rate. This recent change in Medicare reimbursement rates, proposed to go into effect in 2001, will greatly threaten this very effective program that provides intensive services and better access to benefits for a very vulnerable segment of our population.

Through the reimbursement plan currently in place, these HMOs bring better geriatric medicine to a growing number of frail elderly in skilled nursing facilities. These services include heightened physician involvement, daily contact by a geriatric nurse practitioner, better prevention of serious illnesses and more family involvement in care planning. These services are consistent with the administration's "Families First" initiative and are fiscally accountable because they provide more services under fixed monthly budgets.

Recent federal regulatory changes will eliminate essential services and could relegate our parents and grandparents to second class citizenship in the American health care system. Furthermore, these unnecessary rule changes will effectively terminate programs such as the one my company currently provides and result in health care access and affordability problems for the frail elderly. It will also create layoffs of patient care professionals who are working to improve the health status of the frail and aging.

Please continue to allow vulnerable, high-risk groups such as the frail elderly living in skilled nursing facilities to join special programs as their clinical needs warrant. Access to the current system helps to control the growth in Medicare system costs by making it clinically feasible for managed care plans to serve this high risk, high cost frail elderly population.

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We would greatly appreciate your assistance in securing a commitment from the Administration that this new inadequate Medicare reimbursement system will not be implemented, as it will harm a special program that is providing excellent care to a very important population. Ask the Administration to leave this program alone – it is helping thousands of people every day.

Please help us to preserve this important reimbursement program by urging the Administration not to underfund this critically important benefit for our nation's most vulnerable. I have also attached recommended legislative language that might be helpful toward preserving this important program.

Thank you in advance for the thoughtful consideration that we know you will give to this request.

Sincerely yours,

Bruce Yarwood

Attachments

At Issue:
Medicare Reimbursement for HMOs Caring for "Frail Elderly Population"

The Issue

The government must maintain the current Medicare reimbursement rate to HMOs by refusing to institute deeper cuts through a lower, capitated rate. This will allow HMOs to continue to provide quality skilled nursing care for the **frail elderly** population. The proposed 20% – 40% cuts starting in the year 2000 will force HMOs to INCREASE PREMIUMS OF MEMBERS OR LIMIT LEVELS OF REIMBURSEMENT in order to maintain affordability among all members.

What is needed is legislation that will:

First, postpone any Administration action to create a new Medicare reimbursement rate for the frail elderly in skilled nursing facilities with HMO health plans. This action should be postponed until legislation is passed that recognizes the need for an appropriate rate for this category of care.

Second, create a system that will continue to maintain an adequate reimbursement system for the frail elderly in skilled nursing facilities paid for by HMOs. This system should be operative by the Year 2002.

- Research must be conducted now that will provide clinical measurements to serve as the foundation for the new system.

Until the new system is developed, the status of current and future enrollees should not be changed. A legislative exemption, similar to the one provided in the PACE program, should be put in place.

What is at stake?

HMOs will be forced to put tighter limits on the amount of care they are able to provide to tens of thousands of members within the frail elderly population in a nursing home setting. If rates are cut 40% for people needing institutional care, HMOs will experience attrition of these members and no new growth of this frail elderly population.

With deep cuts in Medicare from the Balanced Budget Act of 1997, the health care provider community -- including the long term health care community, HMOs and hospitals -- experienced tens of billions of cuts across the board. However, by the Congressional Budget Office's own admission in March 1999, the cuts were tens of billions of dollars too deep. These cuts have dramatically stretched resources and now threaten to compromise patient care, with the frail elderly being a small, yet critical population punished by these deep cuts.

Why do HMOs receive this special rate for the frail elderly population?

As stated, the frail elderly population requires specialized medical care. The federal government recognizes that as the level of impairment becomes greater in this population, there are also greater "risks" to the HMO which could receive significant underpayment for medical care and services. These special rates for HMOs enable frail elderly patients in nursing homes to receive more intensive services, e.g. pharmacy, nursing, etc., which are necessary for their comfort and survival. The rates also help to control growth and reliance on the Medicare system by making it clinically feasible for managed care plans to serve this high-risk, high-cost group.

The current payment rate to care for the frail elderly population in skilled nursing facilities under fee for service (FFS) is 1.9 times greater than the standard Medicare rate, under which prescription benefits and other services are added. This allows HMOs to provide the level of quality of care that this population requires. The proposed rate is closer to 1.4 times greater than the standard rate. Many providers believe this rate is severely inadequate.

Caring for the Frail Elderly Population

HMOs currently develop specialized programs to enhance the level of primary care in skilled nursing facilities for the frail elderly population. The growth in demand for HMOs to care for this population continues for several reasons:

- As HMO plans become increasingly competitive for market share and offer additional benefits (such as prescription plans and eyeglasses) they will become increasingly attractive to elder populations.
- As HMO members age, costs go up as their level of care increases, especially when they enter the frail elderly population needing skilled nursing services. If the proposed 40% cut goes into place, members will leave the program and go back to the fee for service (FFS) system.

The *Proposed* PIP/HCC Models – Based on Erroneous Assumptions

The new reimbursement programs proposed by the Administration, known as PIP/HCC, will not be sufficient to support this booming segment of frail elderly population. An extensive research study comparing the PIP/HCC models with the current Medicare schedule of reimbursement showed that the PIP/HCC model dangerously underpays for nursing home care. With this type of program put in place, the elderly will suffer from loss of coverage because HMOs will not be able to afford offering this type of care to its members.

The PIP/HCC model is based on erroneous assumptions regarding Medicare costs, which causes the data to be flawed. By failing to take into account expenditure fluctuations due to phase of patient enrollment, the PIP/HCC models create reimbursement rates that are seriously inadequate. For example, the study found that Medicare costs for new entrants to nursing homes were very large around the time of admission, and then dropped dramatically as time progressed. The PIP/HCC model analyzed Medicare costs using only diagnostic information from the beginning of the year by using only this baseline information, there was absolutely no way to predict which individuals would become ill and enter a skilled nursing facility. The PIP/HCC models could not be expected to be accurate for persons who --after the fact-- were found to have become ill and entered a nursing home. By comparison, in correctly analyzing Medicare costs for the whole year, the data show that HCC would underpay by 7% and PIP by 26%. If the PIP/HCC models were put in place as they exist presently, the repercussions for the elderly population would be severe. Both these models need to be modified before they can be used successfully.

With the threat of decreasing Medicare reimbursement rates – the frail elderly suffer.

Enrollment of the elder population in HMOs will increase as the frail elderly age group grows. The bulk of enrollment among the aging population in HMOs is the "healthy elderly" yet this population has the potential to enter the frail elderly population.

The frail elderly population has more than doubled in four years, and this number will continue to grow exponentially in years to come.

For the frail elderly who continue to enroll in HMOs, this heightened level of care may be threatened due to the government's proposed cuts in Medicare reimbursement rates to HMOs for frail elderly populations.

The current Medicare reimbursement rate for frail elderly HMO members works.

Skilled nursing providers are able to accept and care for frail elderly HMO members under a special reimbursement rate set by government. The added Medicare reimbursement now in place ensures that nearly 50,000 of our nation's frail elderly being cared for under HMO plans are receiving quality medical attention from their physician and nurse practitioner in a skilled nursing facility.

The frail elderly living in nursing homes should continue to receive the care they need, and this group should be eligible for enrollment through their HMOs as clinical needs warrant. The nature of illness, and extent of injuries that may occur reinforce the need for open access to this reimbursement rate.

Miscellaneous Background Information on Frail Elderly Crisis within HMOs

The fastest growing segment of the population in the United States is the group 85 years and older.

With significant advances in medicine and technology, elderly Americans are experiencing dramatic increases in life span -- living fuller, longer lives -- yet with increasing medical costs associated with these advances. However, as life span increases, there continues to be an increasing lack of adequate social support systems and integrated chronic care networks for this expanding population of elderly Americans, among them the **frail elderly**.

Who are the "frail elderly?"

A small yet critical segment of this population served by the long term care community is classified as the **frail elderly** – elderly people who need additional, specialized care for activities of daily living (ADLs) due to illnesses and conditions associated with aging. Specialized care, such as the care offered by skilled nursing facilities, helps this population maintain a comfortable way of life in a nursing home setting, instead of a more costly hospital setting.

Although a significant portion of the elder population will be admitted for short stays in a long term care setting for rehabilitation or skilled nursing needs, 55% of those admitted may stay for at least one year, and 21% of those may stay for five years or longer.

The typical profile of frail elderly resident is a woman, over 85, in need of special services due to multiple chronic conditions such as Alzheimer's, diabetes or osteoporosis. (The resident is typically a woman because women live an average of 7 – 9 years longer than men.)

What are the health care needs of the frail elderly?

The frail elderly are becoming increasingly more dependent on long term care facilities at much greater costs associated with their additional care needs.

The daily needs most commonly associated with these elder populations include medication disbursement, feeding, clothing, bathing, assistance with personal needs, and care services such as physical therapies, speech therapies and frequent medical attention by doctors or other skilled medical professionals. The frail elderly population requires several of these activities of daily living (ADLs).

Managed care creates the incentives to provide these enhanced medical care delivery systems in skilled nursing facilities in order to provide for the frail elderly population; not only the advanced medical services, but also primary and preventative health care initiatives.

106TH CONGRESS
1ST SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. RAMSTAD (for himself, [insert names of additional cosponsors from attached list]) introduced the following bill; which was referred to the Committee on _____

A BILL

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

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

SECTION 1. SHORT TITLE.

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

SEC. 2. MODIFICATION OF PAYMENT RULES.

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

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

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

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

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

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

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

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

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

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

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

to achieve appropriate payments for plans serving such beneficiaries.

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

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

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

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

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

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

(i) includes—

"(I) a physician, and

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

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

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

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

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

SEC. 3. CONTINUOUS OPEN ENROLLMENT FOR QUALIFIED INDIVIDUALS.

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

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

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

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

SEC. 4. DEVELOPMENT OF QUALITY MEASUREMENT PROGRAM.

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

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

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

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

Jax to Jill Mendleen

Return original

EVERCARE

The EverCare Sto

Clinical Success Stories Subm

Baltimore Site

Note: These stories are dedicated to the mer

Miriam G. Otterbein

EverCare Account Executive
Who died on October 25, 1998.
Miriam always wanted to hear the EverCare stories.

Edited by: Judith W.Ryan/Mary Ferrell

Letter # 1

Mr. S is a 70-year old man who was new to my EverCare practice. I found him aphasic after an old stroke, mildly demented, almost blind, and unable to feed himself. Having recently experienced frequent falls, he was now spending his time in bed being incontinent of both urine and stool. As I was being oriented to my new patient by the nursing supervisor, she told me about her concerns for him. After his stroke, he had had a nice return of function (except for speech) and was ambulatory around the facility. About six months ago, he had started the decline I was seeing now, but I could find no trigger event or worsening of any particular pathology except his cataracts and vision. The nurse was strongly advocating for cataract surgery for this man and, since I could find no other particular reason for his decline, I agreed with her and ordered the ophthalmology consult. His son, who lived out of state, was not enthusiastic about the idea but agreed. His primary care physician asked, "What do you want to do that for?"

It is not my usual practice to try to achieve miracles or to initiate diagnostic work-ups or interventions that have no realistic benefits to the patient. But there was something in this situation, and the advocacy of his nurse, that made me look twice at Mr. S and consider the alternatives. With agreement, but not much support from his son or physician, Mr. S had a cataract repair of one eye

The transformation had been unbelievable. Although he is still aphasic and sometimes incontinent of urine, Mr. S has gained 15 pounds, is independent in his ambulating (not even a cane) in and outside of the nursing facility, and does not fall. He has regained his stool continence that may have been part of his depression and acting out associated with his lost vision. Although he is not a very social man and apparently never was, he will go into the living room or activity room sit down and watch the events and people. This is such a change from the man I first encountered as an EverCare member and, although I am very pleased to have been part of his improvement, I am also thankful for his nurse who helped me look twice.

Hope are hopeless

The EverCare Story

Clinical Success Stories Submitted by Site

Baltimore Site

Letter # 2

Laura Sorkin's
EverCare/Maryland Second Place Story

Mrs. H is a 91-year old lady who has had a long history of poor circulation in her lower extremities. She has two sons who are health care decision-makers on her behalf and a grandson who is a specialist physician. As I began caring for her, Mrs. H had terrible leg ulcers with cellulitis and her physician had some suspicion that she may also have a deep vein thrombosis. The clinical picture seemed more likely to be arterial insufficiency, but there could also be a venous component. The nursing interventions had been to elevate her legs but her condition worsened. Although her physician was not inclined to order Doppler studies for Mrs. H (and I later found out why), I persuaded him to let me do it and he agreed. I discussed it with her sons and they agreed. The next day I received a phone call from her physician grandson who was furious with me. He wanted to dis-enroll his grandmother from EverCare because we were doing unnecessary testing (even though it was non-invasive and done in the home) and increasing the burden to her and "after all, she's 91." Indeed it was his vigorous response to previous testing attempts that led her physician to avoid testing.

I asked the grandson and Mrs. H's two sons to have a family conference with her physician and me. They came the next day and by then I had the Doppler reports. They clearly indicated no DVT (so the Coumadin was not necessary) and that her problems were entirely arterial. She is definitely not a surgical candidate. The sons were pleased with the outcome of our conference and decided that leaving EverCare was not in their mother's best interest. The Doppler information also provided the nursing staff with convincing evidence to stop elevating her legs and to keep them dependent to promote what little blood flow was possible.

After several week, even though she is very susceptible to skin tears, she is more mobile in her wheelchair because nursing does not insist that she keep her legs elevated, and her leg ulcers are healed. Her sons are pleased with her care from EverCare, and maybe her physician grandson learned that being 91 is not a reason to limit medical care.

The EverCare Story

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Letter # 3

Jimmi Beard's
EverCare/Maryland Third Place Story

Mr. F was an 84-year old member with a very dear and faithful daughter who visited every day. He had been admitted to the nursing home about two and one half years ago with significant pulmonary disease from asbestos exposure. He had been slowly declining over that time, but his disease process did not keep him from being very interactive in the nursing home. He would push other residents around in their wheelchairs and last year her even danced at parties in the home.

Mr. F had sparkling blue eyes and a smile that would light up the room. Everyone in the nursing home loved him. Over the last few months, he became more frail. He used a merry walker for a while and then a wheelchair. A chest x-ray toward the end of the summer, revealed lung cancer. He was very clear, and his daughter concurred, that he wanted nothing extraordinary done at the end of his life.

The final illness was precipitated by a bout of pneumonia. He did not respond this time to treatment and he declined very rapidly. Within about 2 to 3 days, it was clear that this was his terminal episode, and I told his daughter that he would not last more than 24-36 hours. We had talked about this outcome and she was prepared for his death. He was to be buried out of state, and there was one thing his daughter needed to do before he died. She needed to get her hair done at the beauty parlor. Of course, while she was gone he died.

Mr. F's final minutes were spent with me sitting beside his bed, he had Cheyne-Strokes respiration, was mottled, and had his eyes closed. I held his hand and told him it was OK to relax and let go. As I sat with him, the nursing staff (nurses and CNAs), comfortable that I was there, started coming into the room and talking about the good times with Mr. F. They reminisced together telling stories with joy. I don't know if he heard them but, if he did, it would have been a wonderful send-off.

I was not there when his daughter got to the nursing home later that day, but I wrote her a note telling her what his last hour was like as he died. The people who had cared for him, loved him too, and she needed to know that he did not die alone. A week later, she returned to the home looking for me. She embraced me with a big hug and told me how much my note had meant to her. She had been feeling very guilty about not being there for him, and my description of his death had given her a feeling of peace.

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Letter # 4

Carrie Perfetto's
EverCare/Maryland Fourth Place Story

As part of my master's program, I had done a research paper on "Clysis Management of Dehydration." I have never seen it done clinically but was very interested in using it as an intervention when an appropriate situation arose. As I started to explore the options in one of my nursing homes, I found they had a policy and procedure but it was very incomplete and, in reality, clysis had never been used in that facility. None of my physician collaborators were particularly enthusiastic about using it, but I gave them articles to read. When I later discovered there was a Wydase shortage, that most authors mentioned as part of the procedure to enhance fluid absorption, I needed to get additional documentation indicating that Wydase was not essential.

Earlier this year there was an 89-year old gentleman (Mr.L) who was experiencing an episode of pneumonia that we were treating in the facility. He was on Intensive Service Days and had an IV running and was getting antibiotics. He was very demented and kept pulling out the IV. He had a fever, severe dysphagia, and needed treatment to continue. His physician wanted him transferred to the hospital so that IV therapy could be provided. I presented the idea of clysis (and switching the antibiotics to IM) to my physician who was very skeptical. As we spoke with the family about treatment options, they wanted treatment provided but wanted it to be the least invasive treatment possible and to avoid the hospital. The physician was still hesitant about using clysis but reluctantly agreed to let me proceed. The members of the nursing staff, who had never seen clysis done, were also skeptical. Since I had never actually done clysis before, I asked my clinical leader to come to the facility to show me the process. The entire nursing staff gathered to see this "new" technique. We gave a 500cc bolus into the thighs and, in less than 15 minutes, all the fluid was absorbed. The nursing staff was really surprised at how easy clysis was and how quickly the fluid was absorbed. I asked that clysis be repeated once each shift and by the next day Mr L was out of bed and walking.

Since that time, we do clysis about once a month in that nursing home. When I have similar clinical situations and present them to my physicians, they are likely to say, "You want to do that clysis stuff again, don't you." The positive patient outcomes have won over both the physicians and the nursing staff. My current goal (and it has not happened yet) is to have the physicians or nurses call me with a clinical problem and suggest that clysis might be indicated.

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The EverCare Story

Clinical Success Stories Submitted by Site

Minneapolis Site

Letter # 1

An EverCare Story

Submitted by:
Pat Peschman RN C, GNP
Clinical Leader
EverCare, MN

R.W. became an EverCare patient in October of 1996. At the time we assumed her care R.W. was quite unstable. She had been suffering from an episode of herpes zoster with significant pain, large open areas on her right thigh and buttock at the sites of former blisters, a significant decline in functional status and a loss of ten pounds in weight over the previous three weeks. Four different medications had been prescribed for pain control. A dermatologist had been consulted, necessitating a trip to his office for diagnosis and treatment orders. In addition, in the three months prior to joining EverCare, R.W. had been to the emergency room three times for episodes of chest pain and congestive heart failure.

On my initial visit several concerns became immediately apparent. R.W. was quite sedated from the pain medication she was receiving, contributing to the decline in her oral intake. She had not been out of bed for almost two weeks placing her at risk for complications of immobility and contributing to her decline in function. Also, there was no treatment ordered for the open areas on her legs setting up the possibility of secondary infection. When I spoke with R.W's daughter she raised concerns about her recent significant decline and level of sedation. She told me that her mother wanted treatment to prolong her life, but that she hated going to the hospital and became very anxious with any transfer out of the facility.

As the EverCare physician and I reviewed her plan of care several changes were made immediately. A wound treatment protocol was established, doses of pain medications were adjusted and a plan for increasing R.W.'s activity and oral intake was established with the nursing staff. Over the next couple of weeks R.W.'s regimen of pain medications was simplified, allowing better pain control and less

sedation. As her wounds gradually healed, physical therapy was initiated to help her regain her strength and mobility. She began to return to the dining room for her meals and her oral intake gradually improved. Frequent contact with the nursing home allowed early identification of slow progress in her rehabilitation. Working closely with the nursing and physical therapy staff we identified ongoing issues of pain control related to her osteoporosis and a new diagnosis of depression. By adjusting her medication profile and providing close monitoring of her response these problems were gradually improved, allowing her increased time out of her room for interaction with other residents and staff.

R.W.'s significant cardiac disease continued to cause her discomfort and, as a result, she was often anxious. Monthly onsite visits and frequent telephone follow-up with the nursing staff allowed us to recognize changes in her cardiac status in the early stages and initiate fine tuning of her medication profile. As her angina and congestive heart failure became better controlled her anxiety decreased, allowing us to discontinue sedatives that she had previously required.

During her first year with EverCare R.W. experienced an exacerbation of her congestive heart failure and an episode of pneumonia. With both episodes the nursing staff and family initially thought she should go to the hospital, despite how much she disliked being there. The ability of the EverCare nurse practitioner to provide acute visits, support the nursing staff and maintain close contact with the family increased their comfort with having her treated in the nursing home. R.W. had no transfers to the hospital during her first thirteen months as an EverCare patient. R.W.'s daughter has frequently expressed her thanks to us for helping her mother achieve the best quality of life possible, avoid trips to the hospital and keeping her well informed of her mother's condition.

To me, R.W.'s example characterizes the EverCare model. I didn't share this story because we had made extraordinary modifications in her plan of care or a miraculous change in her quality of life, though I know those stories exist. I thought of R.W. because in providing the usual care that is the essence of the EverCare model we were able to make a significant difference in the manner in which her care was provided and ultimately to improve her quality of life. I believe she is a good example of the positive impact we have every day just because we provide care in a way that makes sense for elderly individuals living in a long-term care environment.

The EverCare Story
Clinical Success Stories Submitted by Site

Minneapolis Site

Letter # 2

Sent by Mary Keith:

EverCare success can be measured in many ways. As a nurse practitioner, I measure success for EverCare in the outcomes achieved by adhering to the enhanced care model of providing the right care for the right reason at the right time in the right place with the right provider. The following story illustrates the circuitous pathway that can result and the importance of keeping the goals in sight.

Mrs. J, a 75 year old white female, was admitted to a local nursing home after an extended stay in a hospital—much of the time in an intensive care unit. She had been living at home before developing acute respiratory distress, being intubated in the emergency room, and admitted to MICU.

A difficult hospital course ensued with Mrs. J obtaining a permanent tracheotomy, a PEG tube, several decubiti and MRSA. When she was successfully weaned from the ventilator she was admitted to the facility where I had a caseload of EverCare patients.

Mrs. J presented many challenges and opportunities to our EverCare model of providing enhanced care at the bedside. She was a complex medical patient with significant respiratory compromise secondary to cigarette smoking, a history of heavy alcohol use, general deconditioning, decubiti, MRSA, and depression. She was divorced and maintained good relationships with her three children. Her youngest child was in his early forties, unmarred and occasionally lived with his mother.

At the time I met Mrs. J, she was a full code and was competent to make this decision. After becoming familiar with her history, talking with her about her goals and expectations and completing an assessment, I reviewed the case with my collaborating physician and identified our goals. Our goals were very simple in view of her complexity, but appropriate to her condition. The first goal was a family conference to discuss her current state of health, their expectations, the treatment planned, and advanced directives. Our next goal was to maintain her respiratory status. Skin integrity and healing of her decubiti created a goal. Another goal was to have all nutritional intake become oral. (She was a "recreational eater" and relying on enteral feeding for more than half of her caloric needs.) The next goal was to address her depression. The last initial goal was to begin reconditioning Mrs. J to develop strength and stamina to perform ADLs and ambulate from her room to the dining room.

My first conference with Mrs. J and her youngest son revealed a patient and son in flat out denial about the seriousness of her condition. Mrs. J and her son wanted her to go home. Mrs. J was refusing to feed herself, toilet herself, or go to therapy. She verbally accosted the

staff for getting her up in a chair and for doing pulmonary hygiene. My work was to help them accept the connection between their goal of going home and tasks we were ordering for Mrs. J.

My next family conference involved Mrs. J and all three children. At this conference, I talked again about advance directives because Mrs. J was still not participating in a rehabilitation plan. The two older children supported Mrs. J's decision not to be intubated, but the youngest son was adamant that his mother MUST be intubated if needed. The patient and family then decided to maintain a full codes status for the time being.

Mrs. J was kept out of the hospital for almost two months by vigilant attention from the nursing home staff and the EverCare primary care team. When her system could not overcome a respiratory infection, she again arrested and was placed on a ventilator in the MICU. Weaning was slow, but successful. On return to the facility, her healed decubiti were now open and she had reverted to being 100% enteral feeding.

Mrs. J presented challenges to the nursing and therapy staff because her stated wishes to go home were not consistent with her actions and behavior. My frequent presence gave the staff a forum for ventilating their frustration and allowed us to rework the care plan without Mrs. J becoming a "bad" patient.

Within one month, Mrs. J was again hospitalized, repeating the earlier scenario of the past month. I repeated Mrs. J's mini mental after this hospitalization. My previous mini mental 5 months earlier was 28. Now the results were 15.

At this time I arranged a conference with staff, family, Mrs. J, and the EverCare primary care team. We talked about the futility of her lungs recovering full function and how poor oxygen delivery was affecting Mrs. J. We were gentle, but firm about the limited success of CPR. All three children at this time were in agreement with their mother that she should not be intubated, hospitalized, or have CPR attempted. They did want antibiotic treatment and IVs in the nursing home if needed.

We continued to address mobility, strengthening, nutrition, skin care, and depression along with attention to maintaining pulmonary hygiene. Ten months after Mrs. J became an EverCare member she sustained an overwhelming infection that was not reversed with antibiotics. She lapsed into a coma. I stayed in close contact with her family and made daily visits to monitor her comfort and condition. She died peacefully in her room on the third day of this septic occurrence.

This is a success story because it represents what happens on a daily basis with EverCare patients. Our practice is structured to focus on the geriatric patient in long-term care and allows time for frequent visits, family contact and interface with the nursing home staff. With Mrs. J and her family, we had an evolution in goals. Returning independently to her home at the start of our care changed to a goal of a comfortable life and death in the nursing home. Because of our enhanced care model, we provided the *right* care for the *right* reason at the *right* time in the *right* place with the *right* providers.

The EverCare Story
Clinical Success Stories Submitted by Site

Minneapolis Site

Letter # 3

Sent by Laura Lathrop

This is about a very self-sufficient woman and her desire for self-determination and how the EverCare model supported that.

I first met this remarkable woman in March, 1997. She was 91 years old and had been living in the assisted living area of the nursing home campus since February, 1985. I will call her Mary, which is not her real name. She had been maintaining her autonomy and independence with very little help of the home care staff while she managed her chronic medical conditions. She had a brother and sister-in-law who respected her autonomy but were available to assist when needed. On more than one occasion she was unavailable to see me in the clinic because she was "working on my taxes" or had some other activity she was involved with.

The medical condition which was of primary concern was the chronic loose stools that had resulted from the pelvic radiation secondary to uterine cancer and a colon resection. There was constant follow-up related to control of this physically and socially debilitating condition. It at times was difficult to adequately get a history of the frequency because of her mild dementia. The home care staff provided the best information and that was related to their observation of her apartment. She continued on this plateau of some good days and some bad days as we see with all chronic conditions.

April 1998 she became quite ill with fever, chills and poor intake. She was treated with IM Rocephin and did recover but shortly after that developed C.diff which was treated. Her bowels return to their baseline state but Mary did not. On May 28th, Mary, her brother, and myself met to discuss the fact that she was having more and more difficulty managing in her apartment because of some cognitive decline and her refusal of home care and becoming more reclusive. Mary agreed to a short-term nursing home stay to assess her bowel status, hydration and overall condition. Mary was now unable to walk and needed a wheelchair. She had been very clear at each discussion of advanced directives that she wanted to kept comfortable, not hospitalized, and she wanted nature to take its course. Mary was admitted to the nursing home and given a liter of IV hydration, which she agreed to. When I saw her again on June 1, she had continued to decline and was uncomfortable. She was moaning and had a very rapid respiratory rate. After discussion with the brother and sister-in-law, it was decided to discontinue the IV and start morphine for comfort. Mary died the next evening.

As I talked to the brother and the home care staff after Mary's death, I realized that this smooth transition from independence to a peaceful and comfortable death might not have happened in the traditional setting. She most certainly would have required a hospital stay to receive the skilled care in the nursing home, a place that she recognized as a hazard to her health and which she wanted to avoid. She had said many times that she was ready to die and just wanted to be comfortable. The brother also emphasized that the close monitoring by the nurse practitioner allowed for easy transition from one intervention to another as Mary's condition changed. This would not have been possible in the usual clinic setting. Mary's brother, the home care staff, and I shared the same satisfaction: that this was the way Mary had wanted it and that made it all the more beautiful.

The EverCare Story

Clinical Success Stories Submitted by Site

Minneapolis Site

Letter # 4

Sent by Lowi Sipprell

Mrs. H is a 90-year old female residing at Texas Terrace Nursing Home. In the early morning hours of 12/7/98, she fell and the on-call MD was called. Dr. McFadden requested a portable X-ray company to come into the nursing home to x-ray the hip to r/o a fracture. The x-ray result was a fracture as suspected. Dr. McFadden arose at 4:00AM and met Mrs. H at Fairview Riverside Hospital as a direct admit (avoiding a trip through the ER) to complete a history and physical. The orthopedic surgeons (Drs. O'Neal and et all) had been contacted earlier and Mrs. H was in the OR by 7:30 AM. The hospital convalescence went very well and Dr. Stein (the primary EverCare MD) discharged Mrs. H to Texas Terrace Nursing Home on 12/9/98 arriving at 6:30PM. At the time of discharge, she was walking with a walker and an assist of one. The next morning 12/10/98, the EverCare Primary Team (Dr. Stein and Lowie Sipprell NP) examined Mrs. H, reviewed her progress, requested Physical Therapy to evaluate and treat.

This is a wonderful orchestration of stellar patient care!! Each team member individually played a vital role, yet only able to perform when dependent on one another!

EVERCARE®

The EverCare Story

Clinical Success Stories Submitted by Site

Tampa Site

Letter # 1

THE EVERCARE STORY

AWAKENING

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

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

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

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

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

EverCare®

The EverCare Story

Clinical Success Stories Submitted by Site

Baltimore Site

Note: These stories are dedicated to the memory of

Miriam G. Otterbein

EverCare Account Executive
Who died on October 25, 1998.
Miriam always wanted to hear the EverCare stories.

Edited by: Judith W.Ryan/Mary Ferrell

Letter # 1

Mr. S is a 70-year old man who was new to my EverCare practice. I found him aphasic after an old stroke, mildly demented, almost blind, and unable to feed himself. Having recently experienced frequent falls, he was now spending his time in bed being incontinent of both urine and stool. As I was being oriented to my new patient by the nursing supervisor, she told me about her concerns for him. After his stroke, he had had a nice return of function (except for speech) and was ambulatory around the facility. About six months ago, he had started the decline I was seeing now, but I could find no trigger event or worsening of any particular pathology except his cataracts and vision. The nurse was strongly advocating for cataract surgery for this man and, since I could find no other particular reason for his decline, I agreed with her and ordered the ophthalmology consult. His son, who lived out of state, was not enthusiastic about the idea but agreed. His primary care physician asked, "What do you want to do that for?"

It is not my usual practice to try to achieve miracles or to initiate diagnostic work-ups or interventions that have no realistic benefits to the patient. But there was something in this situation, and the advocacy of his nurse, that made me look twice at Mr. S and consider the alternatives. With agreement, but not much support from his son or physician, Mr. S had a cataract repair of one eye

The transformation had been unbelievable. Although he is still aphasic and sometimes Incontinent of urine, Mr. S has gained 15 pounds, is independent in his ambulating (not even a cane) in and outside of the nursing facility, and does not fall. He has regained his stool continence that may have been part of his depression and acting out associated with his lost vision. Although he is not a very social man and apparently never was, he will go into the living room or activity room sit down and watch the events and people. This is such a change from the man I first encountered as an EverCare member and, although I am very pleased to have been part of his improvement, I am also thankful for his nurse who helped me look twice.

Arent Fox Kintner Plotkin & Kahn

AMERICAN ASSOCIATION OF BIOANALYSTS
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TELEPHONE: (314) 241-1445 FACSIMILE: (314) 241-1449 E-MAIL: aab1445@aol.com

Meeting with Christopher C. Jennings
Deputy Assistant to the President for Health Policy
Old Executive Office Building (17th & G Streets, NW, Room 472)
Washington, DC 20502 — (Tel) 202-456-5560
Wednesday, July 28, 1999, 12:00 Noon

I. Introduction of Meeting Participants

- Mr. Alvin Salton
- Mr. Robert Waters
- Ms. Lori Housman
- Mr. William Applegate

II. President Clinton's Plan to Modernize and Strengthen Medicare for the 21st Century

- Appreciation for the President's leadership and continuous efforts to preserve and strengthen the Medicare program.

III. Overview of Clinical Laboratory Community

- Cost Effective Service with Declining Expenditures
  - Critical role of clinical laboratory services in health care.....early diagnosis, treatment & management;
  - Medicare expenditures for clinical laboratory services have decreased steadily during the last four years (1994 to 1997) while enrollees have increased during the same period; and
  - Amount Medicare paid annually for clinical laboratory services substantially declined from $120 per enrollee in 1994 to $105 per enrollee in 1997.

- Disproportionate Reductions Cannot Continue to be Absorbed
  - Over the past 15 years, Congress has systematically reduced the fee schedule cap and reduced or frozen CPI increases for clinical laboratory services;
  - Balanced Budget Act (BBA) of 1997 reduced the Medicare fee schedule cap for clinical laboratory services to 74 percent of the national median and froze the payment rate until 2002;
  - OBRA 1993 reduced Medicare reimbursement for clinical laboratory services by more than 14 percent;

- The President's Medicare reform proposal seeks to cut clinical laboratory services by $8 billion dollars over a 10 year period through re-instituting a 20 percent beneficiary co-payment; and
- The co-payment proposal results in an additional 20 to 30 percent cut for clinical laboratory services.

IV. Implementation of Co-payments for Clinical Laboratory Services

- How would it work?

  - Copayments for laboratory services have proven ineffective in the past and were eliminated by Congress in DEFRA 1984;
  - If copayments were re-implemented, laboratories would have to produce two claims — one to the Medicare program and one to the patient;
  - On average, it costs between $3 and $5 dollars to produce an additional invoice covering the copayment;
  - In 1997, the average charge for a clinical laboratory service to a Medicare Part B enrollee was $9.66 (HCFA Office of Actuary);
  - A 20 percent copayment for a $9.66 procedure would be $1.93;
  - The cost to produce an invoice for that amount would be $1 to $3 dollars greater than the cost of the actual copayment;
  - If a copayment system were implemented, over 75 percent of the top 100 most utilized clinical laboratory tests would result in a beneficiary copayment of less than $2.50 (1996 Medicare Part B Extract and Summary System);
  - A full 19 percent of these tests would result in a copayment of less than $1.00; and
  - Past experience with co-payments frequently results in multiple attempts (required by law under federal anti-fraud statutes) to collect these fees — thus further increasing the cost and real cut to clinical laboratories.

V. Background/Rationale for the President's Medicare Reform Proposal & 20 Percent Copayment for Clinical Laboratory services

Medicare Reform Proposal, Detailed Description, July 2, 1999

- *"Clinical laboratory services represents a fast-growing Medicare Service."*

Response: Medicare Part B spending on clinical laboratory services is declining in absolute terms while overall Medicare spending for other services has increased. The percent of Part B outlays for clinical laboratory services has decreased steadily from 2.6 percent in 1994 to 1.8 percent in 1997. This occurred while the number of Medicare enrollees actually increased an average of 1.4 percent per year during the same period. The result is that the amount paid annually for clinical laboratory

services substantially declined from $120 per enrollee in 1994 to $105 per enrollee in 1997 (HCFA Office of the Actuary).

- *"Having beneficiaries contribute towards their lab services would make cost-sharing requirements under Part B more uniform and easier to understand."*

Response: Congress, with the support of HCFA, eliminated co-payments for clinical laboratory services in DEFRA 1984. Past experience with these co-payments for clinical laboratory services resulted in confusion on the part of the beneficiary and in difficulty in collecting the fees. Federal anti-fraud statutes require that the laboratory collect these amounts. Second, third and fourth collection attempts further increase the cost to clinical laboratories — resulting in additional real-cuts to laboratory services.

- *"It also could cut down on fraud and help reduce over-use."*

Response: Patients do not decide when to order testing nor do they select the testing laboratory. Thus, imposition of co-payment obligations on Medicare beneficiaries will not curtail utilization.

The Congressional Budget Office noted:

Cost-sharing probably would not affect enrollees' use of laboratory services substantially, . . . because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing.

- *"This proposal would waive the Part B deductible and 20 percent coinsurance rate for preventive services for which cost sharing is not already waived under current law."*

- *"To promote prevention, no cost sharing will be required for any preventive benefits. Existing co-payments and deductibles for every preventive service covered by Medicare,.....will be eliminated."*

Response: Clinical laboratory services serve a critical role in the detection, diagnosis and treatment of disease. As the first point of intervention, test results often serve as the foundation for the diagnosis and management of disease. Advances in laboratory testing have made it possible for patients to be diagnosed earlier and treated sooner.

In the interest of health and in containing costs, it will not serve the system well to discourage beneficiaries from seeking clinical laboratory tests that have been

ordered by a physician, based on medical judgement in the normal process of diagnosis. Why penalize patients that have a physician- identified need for tests that are critical to their diagnosis and treatment?

Medicare Reform Proposal, Preview Description, June 29, 1999

- *"The modest lab co-payment would help prevent overuse, reduce fraud, and has been advocated by the Medicare Payment Advisory Commission."*

Response: MedPac has not specifically addressed or made recommendations on the issue of co-payments for clinical laboratory services.

AMERICAN ASSOCIATION OF BIOANALYSTS

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July 22, 1999

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

Dear Chairman Roth:

On behalf of the American Association of Bioanalysts (AAB), we appreciate the opportunity to provide written comments to the Senate Finance Committee on the President's proposal to reform the Medicare program. AAB represents the directors and owners of clinical community-based laboratories.

As you know, clinical laboratory services serve a critical role in the detection, diagnosis and treatment of disease. As the first point of intervention, test results often serve as the foundation for the diagnosis and management of disease. Advances in laboratory testing have made it possible for patients to be diagnosed earlier and treated sooner. At the cutting edge of biotechnology, laboratory diagnostics are a critical part of the movement toward less invasive intervention and preventive health care services.

As the providers of clinical laboratory services to millions of Americans, we are very concerned about the recent White House Medicare proposal to further reduce reimbursement for clinical laboratory services by $8 billion dollars over the next ten years through a re-implementation of a 20 percent beneficiary copayment for clinical laboratory services. Copayments for laboratory services have proven ineffective in the past and were eliminated by Congress, with the support of the Health Care Financing Administration, in DEFRA 1984. Simply put, copayments do not make sense or sound public policy for patients or providers.

For your review, we have attached written comments outlining AAB's concerns with the President's proposal to reform the Medicare program. As you move forward in developing your own proposal, please do not hesitate to contact AAB if we may be of assistance to you or your staff.

Sincerely,

Mark Birenbaum, Ph.D.
Executive Director

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COMMITTEE ON FINANCE
UNITED STATES SENATE

Hearing on the
President's Proposal to Reform Medicare

Thursday, July 22, 1999

LABORATORY COPAYMENTS
Does Not Make Sense or Sound Public Policy

In the past, some budget proposals have called for the imposition of Medicare beneficiary copayment obligations on laboratory testing services. Most recently, the Clinton Administration proposed to implement a 20 percent copayment for clinical laboratory services. This proposal is seeking $8 billion dollars from clinical laboratory services over the next ten years. The reinstitution of the coinsurance requirement, which Congress deleted in 1984 with the support of the Health Care Financing Administration ("HCFA") and the laboratory industry, would add to the health care costs already borne by Medicare beneficiaries and have an injurious effect on laboratories.

The cost of billing the coinsurance would often exceed the amount collected.

If coinsurance were reimposed, laboratories presumably would have to produce two claims - one to the Medicare Program and one to the patient. On average, laboratories estimate it would cost between $3 and $5 just to produce the additional invoice covering the coinsurance. In many instances, this cost would be a substantial percentage of the amount collected from the patient and could easily exceed collected amounts. For example, in 1997 the average charge for clinical laboratory services to a Medicare Part B enrollee was $9.66 (HCFA Office of the Actuary). A 20 percent copayment for $9.66 would be $1.93. The cost to produce a copayment invoice for the 1997 average patient cost of $9.66 would be $1 to $3 dollars more than the collected amount. This does not make sense and is not good public policy.

The following chart illustrates the approximate coinsurance amount for several commonly ordered tests. For these common tests, the collection costs exceed the coinsurance payments:

	Cap	Coinsurance
Multichannel chemistry test	**$14.86**	**$2.98**
CBC, with differential	**$10.36**	**$2.02**
Urinalysis	**$4.24**	**$0.85**

In many instances, the costs of collection would be even higher than $3 to $5. For example, if the patient did not pay after receiving the first invoice, follow-up would be necessary, thus increasing the costs to the laboratory. Furthermore, past experience with coinsurance suggests that many laboratories will have to write off from 20 to 50% of the billed amounts as uncollectible, despite a federal requirement that labs attempt to collect these amounts.

These collection problems are the very reason that coinsurance was eliminated by Congress as part of DEFRA '84, with the support of HCFA and the laboratory industry. In exchange for eliminating the copayment, Congress mandated the current fee schedule methodology. Over the past fifteen years Congress has systematically reduced the fee schedule cap and reduced or frozen CPI increases for laboratory services. The Balanced Budget Act of 1997 reduced the cap to 74 percent of the national

median and froze the payment rate until 2002. To reinstate copayments and the resulting costs to laboratories on top of these real cuts, is unwarranted and unfair.

Reinstitution of coinsurance imposes an additional cut for labs.

Because of the costs of billing and the increase in bad debt write-offs, coinsurance actually constitutes a substantial cut in Medicare reimbursement.

Some laboratories estimate that coinsurance would effectively reduce this reimbursement by a minimum of 15 percent.

In recent years, laboratories have absorbed significant reductions in reimbursement as a result of deficit reduction efforts. In addition to reductions in the 1997 Balanced Budget Act, laboratories were subject to cuts in Medicare reimbursement of more than 14 percent as a result of reductions mandated by OBRA '93. This differs from the reduced increases the government granted to physicians and hospitals. Most laboratories cannot continue to absorb the costs of coinsurance on top of these other reductions.

Reinstitution of coinsurance would hurt Medicare beneficiaries.

Imposition of coinsurance would shift the costs of the Medicare program to beneficiaries and force them to incur an additional $7 billion in out-of-pocket expenses.

This change would place an additional burden on Medicare beneficiaries, a burden that Congress specifically relieved them of in 1984.

As noted above, this provision constitutes a cut in Medicare reimbursement for laboratories. A reduction of that size, coupled with the Balanced Budget Act of 1997 and the Medicare cuts imposed on laboratories by OBRA '93 as well as previous budget laws, would adversely affect both the quality of services that laboratories are able to provide and the access to services that beneficiaries currently enjoy.

Coinsurance for laboratory services would have no effect on utilization of services.

Patients do not decide when to order testing nor do they select the testing laboratory. Thus, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization.

In a recent analysis of cost-sharing, the Office of Technology Assessment indicated that:

> [Participants in cost-sharing plans were much less likely to seek medical attention than others, but once they did, the amount and cost of their care was largely *unaffected* by cost-sharing and apparently was determined principally by their physician.[1]

The Congressional Budget Office also noted:

> Cost-sharing probably would not affect enrollees' use of laboratory services substantially, . . . because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing.[2]

Coinsurance for laboratory services could invite abuse.

Because the typical copayment amounts would be small and the administrative burden of collecting them is great, some laboratories will likely be pressured to agree to requests that they waive receipt of copayment amounts from beneficiaries. Such practices would create legal uncertainty and competitive problems because the Office of Inspector General has issued a fraud alert that warns that such waivers may well be unlawful.

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1. OTA, "Benefit Design: Patient Cost-Sharing" at 5 (February, 1994).

2. CBO, "Reducing the Deficit: Spending and Revenue Options" at 140 (February, 1990).

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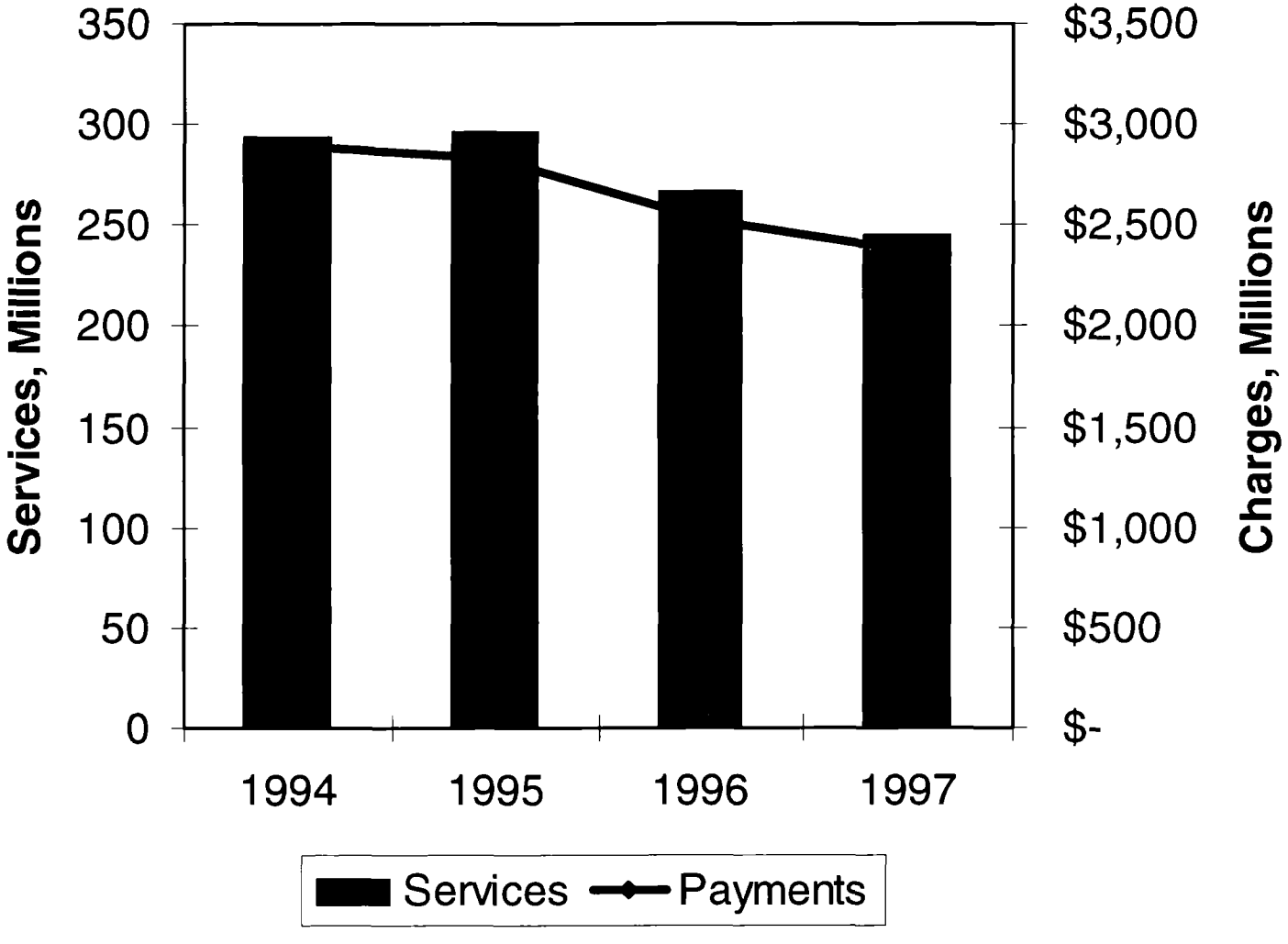
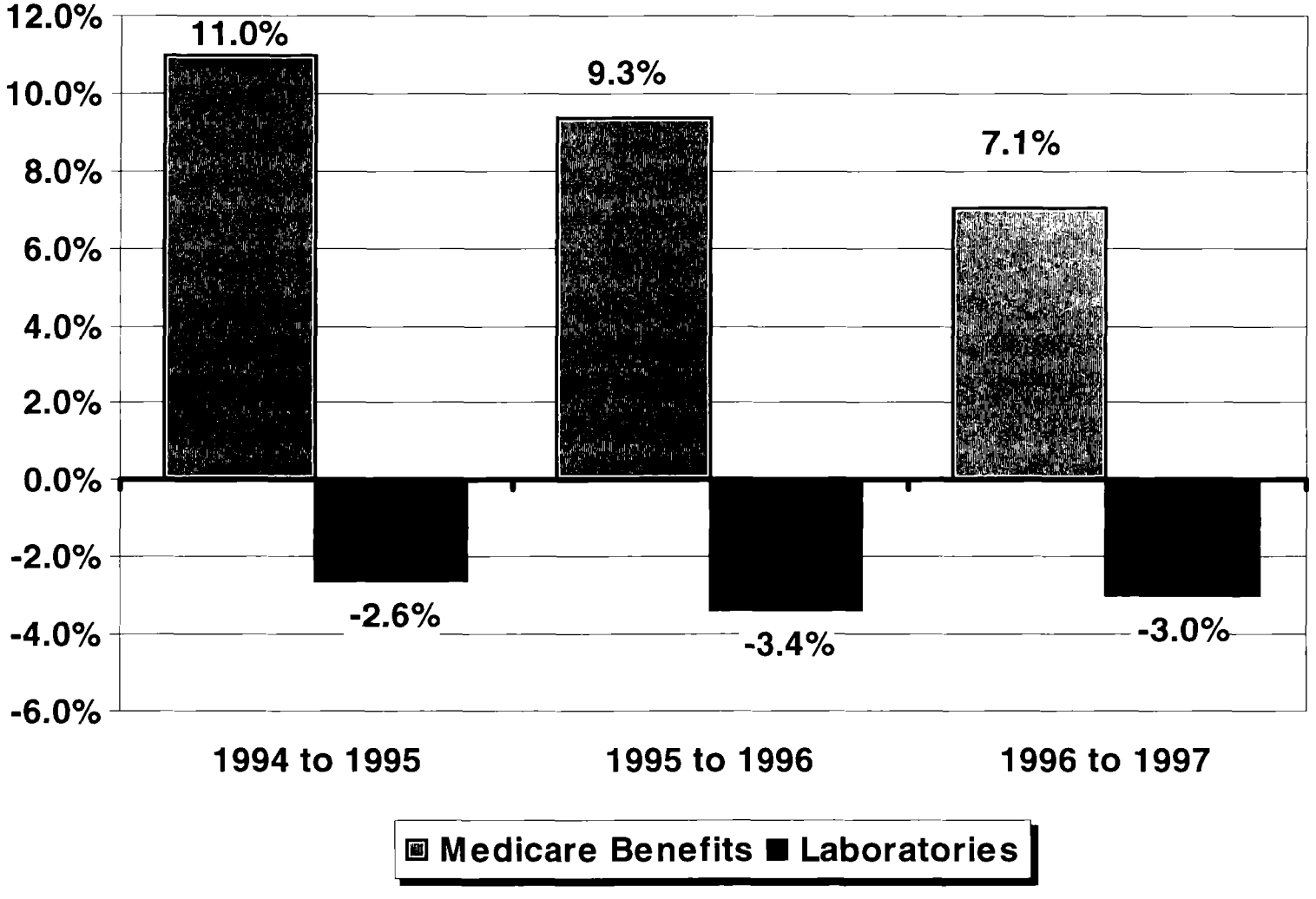
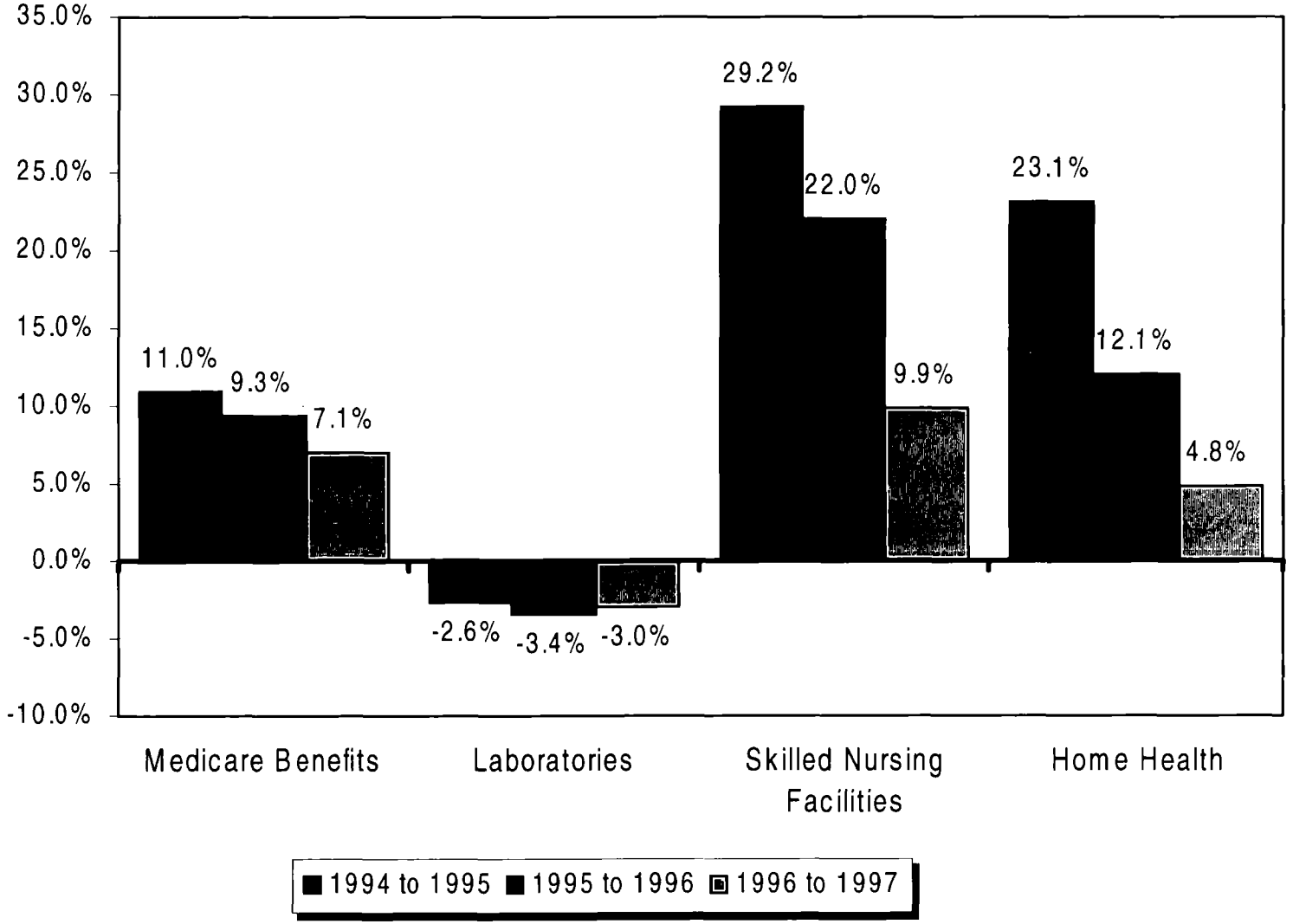
Services & Payments for Part B Lab Services



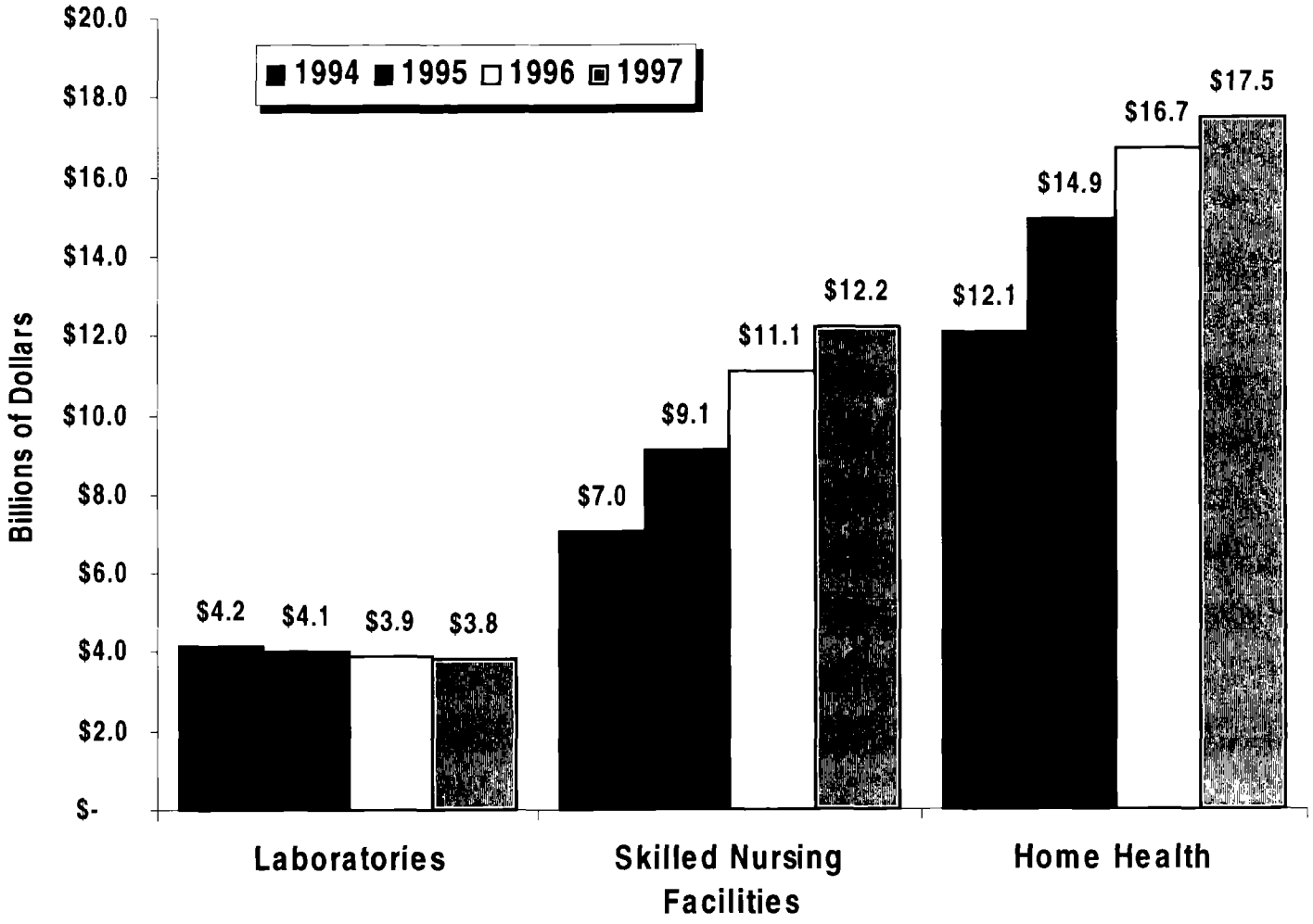
Growth Rates in Part B Medicare Spending



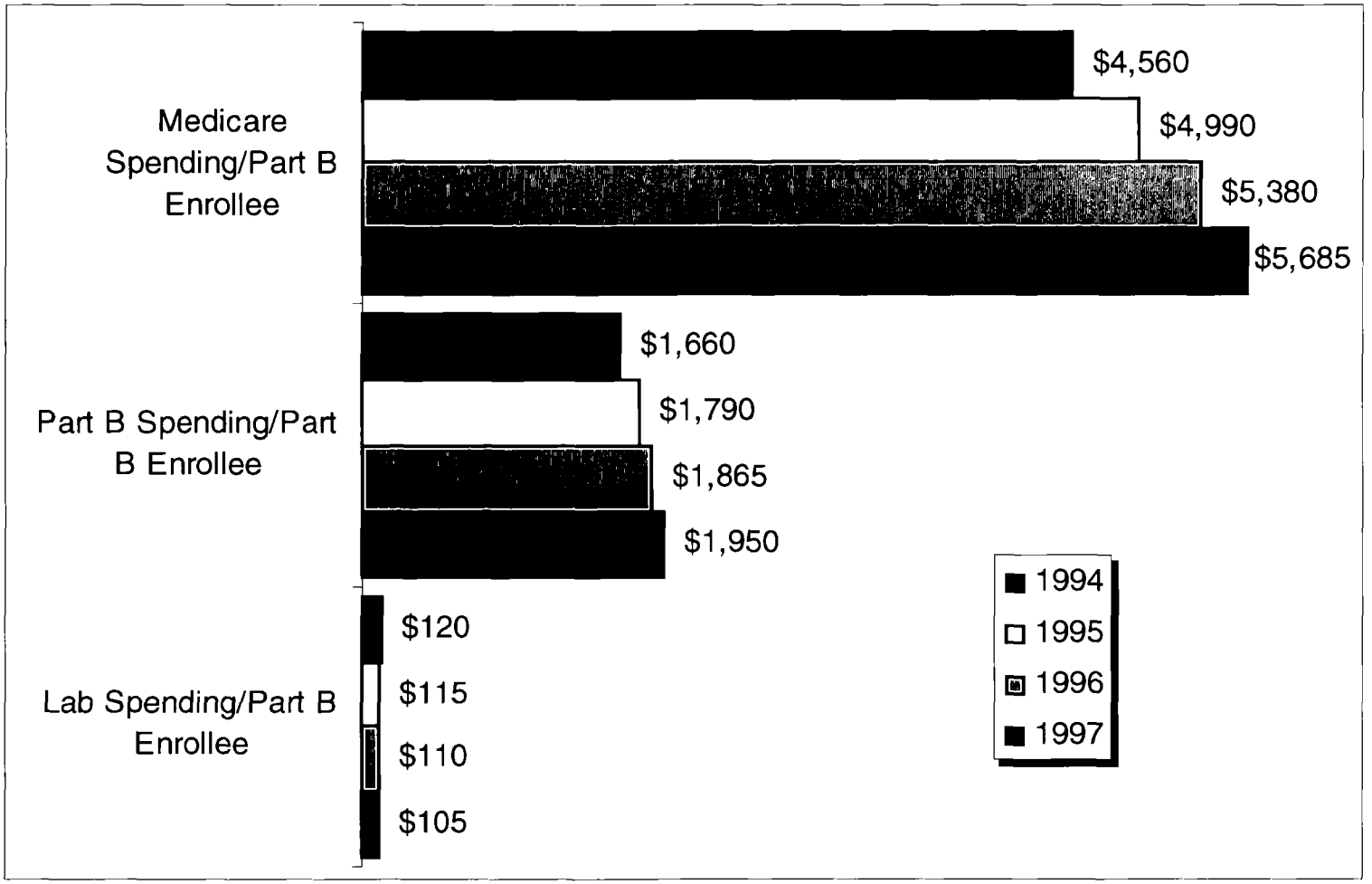
Growth of Part B Spending vs Overall Medicare



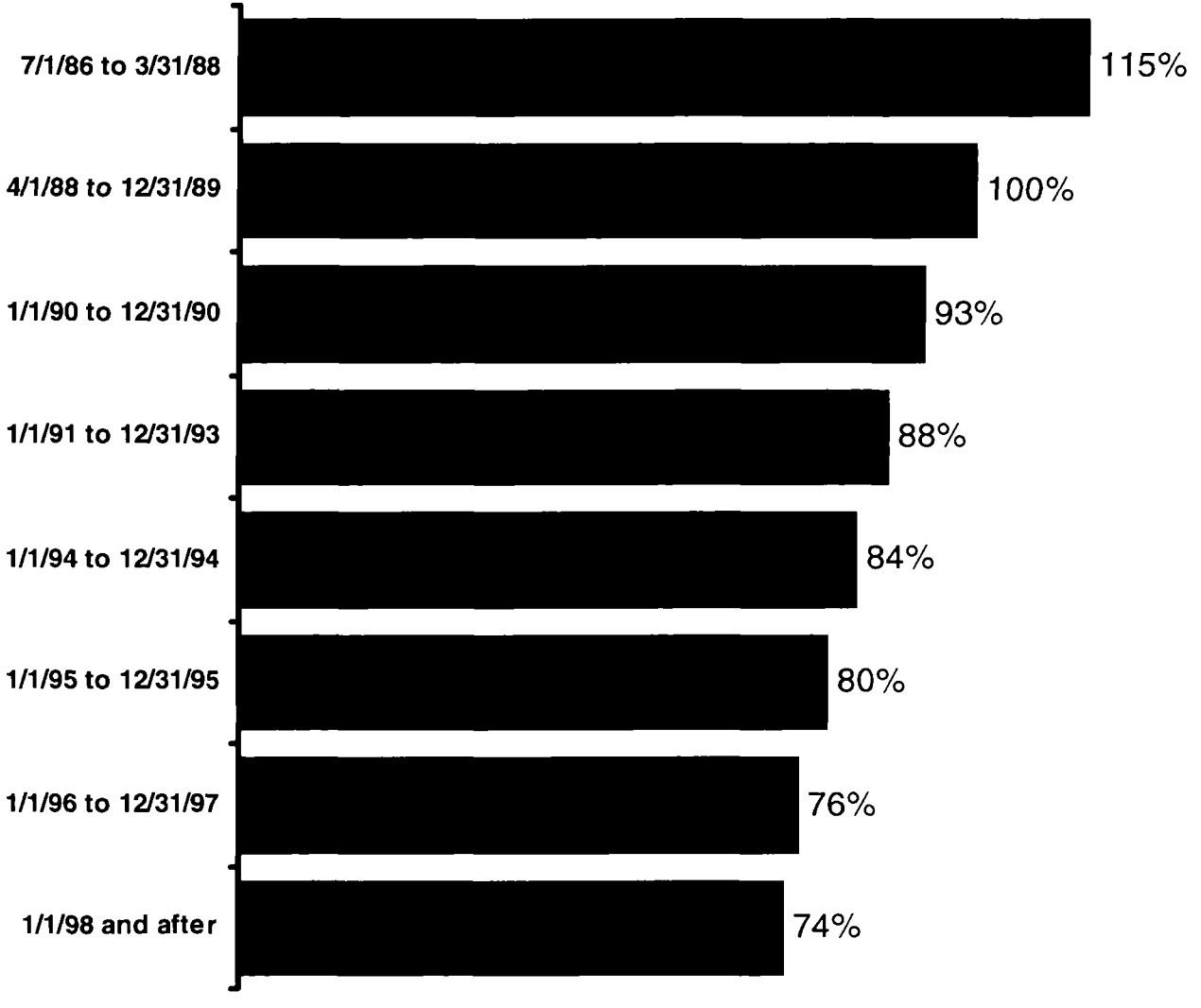
Actual Part B Medicare Dollar Spending



Dollar Spending per Medicare Program Enrollee



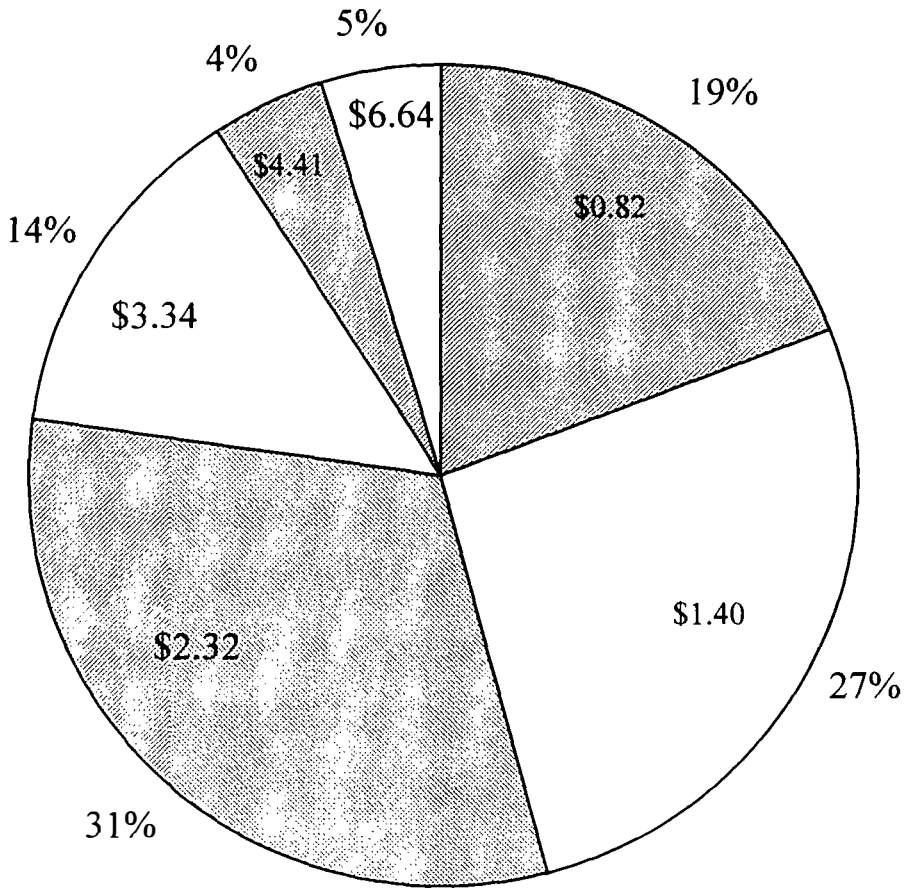
National Pay CAPS



Medicare Beneficiaries Would Be Required to Write *Very* Small Checks to Pay for Coinsurance for the Top 100 Clinical Laboratory Procedures

Each segment of the pie represents the percentage of procedures, weighted by utilization, and the corresponding coinsurance amounts.

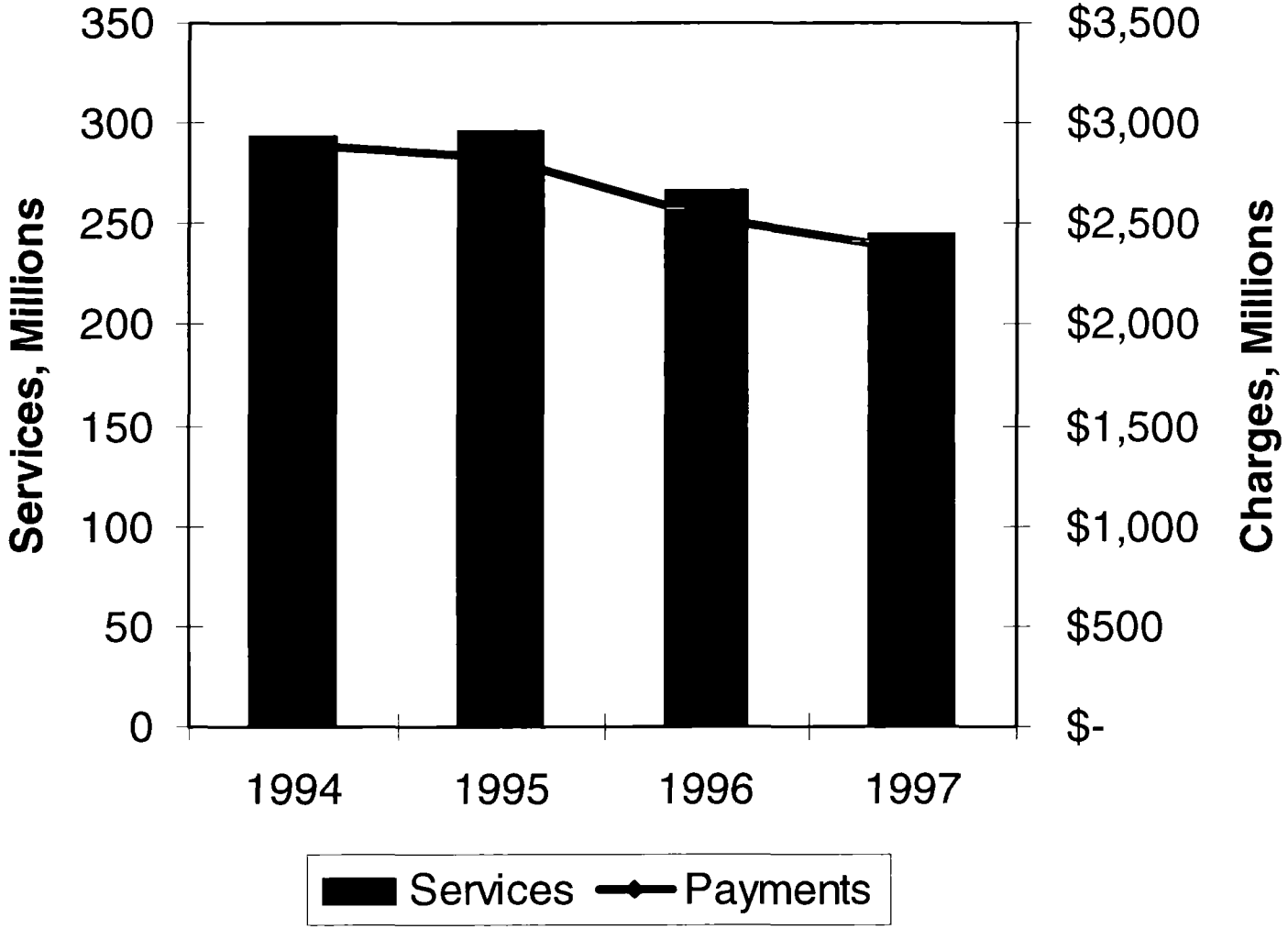
For over 75 percent of lab procedures, beneficiaries would be paying less than $2.50 out-of-pocket.



Source: 1996 Medicare Part B Extract and Summary System

Arent Fox
7/27/99

Services & Payments for Part B Lab Services



AMERICAN ASSOCIATION OF BIOANALYSTS
917 LOCUST STREET • SUITE 1100 • ST. LOUIS, MISSOURI 63101-1413
TELEPHONE: (314) 241-1445 FACSIMILE: (314) 241-1449 E-MAIL: aab1445@aol.com

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20502

Dear President Clinton:

On behalf of the nation's clinical laboratories, we appreciate your leadership and continuous efforts to preserve and strengthen the Medicare program. For your consideration, the Clinical Laboratory Coalition would like to provide you with the attached recommendations for improving the Medicare program.

If you or your staff have any questions or require additional information, please do not hesitate to contact any of the member organizations of the Clinical Laboratory Coalition or the American Association of Bioanalysts at (314) 241-1445.

Sincerely,

Mark S. Birenbaum, Ph.D.
Administrator

Attachment

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20502

Dear President Clinton:

On behalf of the nation's clinical laboratories, we appreciate your leadership and continuous efforts to preserve and strengthen the Medicare program. However, we are extremely concerned about the recent White House Medicare proposal to: 1) further reduce reimbursement for clinical laboratory services by $8 billion dollars over the next ten years; and 2) re-implement a 20 percent beneficiary copayment for clinical laboratory services. Simply put, our nation's clinical laboratories cannot continue to absorb these significant and disproportionate annual reductions that Congress and the Administration have continued to impose over the last 15 years.

Clinical Laboratory Services are Essential

As you know, clinical laboratory services serve a critical role in the detection, diagnosis and treatment of disease. As the first point of intervention, test results often serve as the foundation for the diagnosis and management of disease. Advances in laboratory testing have made it possible for patients to be diagnosed earlier and treated sooner. At the cutting edge of biotechnology, laboratory diagnostics are a critical part of the movement toward less invasive intervention and preventive health care services.

Copayments are Unsound Public Policy

Copayments for laboratory services have proven ineffective in the past and were eliminated by Congress in DEFRA 1984. If copayments were re-implemented, laboratories would have to produce two claims — one to the Medicare program and one to the patient. On average, it costs between $3 and $5 dollars to produce an additional invoice covering the copayment. In 1997, the average charge for a clinical laboratory service to a Medicare Part B enrollee was $9.66 (HCFA Office of Actuary). A 20 percent copayment for a $9.66 procedure would be $1.93. The cost to produce an invoice for that amount would be $1 to $3 dollars greater than the cost of the actual copayment. This does not make sense or sound public policy for patients or providers.

If a copayment system were implemented, over 75 percent of the top 100 most utilized clinical laboratory tests would result in a beneficiary copayment of less than $2.50 (1996 Medicare Part B Extract and Summary System). A full 19 percent of these tests would result in a copayment of less than $1.00.

Copayments Do Not Reduce Utilization of Services

Patients do not decide when to order clinical laboratory testing nor do they select the testing laboratory. Thus, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization.

Clinical Laboratories Cannot Continue to Absorb Disproportionate Reductions

During the last fifteen years Congress has systematically reduced the fee schedule cap and reduced or frozen the Consumer Price Index (CPI) increases for laboratory services. The Balanced Budget Act of 1997 reduced the cap to 74 percent of the national median and froze the payment rate until 2002. To reinstate copayments and the resulting costs to laboratories on top of these real cuts, is unwarranted and simply unfair. Because of the costs of billing and the increase in bad debt write-offs, copayments actually constitute a substantial cut in Medicare reimbursement. Some laboratories estimate that copayments would effectively reduce this reimbursement by a minimum of 15 percent.

In recent years, laboratories have absorbed significant reductions in reimbursement as a result of deficit reduction efforts. In addition to reductions in the 1997 Balanced Budget Act, laboratories were subject to cuts in Medicare reimbursement of more than 14 percent as a result of reductions mandated by OBRA 1993. This is in contrast to the increases the government granted to other health care providers. Most laboratories cannot continue to absorb the costs of copayments in addition to these existing reductions.

Medicare Spending for Clinical Laboratory Services is Steadily Declining

Medicare Part B spending on clinical laboratory services is declining in absolute terms while overall Medicare spending for other services has increased. The percent of Part B outlays for clinical laboratory services has decreased steadily from 2.6 percent in 1994 to 1.8 percent in 1997. This occurred while the number of Medicare enrollees actually increased an average of 1.4 percent per year during the same period. The result is that the amount paid annually for clinical laboratory services substantially declined from $120 per enrollee in 1994 to $105 per enrollee in 1997 (HCFA Office of the Actuary).

For these reasons, we respectfully request the elimination of additional funding reductions for clinical laboratory services from the Administration's Medicare reform proposal. In addition, we would welcome the opportunity to meet with the Administration to further discuss how we can work more closely to accomplish our mutual goals of protecting patients and preserving the Medicare program.

Sincerely,

American Association of Bioanalysts
American Medical Laboratories, Inc.
American Society of Clinical Pathologists
Clinical Laboratory Management Association
Roche Diagnostics
American Medical Technologists
College of American Pathologists
American Association of Blood Banks
American Association for Clinical Chemistry
American Clinical Laboratory Association
American Society for Microbiology

cc: Donna E. Shalala, Secretary, Department of Health and Human Services
Nancy-Ann Min DeParle, Administator, HCFA
Christopher C. Jennings, Deputy Assistant to the President for Health Policy

CAROLYN McCARTHY
4TH DISTRICT, NEW YORK

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(202) 225-5516
(202) 225-5758 (fax)

1 FULTON AVENUE, SUITE 12
HEMPSTEAD, NEW YORK 11550
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CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

COMMITTEE ON EDUCATION AND THE WORKFORCE
SUBCOMMITTEES:
EMPLOYER EMPLOYEE RELATIONS
POSTSECONDARY EDUCATION, TRAINING AND LIFE LONG LEARNING
COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE:
GOVERNMENT PROGRAMS AND OVERSIGHT

E-MAIL:
HTTP://WWW.HOUSE.GOV/WRITEREP/
WEBSITE:
HTTP://WWW.HOUSE.GOV/CAROLYN.MCCARTHY/

Medicare Reform
Taking a Careful & Thoughtful Approach

Dear Colleague:

As we move forward and work collectively to strengthen and modernize the Medicare Program, I believe it is imperative that we take a very careful and thoughtful approach to reforming this important component of our nation's health care system. Recently, the Administration unveiled its proposal to reform Medicare. While I commend the Administration for their efforts and dedication to improve and preserve the program, I am concerned that some of the plan's cost savings have not been well developed and may place a greater burden on patients and health care providers.

To generate cost savings for this plan, the Administration has proposed to cut clinical laboratory services by $8 billion dollars over a 10 year period. The plan seeks to accomplish this savings by charging Medicare enrollees a copayment for each laboratory test performed. In consultation with clinical laboratories in my own district and with the American Association of Bioanalysts (AAB), it has been brought to my attention that the cost of producing an additional copayment invoice usually is more than the actual cost of the copayment. This does not make sense; is not sound public policy; and simply results in greater out-of-pocket expenses for beneficiaries.

Example: If coinsurance were implemented, laboratories would presumably have to produce two claims — one to the Medicare Program and one to the patient. On average, it costs between $3 and $5 dollars to produce the additional invoice covering the copayment. In 1997 the average charge for clinical laboratory services to a Medicare Part B enrollee was $9.66 (HCFA Office of Actuary). A 20 percent copayment for $9.66 would be $1.93. The cost to produce an invoice for that amount would be $1 to $3 dollars greater than the cost of the actual copayment. For your information, I have attached additional data on this issue from the American Association of Bioanalysts (AAB).

In closing, I urge all of my colleagues to take a cautious and thoughtful approach as we identify and develop measures to preserve the future of our Medicare Program.

Sincerely,

Carolyn McCarthy

Carolyn McCarthy
Member of Congress

LABORATORY COPAYMENTS
Does Not Make Sense or Sound Public Policy

In the past, some budget proposals have called for the imposition of Medicare beneficiary copayment obligations on laboratory testing services. Most recently, the Clinton Administration proposed to implement a 20 percent copayment for clinical laboratory services. This proposal is seeking $8 billion dollars from clinical laboratory services over the next ten years. The reinstitution of the coinsurance requirement, which Congress deleted in 1984 with the support of the Health Care Financing Administration ("HCFA") and the laboratory industry, would add to the health care costs already borne by Medicare beneficiaries and have an injurious effect on laboratories.

The cost of billing the coinsurance would often exceed the amount collected.

If coinsurance were reimposed, laboratories presumably would have to produce two claims - one to the Medicare Program and one to the patient. On average, laboratories estimate it would cost between $3 and $5 just to produce the additional invoice covering the coinsurance. In many instances, this cost would be a substantial percentage of the amount collected from the patient and could easily exceed collected amounts. For example, in 1997 the average charge for clinical laboratory services to a Medicare Part B enrollee was $9.66 (HCFA Office of the Actuary). A 20 percent copayment for $9.66 would be $1.93. The cost to produce a copayment invoice for the 1997 average patient cost of $9.66 would be $1 to $3 dollars more than the collected amount. This does not make sense and is not good public policy.

The following chart illustrates the approximate coinsurance amount for several commonly ordered tests. For these common tests, the collection costs exceed the coinsurance payments:

	Cap	Coinsurance
Multichannel chemistry test	**$14.86**	**$2.98**
CBC, with differential	**$10.36**	**$2.02**
Urinalysis	**$4.24**	**$0.85**

In many instances, the costs of collection would be even higher than $3 to $5. For example, if the patient did not pay after receiving the first invoice, follow-up would be necessary, thus increasing the costs to the laboratory. Furthermore, past experience with coinsurance suggests that many laboratories will have to write off from 20 to 50% of the billed amounts as uncollectible, despite a federal requirement that labs attempt to collect these amounts.

These collection problems are the very reason that coinsurance was eliminated by Congress as part of DEFRA '84, with the support of HCFA and the laboratory industry. In exchange for eliminating the copayment, Congress mandated the current fee schedule methodology. Over the past fifteen years Congress has systematically reduced the fee schedule cap and reduced or frozen CPI increases for laboratory services. The Balanced Budget Act of 1997 reduced the cap to 74 percent of the national

median and froze the payment rate until 2002. To reinstate copayments and the resulting costs to laboratories on top of these real cuts, is unwarranted and unfair.

Reinstitution of coinsurance imposes an additional cut for labs.

Because of the costs of billing and the increase in bad debt write-offs, coinsurance actually constitutes a substantial cut in Medicare reimbursement.

Some laboratories estimate that coinsurance would effectively reduce this reimbursement by a minimum of 15 percent.

In recent years, laboratories have absorbed significant reductions in reimbursement as a result of deficit reduction efforts. In addition to reductions in the 1997 Balanced Budget Act, laboratories were subject to cuts in Medicare reimbursement of more than 14 percent as a result of reductions mandated by OBRA '93. This differs from the reduced increases the government granted to physicians and hospitals. Most laboratories cannot continue to absorb the costs of coinsurance on top of these other reductions.

Reinstitution of coinsurance would hurt Medicare beneficiaries.

Imposition of coinsurance would shift the costs of the Medicare program to beneficiaries and force them to incur an additional $7 billion in out-of-pocket expenses.

This change would place an additional burden on Medicare beneficiaries, a burden that Congress specifically relieved them of in 1984.

As noted above, this provision constitutes a cut in Medicare reimbursement for laboratories. A reduction of that size, coupled with the Balanced Budget Act of 1997 and the Medicare cuts imposed on laboratories by OBRA '93 as well as previous budget laws, would adversely affect both the quality of services that laboratories are able to provide and the access to services that beneficiaries currently enjoy.

Coinsurance for laboratory services would have no effect on utilization of services.

Patients do not decide when to order testing nor do they select the testing laboratory. Thus, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization.

In a recent analysis of cost-sharing, the Office of Technology Assessment indicated that:

> [Participants in cost-sharing plans were much less likely to seek medical attention than others, but once they did, the amount and cost of their care was largely *unaffected* by cost-sharing and apparently was determined principally by their physician.[1]

The Congressional Budget Office also noted:

> Cost-sharing probably would not affect enrollees' use of laboratory services substantially. . . . because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing.[2]

Coinsurance for laboratory services could invite abuse.

Because the typical copayment amounts would be small and the administrative burden of collecting them is great, some laboratories will likely be pressured to agree to requests that they waive receipt of copayment amounts from beneficiaries. Such practices would create legal uncertainty and competitive problems because the Office of Inspector General has issued a fraud alert that warns that such waivers may well be unlawful.

---

1. OTA, "Benefit Design: Patient Cost-Sharing" at 5 (February, 1994).

2. CBO, "Reducing the Deficit: Spending and Revenue Options" at 140 (February, 1990).

Congress of the United States
House of Representatives
Washington, D.C.

January 19, 1999

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Ave, SW
Washington, DC 20201

Dear Ms. DeParle;

We are writing on behalf of the residents and administrators of a skilled nursing facility (SNF) in our state, the Bethany-St. Joseph Care Center of La Crosse, Wisconsin. Bethany-St. Joseph is the only SNF in the region with a certified program for ventilator dependent patients. According to the administrator of this facility, Mr. Tom Rand, recent, drastic changes in Medicare reimbursement forced the ventilator dependent program to be discontinued on Dec. 31, 1998. We have several concerns about this dire situation.

First, the facility received very limited notice of this considerable reduction in reimbursement for all high cost outlier type of residents. Mr. Rand estimates that the facility will lose between $150 and $300 per day below the actual cost of providing care. As the region's only SNF that provides this specialized and costly care, this short notice is inappropriate.

Second, while Bethany St. Joseph's mission requires that it continue caring for its current patients for as long as they need care, it cannot accept any new ventilator dependent patients. Just in the past few weeks, they have turned away several new patients from surrounding states. Without this program, these patients are forced into hospitalization. We are concerned about the soundness and cost-effectiveness of a policy which forces patients into hospitalization.

Third, it appears that the new level of reimbursement does not include any provisions for outlier status payment. We believe that accounting for statistical outliers -- such as ventilator dependent patients or other very high cost patients -- is crucial to calculating an appropriate payment for a facility. Adjustments must be made to provide adequate care to patients of this type.

In light of these concerns, we are requesting that you review the problems created by PPS for ventilator dependent patients and consider granting a delay of at least 90 days before implementing PPS for this facility. Both we and Mr. Rand understand the importance of PPS to preserving the integrity of the SNF benefit. Our request for special dispensation in this case is an effort to more accurately reflect the cost of these frail and dependent patients.

Thank you in advance for your timely response to our concerns. We have enclosed correspondence from Mr. Rand for your further information. We appreciate any guidance you are able to provide.

Sincerely,

Rep. Ron Kind

Senator Russ Feingold

Senator Herb Kohl

Enclosure

43 senators calling for Medicare changes

MJS 5/22/99 Milwaukee Journal Sentinel

By Jor Manning
of the Journal Sentinel staff

Nursing homes could close, they warn

Nursing homes may be forced to close, cut programs or lay off workers if new Medicare regulations are not changed, 43 U.S. senators warned in a letter this week to the Department of Health and Human Services.

The regulations reduce the money paid to nursing homes for treating patients with complex medical needs.

Such patients are increasingly being stranded in hospitals because nursing homes are no longer fully reimbursed for the costs of their care and are reluctant to admit them.

"People are starting to realize this doesn't make sense," said John Sauer, executive director of the Wisconsin Association of Homes and Services for the Aging, a trade group representing not-for-profit nursing homes.

The problem, which many predict will only become worse, stems from the Balanced Budget Act of 1997, which cut Medicare spending.

The law was designed to preserve Medicare's future solvency.

But nursing homes, patients and hospitals are beginning to feel the pinch from the cuts that went into effect at the beginning of the year.

"There clearly are cases costing us (nursing homes) hundreds of dollars a day. Facilities are just now understanding what this means," Sauer said.

Spending cuts mandated by the law have gone too far, the senators warned, and "may reduce rates substantially more than was intended and projected at the time of enactment" of the law.

But nursing homes aren't the only ones caught in a financial pinch by the Medicare cuts. Hospitals lose money when they are forced to provide lengthy treatment for Medicare patients whose care is paid for at predetermined rates.

The new system is called the prospective payment system — PPS.

The program calls for nursing homes to receive a set amount for patient care. PPS replaces a payment method based on actual cost of care.

Nursing home officials say the new system doesn't provide adequate cost coverage for the care of patients with complex needs.

In the letter to HHS Secretary Donna Shalala, the senators expressed "deep concerns about the growing crisis in the nursing home industry.

We are concerned that payment rates for skilled nursing facilities are well below the levels envisioned by Congress, and this reduction in payments could seriously erode the quality of care available to our seniors."

"If HCFA (the Health Care Financing Administration) does not revise the regulations, we fear we will soon see closings of facilities, layoffs of dedicated care givers, reduction in access to skilled nursing home services, and erosion of the quality of care," the senators wrote.

HCFA is the governmental agency in charge of Medicare, federal health insurance for the elderly.

Sen. Russ Feingold (D-Wis.) was one of the letter's signers. Shalala's office said Friday the secretary had not yet received the letter.

Nursing home administrators say their costs continue to

Please see LETTER *page 3*

Letter/Senators say new Medicare rules need changing

From page 1

mount and the facilities have a responsibility to their owners, sponsors and residents to not take patients who are going to drain tight budgets, said Richard Rau, president of the Wisconsin Health Care Association and administrator of Clement Manor Health Care Center and Mount Carmel Health and Rehabilitation Center.

"Nursing homes have to be very careful who they take these days," Rau said.

One patient at a facility Rau oversees has run up $19,000 in pharmacy costs not covered by Medicare.

Besides those with pharmaceutical demands, patients with complex needs include those on ventilators and those with tracheostomies (surgical openings in the neck through which a breathing tube can be inserted), patients receiving intravenous drugs and fluids, chemotherapy patients and those needing intensive wound care.

"How many of those patients can we take? How can we afford to do that?" Rau asked.

"You can't make it up on volume."

The nursing home industry as well as hospital organizations are lobbying Congress to make changes in the law to restore some of the funding.

"Medicare's attempt to save money has gone awry. What's happening is they set out to try to save dollars, but as we keep patients in high-cost settings, we are not achieving what Congress set out to do, and that was save money," said Nadine Grate, director of federal issues for the Wisconsin Health and Hospital Association.

Congress is the only body that can change the situation, officials say.

"HCFA says its hands are tied. It has to go by the act. So Congress will have to pass a law for more money," said Joel Lubarsky, a CPA and national director of long-term care services for BDO Seidman, an accounting and consulting firm.

But, even with a willing Congress, it could take two years or longer to straighten out the under-funding problem, Lubarsky said.

"What do we do between now and then?" he said, warning that nursing homes will have to pay less in salaries, lay off employees, and cut services to keep from going out of business.

"The government is going to have to change the system if they want quality care," Lubarsky said, adding that the Balanced Budget Act, originally designed to save $9.5 billion in nursing home costs over five years, will save an estimated $16 to $17 billion, far more than the original target.

Bill Barzan, WHA vice president for Southeastern Wisconsin, acknowledged that hospitals were having a hard time finding nursing homes to accept complex patients.

Placements can generally be made, but there are long delays, he said.

"While we do not now have large numbers of patients stacked up in hospitals, we expect this problem to get worse," Barzan said.

Washington, DC 20515

June 17, 1999

William Jefferson Clinton
President of the United States of America
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr President-

We are writing to make you aware of our grave concerns about the impact of the current Medicare cuts as you continue to craft a blueprint for responsible Medicare reform. We welcome your leadership and hope to work closely with you throughout the debate. We share a common goal of extending the solvency of Medicare beyond 2015. However, we strongly object to making further cuts or reductions in the Medicare program.

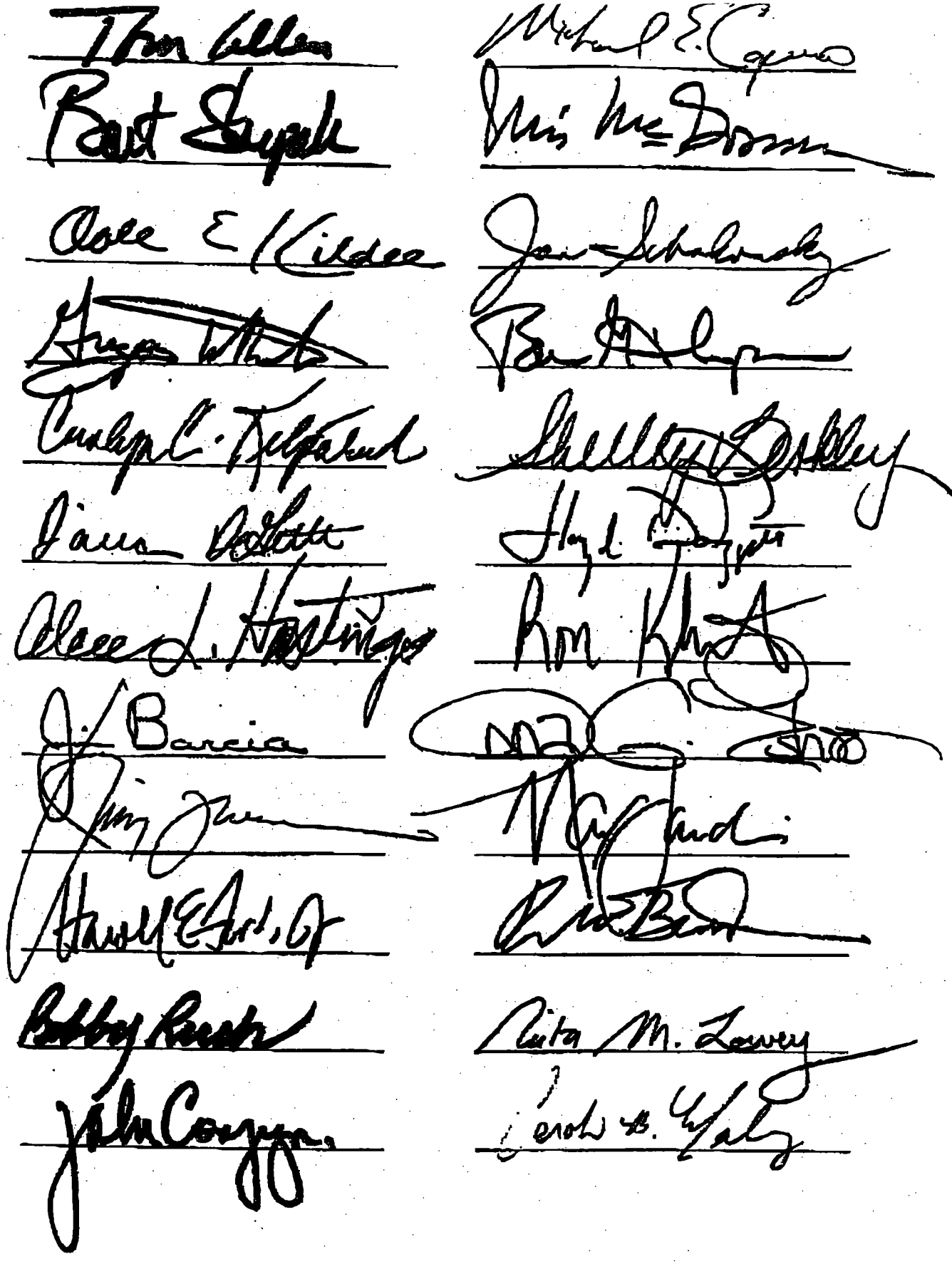
The Balanced Budget Act of 1997 (BBA) made substantial cuts to the Medicare program. While we understand and support the need to address cost savings and issues of fraud and abuse, in some cases we believe the cuts have exceeded their congressionally intended result. Some of these cuts have already led to worst case scenarios where Medicare beneficiaries are being denied access to care.

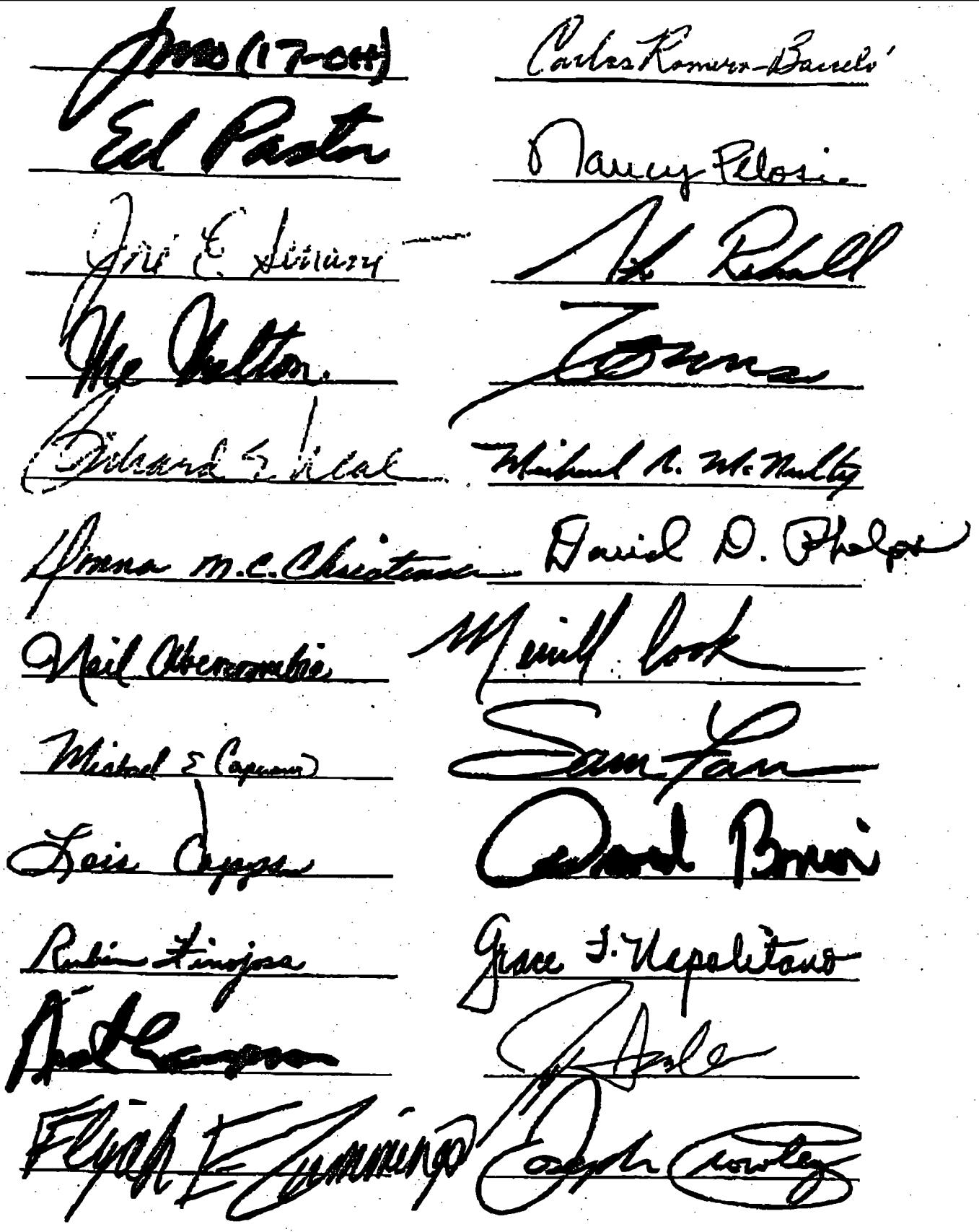
For example, home health patients around the nation are left without care as home care agencies shut their doors due to reduced reimbursements. Hospitals are already struggling with the difficult decision to cut critical services due to reduced Medicare payments and are anticipating a need to reduce services further when the Outpatient Prospective Payment System and other scheduled cuts are in place. Nursing homes are working to continue to provide adequate care as Medicare cuts are enacted. The bottom line is that the cuts established by the BBA have gone deeper than Congress ever anticipated. Budget savings resulting from the cuts have already far surpassed Congressional Budget Office estimates and congressional expectations.

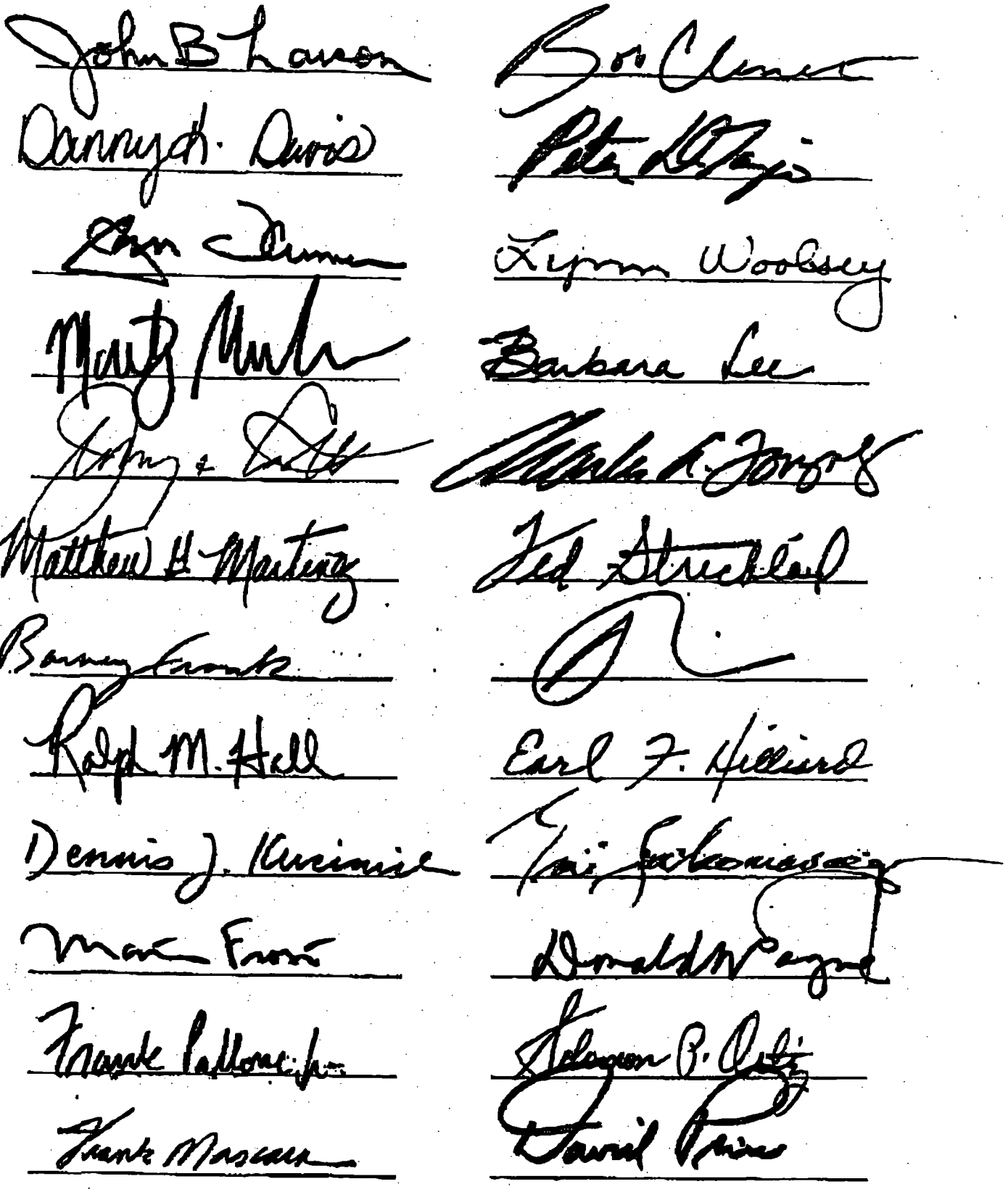
Many of us supported the BBA; none of us intended to deny patients care. As you examine proposals to reform Medicare, it is our hope that you will not make further cuts and that you will consider restoring several key benefits that were essentially delivered fatal blows by the BBA.

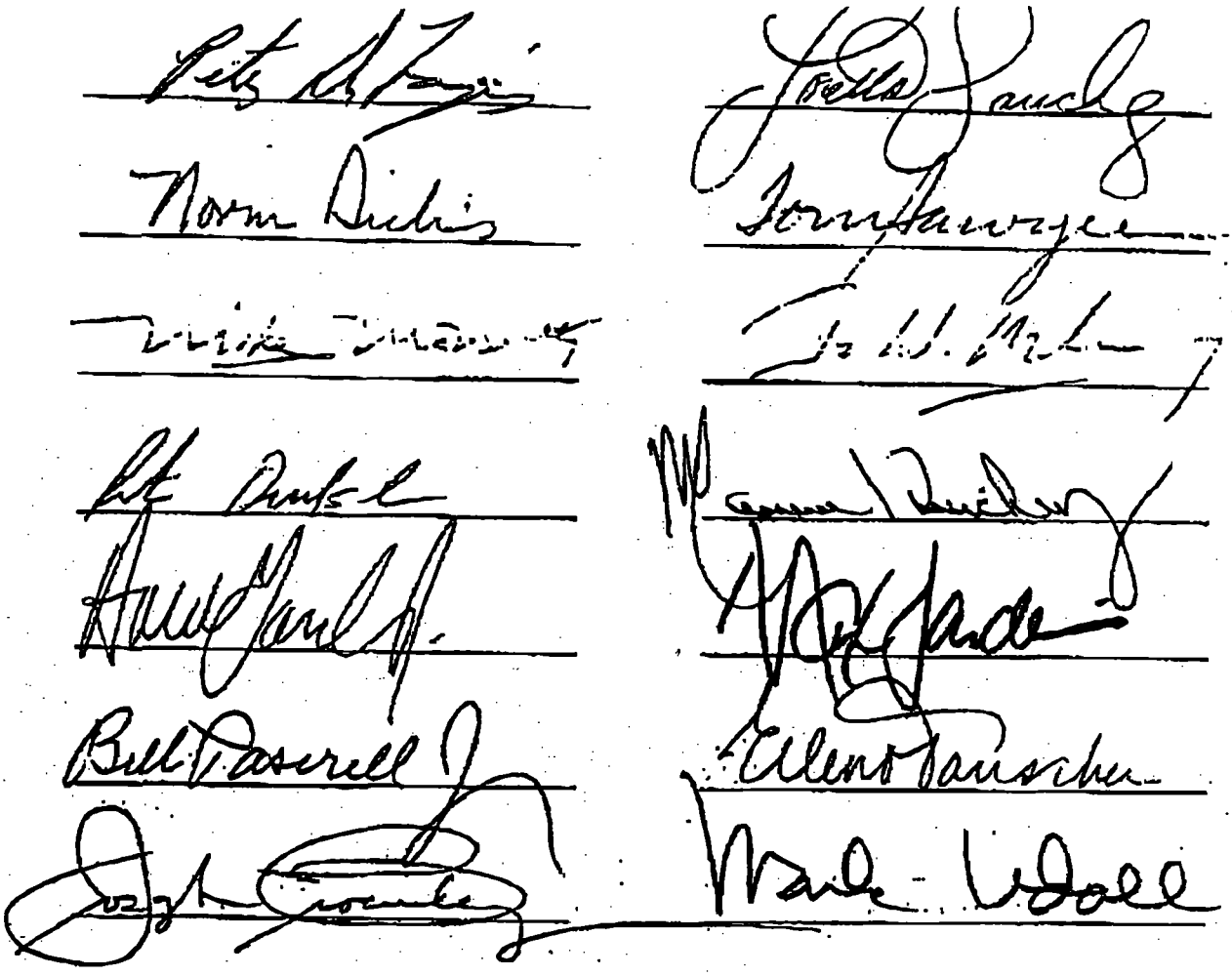
We are strongly supportive of your efforts to strengthen Social Security and Medicare before using the surplus for other purposes. In addition, we urge you not to make any further cuts to Medicare. We stand ready to work with you and appreciate your leadership on this critical issue. It is important that the negative consequences of the cuts made under the BBA are addressed as part of that process.

Sincerely,









Signers on the 6/17/99 letter to President Clinton

Debbie Stabenow D
Robert Weygand D
David Phelps D
Max Sandlin D
Nick Rahall D
Carlos Romero-Barcelo D
Donna Christian-Christensen D
Michael Capuano D
Carolyn Maloney D
Nancy Pelosi D
Harold Ford, Jr. D
James Traficant, Jr. D
Edolphus Towns D
Bobby Rush D
Neil Abercrombie D
Sam Farr D
Richard Neal D
Merril Cook R
Jose' Serrano D
Ken Bentsen D
Ed Pastor D
Nita Lowey D
Michael McNulty D
Jim Turner D
James McGovern D
John Conyers, Jr. D
Lois Capps D
Ike Skelton D
Carolyn Kilpatrick D
Joseph Crowley D
Barney Frank D
Lloyd Doggett D
Martin Meehan D
Lynn Woolsey D
Barbara Lee D
Bob Clement D
Anthony David Weiner D
Ted Strickland D
Matthew Martinez D
Jerry Costello D
Charles Gonzalez D
Ralph Hall D

Elijah Cummings D
John Tanner D
Danny Davis D
Peter Defazio D
John Larson D
Martin Frost D
Earl Hilliard D
Mark Udall D
Donald Payne D
Frank Mascara D
Eni F.H. Faleomavaega D
Solomon Ortiz D
Dennis Kucinich D
Tom Allen D
Bart Stupak D
Dale Kildee D
Janice Schakowsky D
Shelly Berkley D
Diana DeGette D
Lloyd Doggett D
Alcee Hastings D
Ron Klink D
Jim Barcia D
Anna Eshoo D
David Bonior D
Ruben Hinojosa D
Grace Flores Napolitano D
Nick Lampson D
Jay Inslee D
Gregory Meeks D
Loretta Sanchez D
Norman Dicks D
Thomas Sawyer D
Michael McNulty D
James Maloney D
Peter Deutsch D
Maurice Hinchey D
William Pascrell D
Ellen Tauscher D
David Price D
Frank Pallone D

TOTAL P.08

Congress of the United States
Washington, DC 20510

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

Dear Mr. President:

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

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

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

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

Sincerely,

United States Senate

WASHINGTON, DC 20510

May 19, 1999

The Honorable Donna Shalala
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madame Secretary:

We are writing to express our deep concern about the growing crisis in the nursing home industry. We are concerned that payment rates for Skilled Nursing Facilities (SNFs) are well below the levels envisioned by Congress, and this reduction in payments could seriously erode the quality of care available to our seniors.

The Balanced Budget Act of 1997 (BBA) has produced a number of positive results. We have a balanced budget, and Medicare's solvency has been extended by many years.

However, it should not come as a surprise that implementing complex legislation such as the Medicare provisions in the BBA is producing some unexpected and undesirable consequences in certain sectors.

In particular, we believe that the regulations implementing the SNF payment changes may reduce rates substantially more than was intended and projected at the time of enactment. If HCFA does not revise the regulations, we fear we will soon see closings of facilities, layoffs of dedicated care-givers, reductions in access to SNF services, and erosion in the quality of care.

We urge you to use your authority to revisit the regulations to ensure the transition to the new prospective payment system (PPS) does not harm beneficiaries with unnecessary reductions in payment rates that go beyond what any of us anticipated. In particular, we would urge you to revise the regulations to reflect the needs of medically complex patients, particularly their need for non-therapy ancillary services.

We know you share our commitment to ensuring that elderly and disabled Medicare beneficiaries receive the highest quality care. We would like to work with you in a bipartisan fashion to address this impending crisis in whatever manner is appropriate.

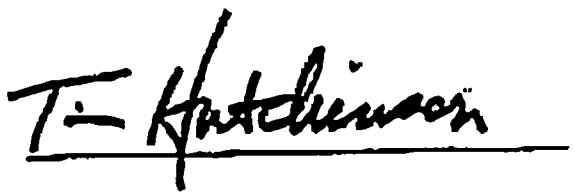
Sincerely,

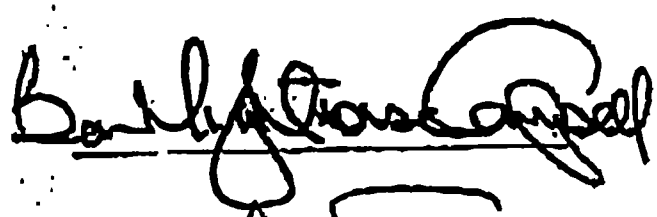
Pete V. Domenici

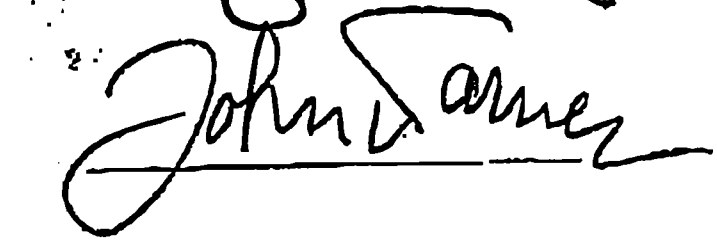
Jeff Bingaman

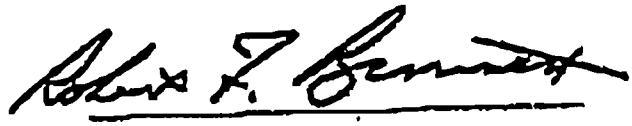
Ron Wyden

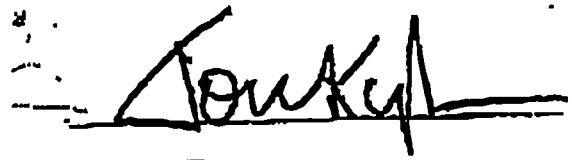

SNF AS

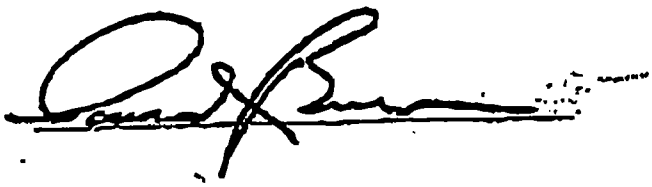


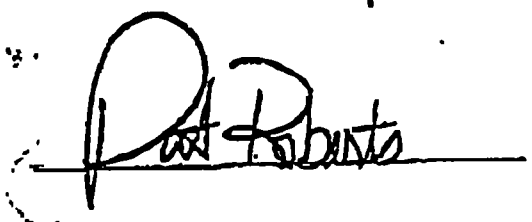


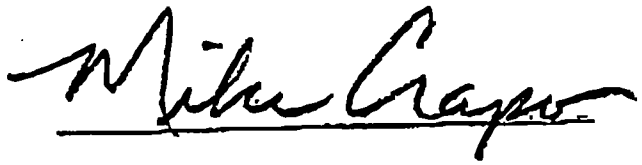


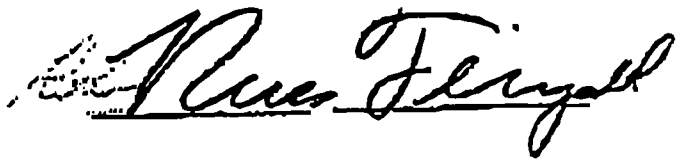


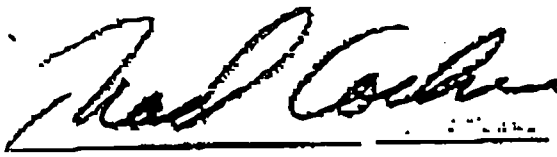


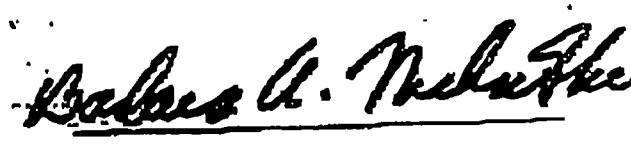


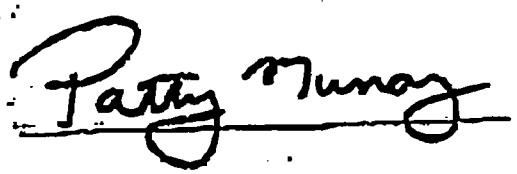


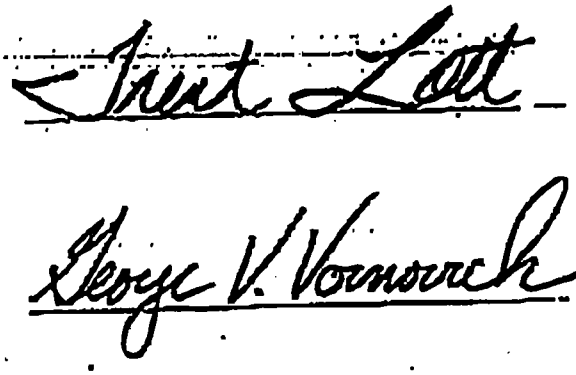


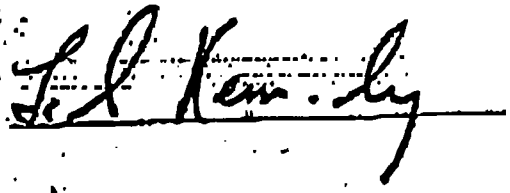


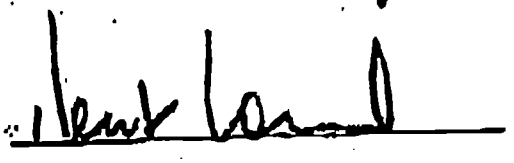


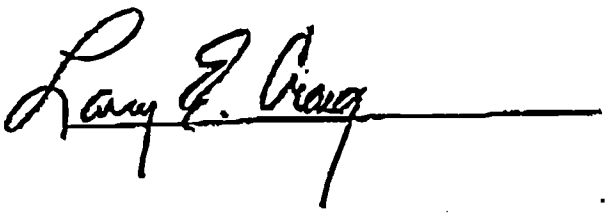


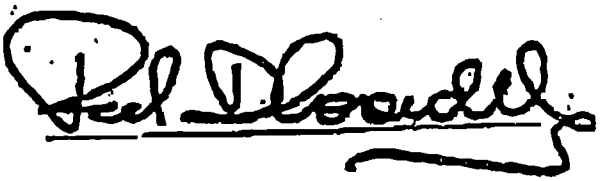


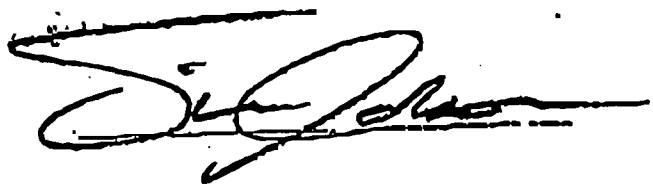


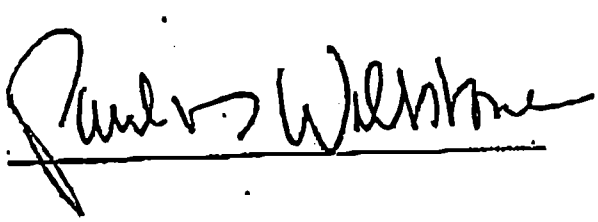


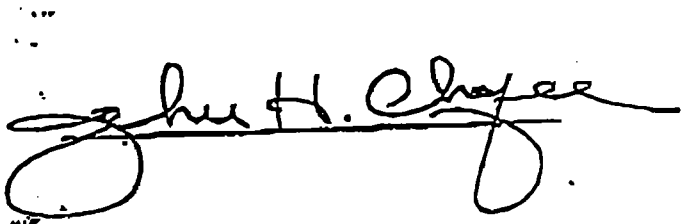


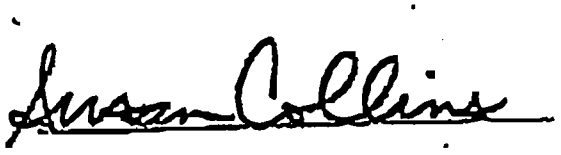


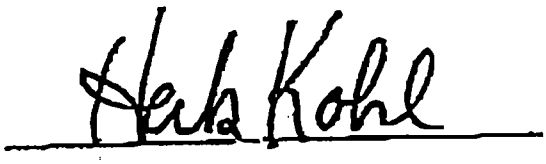












John McCain

Barbara Boxer

Republican	Democrat
Domenici	Bingaman
Bunning	J. Kerrey
Bennett	Wyden
Burns	Durbin
Grams	Cleland
Crapo	Landrieu
Campbell	Sarbanes
Cochran	Reid
Warner	Lautenberg
Roberts	Levin
Hutchinson	Dorgan
Santorum	R. Kerry
McConnell	Daschle
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Lott	Robb
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G. Smith	Murray
Hatch	Conrad
Hagel	Feingold
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Ashcroft	Baucus
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Coverdell	Kohl
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Voinovich	
DeWine	
Collins	
Sessions	
Brownback	
Shelby	
Chafee	
Lugar	
McCain	

LINDSEY GRAHAM
3rd District, South Carolina

EDUCATION AND THE WORKFORCE COMMITTEE
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Aiken, SC 29801
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Congress of the United States
House of Representatives
Washington, DC 20515–4003

July 20, 1999

Help Preserve Quality Nursing Home Care for America's Elderly

Dear Colleague:

Many of you may be aware of the crisis facing Skilled Nursing Facilities (SNF) in the wake of the Balanced Budget Act of 1997 (BBA). HCFA's implementation of the BBA is under-reimbursing SNF's and other providers far beyond the wishes of Congress when it passed the BBA.

This year alone, total Medicare spending is anticipated to be $20 billion less than Congress voted for in the BBA. While most agree that savings in Medicare were necessary, few would agree that such drastic cuts in Medicare are in the best interests of today's seniors. The effects of these cuts are starting to drain the capabilities of providers, particularly SNFs, to provide care. These cuts are forcing the closure of numerous nursing facilities, requiring cutbacks in personnel and sacrificing the quality of care that our elderly have come to rely upon.

I would like to see the House direct the Secretary of Health and Human Services to reevaluate the implementation of the Medicare cuts to ensure that the medical needs of senior citizens are not being forgotten. If you would like to see this oversight remedied, please call or e-mail Dan Nodes in my office at 5-5301 to sign on to the attached letter to Secretary Shalala. The deadline for signing is July 30, 1999.

Sincerely,

Lindsey O. Graham
Member of Congress

ROBERT G. TORRICELLI
NEW JERSEY

COMMITTEES:

GOVERNMENT AFFAIRS

JUDICIARY

RULES AND ADMINISTRATION

FOREIGN RELATIONS

United States Senate

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Senator_Torricelli@Torricelli.Senate.Gov

June 3, 1999

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

Dear Mr. President:

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

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

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

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

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

Sincerely,

ROBERT G. TORRICELLI
United States Senator

RGT:km

AHCA
American Health Care Association

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Washington, DC 20005-4014
202 842-4444
FAX: 202 842-3860

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AHCA 50 Celebrating Service

Writer's Telephone: 202-898-2858
Writer's E-mail: byarwood@ahca.org

April 29, 1999

Nancy Ann Min DeParle, Administrator
Health Care Financing Administration
7500 Security Blvd
Baltimore, MD 21244-1850

Dear Administrator DeParle:

The new prospective payment system (PPS) for skilled nursing facilities (SNFs) has been onerous on providers and the residents for whom we provide care. On behalf of the American Health Care Association (AHCA), I am writing to request your help.

The Balanced Budget Act of 1997 (BBA) projected that SNFs would face $9.5 billion in cuts over five years. New Congressional Budget Office (CBO) estimates show that the actual cuts will be $16.6 billion – 75% more than Congress ever intended. This $7.1 billion under-spending is far too much for the provider community to withstand without having a terrible impact on the delivery of health care services to America's seniors. Its negative impact is being seen in lost jobs within the industry and its effects will trickle down to patients. Funding must be restored to the system immediately.

I want to share with you some of our thoughts as to how HCFA and the Administration can best accomplish this. Congress, MedPAC, and HCFA have recognized the reimbursement system for SNFs is flawed because it does not account for the higher acuity patients requiring medically complex services such as prescriptions and respiratory care. New funding should be restored to the system. There are several options for doing so by HCFA administratively. One or a combination of these options could restore the $7.1 billion to the system.

First, you could target high cost patients either through a patient-condition based payment modifier or a multiplier factor.

Second, the market basket update index used by HCFA understates the annual change in the costs of providing an appropriate mix of goods and services taking place in a SNF. Change in the type and delivery of services are not included in the market basket index. The BBA specifically instructs the Secretary to establish a SNF market basket index that "reflects changes over time in the prices of an appropriate mix of goods and services

included" in a SNF. HCFA should replace the current market basket index with an index that reflects the average annual change in the prices of SNF outputs. Currently, the Bureau of Labor Statistics has such an index, which, if used, could provide immediate relief to providers and beneficiaries. This change could be made administratively.

A third solution would be to give facilities the option of continuing to be reimbursed under the current transition rate or to be reimbursed the full federal rate. SNF PPS rates are being transitioned to a 100% federal rate over three years. The transition rates are a blend of 1995 facility specific historical costs and a federal rate. In year one the blend is 75%/25%, year two is 50%/50%, and year three is 25%/75%. Facilities that changed the type and volume of services after 1995 are disadvantaged by the transition rate and would be better served under the federal rate.

Let me add that these excessive cuts have posed a very real and immediate threat to the delivery of skilled care services as well as access to these services. Providers and residents need relief – and we need it now. I urge you to work cooperatively and in a bipartisan fashion with Congress to address our concerns. This is the problem that needs to be solved immediately.

I look forward to working closely with you to move forward on the critical issues.

Sincerely,

Bruce Yarwood
Legislative Counsel

As you know we need help!
Thanks!

SUSAN M. COLLINS
MAINE

172 R LSENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-XXXX
(202) 224-2693 (FAX)

COMMITTEES
GOVERNMENTAL AFFAIRS
HEALTH, EDUCATION, LABOR, AND PENSIONS
SPECIAL COMMITTEE ON AGING

United States Senate

WASHINGTON, DC 20510-1904

July 27, 1999

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

Dear Chairman Roth:

Earlier this year, we introduced S. 1310, the Medicare Home Health Equity Act of 1999, which makes needed adjustments to the Balanced Budget Act of 1997 (BBA) and related federal regulations to ensure that Medicare beneficiaries continue to have access to medically necessary home health services. As you prepare for Finance Committee action on Medicare later this year, we would urge you to consider incorporating provisions from S. 1310 in the Chairman's Mark.

America's home health agencies provide invaluable services that have enabled a growing number of our most frail and vulnerable Medicare beneficiaries to avoid hospitals and nursing homes and stay just where they want to be — in the comfort and security of their own homes.

In 1996, home health was the fastest growing component of Medicare spending, consuming one out of every eleven Medicare dollars, compared with one in every forty in 1989. This rapid growth in home health spending understandably prompted Congress and the Administration, as part of the Balanced Budget Act of 1997, to initiate changes that were intended to make the program more cost-effective and efficient. Therefore, there was widespread support for the provision in the Balanced Budget Act of 1997 which called for the implementation of a prospective payment system for home care. Until this system can be implemented, home health agencies are being paid according to an "interim payment system," or IPS.

In trying to get a handle on costs, however, Congress and the Administration created a system that penalizes efficient agencies and that may be restricting access for the very Medicare beneficiaries who need care the most — the sicker seniors with complex, chronic care needs like diabetic, wound care patients, or IV therapy patients who require multiple visits. According to a recent survey by the Medicare Payment Advisory Commission, almost 40 percent of the home health agencies surveyed indicated that there were patients whom they previously would have accepted whom they no longer accept due to the IPS. Thirty-one percent of the agencies admitted that they had discharged patients due to the IPS. These discharged patients tended to be those with chronic care needs who required a large number of visits and were expensive to serve.

Last year's Omnibus Appropriations bill did provide a small measure of relief for home health agencies. We are concerned, however, that this proposal did not go far enough to relieve the financial distress that cost-effective agencies are experiencing. Earlier this year, the Permanent Subcommittee on Investigations (PSI) held a hearing where witnesses testified about the financial distress and cash-flow problems that cost-efficient agencies across the country are experiencing. Witnesses expressed concern that these problems are inhibiting their ability to deliver much-needed care, particularly to chronically ill patients with complex care needs. Some agencies have closed because the reimbursement levels under Medicare fell so far short of their actual operating costs. Others are laying off staff or declining to accept new patients with more serious health problems. Moreover, the financial problems that home health agencies have been experiencing have been exacerbated by a number of new regulatory requirements imposed by HCFA, including the implementation of OASIS, the new outcome and assessment information data set; new requirements for surety bonds; sequential billing; IPS overpayment recoupment; and a new 15-minute increment home health reporting requirement.

The legislation we have introduced, S. 1310, the Medicare Home Health Equity Act, is cosponsored by a bipartisan group of 21 of our colleagues. Among other provisions, the bill eliminates the automatic 15 percent reduction in Medicare home health payments now scheduled for October 1, 2000, whether or not a prospective payment system is enacted. When the Balanced Budget Act was enacted, CBO reported that the effect of the BBA would be to reduce home health expenditures by $16.1 billion between fiscal years 1998 and 2002. CBO's March 1999 revised analysis estimates those reductions to exceed $47 billion — three times the anticipated budgetary impact. A further 15 percent cut would be devastating to cost-efficient providers and would further reduce seniors' access to care. Moreover, it is unnecessary since the budget target for home health outlays will be achieved, if not exceeded, without it.

The legislation will also provide supplemental "outlier" payments to home health agencies on a patient-by-patient basis, if the cost of care for an individual is considered to be significantly higher than average due to the patient's particular health and functional condition. This provision would remove the existing financial disincentive for agencies to care for patients with intensive medical needs who, according to recent reports issued by both the General Accounting Office (GAO) and the Medicare Payment Advisory Commission (MedPAC), are the individuals most at risk of losing access to home health care under the IPS.

The current IPS unfairly penalizes historically cost-efficient home health agencies that have been most prudent with their Medicare resources. Our legislation builds on reforms in last year's Omnibus Appropriations Act by gradually raising low-cost agencies' per-beneficiary limits up to the national average over three years, or until the new home health prospective payment system is implemented and IPS is terminated.

To decrease total costs in order to remain under their per-beneficiary limits, agencies have had to significantly reduce the number of visits to patients, which has, in turn, increased the cost of each visit. Implementation of OASIS has also significantly increased agencies' per-visit costs. Therefore, the legislation will increase the IPS per-visit cost limit from 106 to 108 percent of the national median.

Other provisions of the legislation will: extend the current IPS overpayment recoupment period from one to three years without interest; revise the surety bond requirement for home health agencies to more appropriately target fraud; eliminate the 15-minute incremental reporting requirement; and maintain the Periodic Interim Payment (PIP) program through the first year of implementation of the prospective payment system to ensure that such a dramatic change in payment systems does not create new cash-flow problems for these agencies.

The Medicare Home Health Equity Act of 1999 will provide a measure of financial and regulatory relief to beleaguered home health agencies in order to ensure that Medicare beneficiaries have access to medically-necessary home health services, and we encourage you to include the provisions of the legislation in the measure that will be marked up by the Finance Committee later this year.

Sincerely,

Susan M. Collins

Christopher S. Bond

John Chafee

Alicia Logan

Mark R Laffey

Wayne Allard

Pat Roberts

United States Senate

WASHINGTON, DC 20510

June 10, 1999

Dear Colleague,

We ask you to join us in sending the attached letter to Nancy Ann Min DeParle, Administrator of the Health Care Financing Administration, to make sure that hospital outpatient departments do not suffer an unintended $850 million per year cut in payments.

The attached letter opposes the Department's Notice of Proposed Rulemaking for implementation of the outpatient prospective payment system, as required by the 1997 Balanced Budget. Congress must clarify that an unintended minor technical change in the statutory language will impose an additional 5.7 percent, $850 million per year cut on top of the fully contemplated $7.2 billion reduction in outpatient payments. We need to send a strong message to HCFA that the NPRM is inconsistent with Congressional intent. The attached letter more fully explains how this problem arose.

The Balanced Budget Act of 1997 imposed tough cuts on providers. The BBA included intended reductions in outpatient payments through implementation of outpatient PPS. This additional $850 million per year cut, however, was not anticipated or intended by the House or Senate. Its inclusion in HCFA's proposed rule will only unnecessarily threaten the continued viability and quality of hospital outpatient services..

We hope you will join our efforts to stop one of the Balanced Budget Act's unintended consequences. If you have any questions please call Ellen Doneski in Senator Rockefeller's office at 4-5663, Brad Prewitt in Senator Cochran's office at 4-3063, Karen Davenport in Senator Kerrey's office at 4-9280.

Because this issue is time-sensitive, we appreciate your response by June 15, 1999. Thank you for your consideration.

Sincerely,

United States Senate

WASHINGTON, DC 20510

Draft Letter to HCFA Administrator
The Honorable Nancy Ann Min DeParle

Dear Madame Administrator:

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

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

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

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

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

Sincerely,

_____ _____

_____ _____

United States Senate

WASHINGTON, DC 20510

June 18, 1999

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

Dear Madame Administrator:

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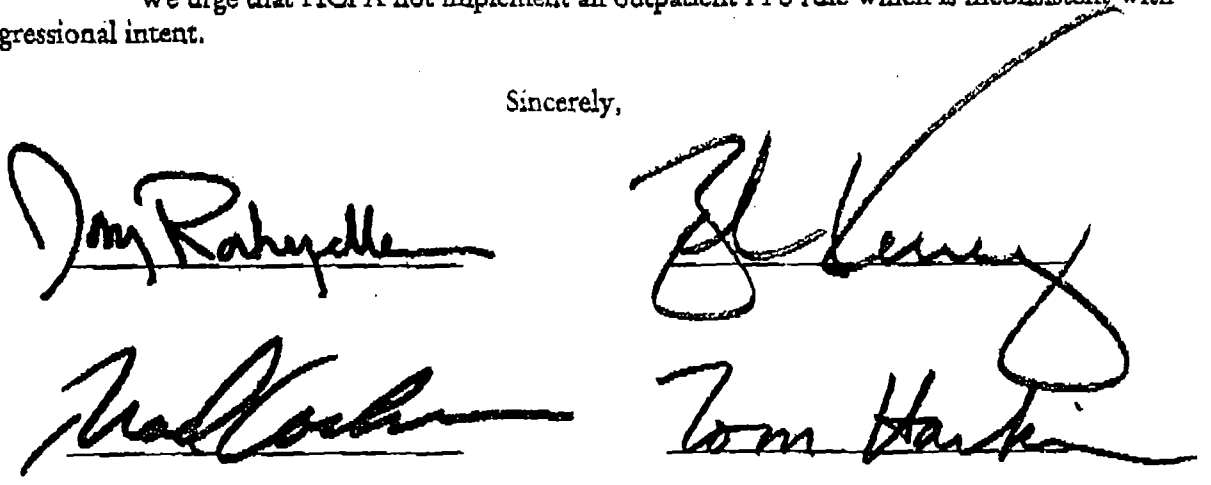
We urge that HCFA not implement an outpatient PPS rule which is inconsistent with Congressional intent.

Sincerely,



--more--

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

June 18, 1999

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

Dear Nancy-Ann:

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

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

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

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

Sincerely,

Bill Thomas

Bill Thomas
Chairman

May 21, 1999

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

Dear Ms. DeParle:

On behalf of our 5,000 member hospitals, health systems and other providers of care, the American Hospital Association (AHA) is growing increasingly concerned about the outpatient prospective payment system (PPS). During the development of the Balanced Budget Act, Congress, HCFA, seniors and hospitals agreed that beneficiaries were paying too high a share of the payments hospitals receive for providing outpatient care. All parties also agreed that the program should shoulder the financial burden of reducing beneficiaries' liability to 20 percent of total payments. Thus, program payments were set by the BBA to gradually increase to 80 percent of total payments for outpatient care.

We believe HCFA has misinterpreted the intent of Congress by reducing hospital payments to offset reduced beneficiary coinsurance. The language of the House and Senate bills clearly placed the financial burden of this change on the Medicare program. The conference report clearly states that the PPS "would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." A legal analysis of the statute supporting our view is attached to this letter.

Moreover, we were informed last week by HCFA that the offset -- 5.7% or $4.3 billion over five years -- is now almost twice as large as previously estimated. Part of the revision is because HCFA failed to include in the initial estimates the impact of discounting payments for multiple surgeries performed on the same day. This policy is not required by statute.

These policies endanger the delivery of emergency and outpatient care to America's seniors. According to the Medicare Payment Advisory Commission, Medicare only covers 82 cents of every dollar in Medicare outpatient care costs today and further reductions in the level of payment are clearly untenable. We urge you to correct this inequity, as Congress intended, by having program funds offset reductions in beneficiary coinsurance.

Washington, DC Center for Public Affairs
Chicago, Illinois Center for Health Care Leadership

Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2802
(202) 638-1100

Should you have any questions about these issues, please contact me, Carmela Coyle, senior vice president for policy (202) 626-2266, or Deborah Williams (202) 626-2340. We look forward to meeting with you soon.

Sincerely,

Rick Pollack

Rick Pollack
Executive Vice President

Attachment

United States Senate

WASHINGTON, DC 20510

June 18, 1999

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

Dear Madame Administrator:

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

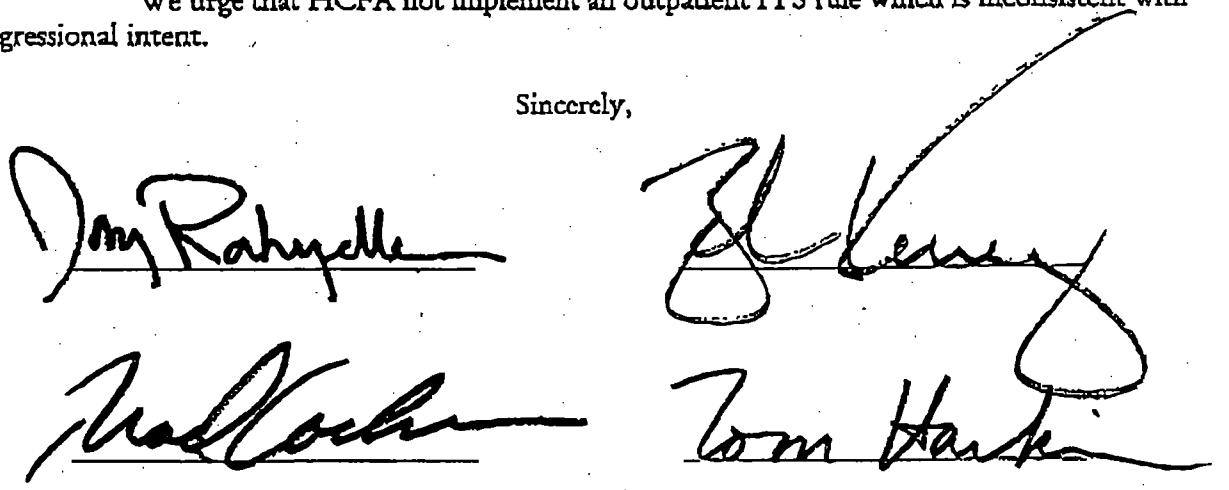
With the encouragement of Congress, HCFA, seniors' representatives and providers cooperatively developed the outpatient PPS policy. The new policy was designed to address a longstanding flaw in outpatient payment policy and to gradually rationalize Medicare's outpatient copayments, without imposing unmanageable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

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

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

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

Sincerely,



--more--

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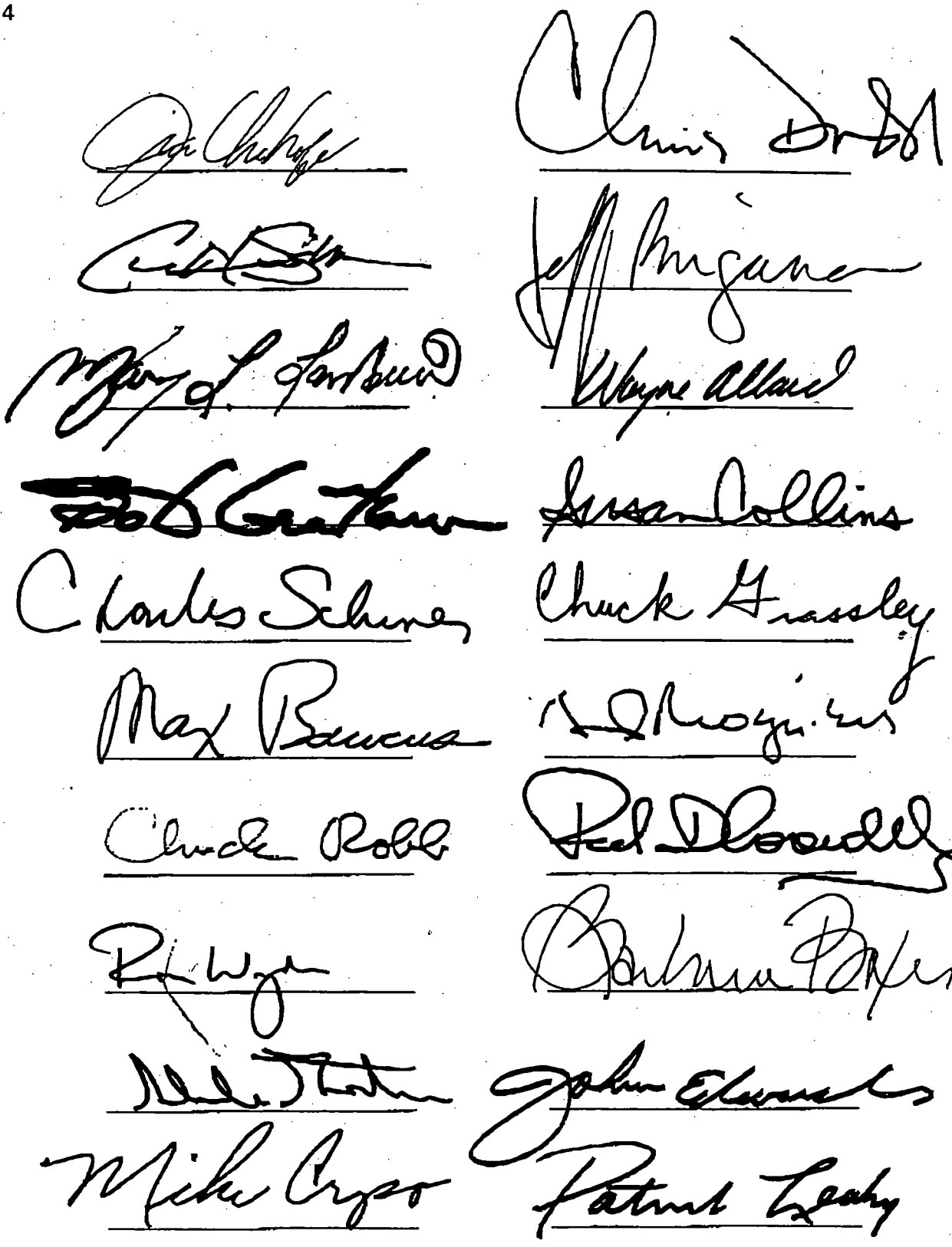

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