May 28, 1999

Mr. Chris Jennings
Deputy Assistant to the President
for Health Policy Development
Old Executive Office Building, Room 216
17th Street & Pennsylvania Avenue, NW
Washington, D.C. 20503

Dear Chris:

Per your conversation with Rick Pollack, enclosed please find a copy of a letter we sent to HCFA Administrator Nancy-Ann DeParle on the outpatient PPS issue strongly objecting to HCFA's interpretation of the 1997 Balanced Budget Act requiring hospitals to fund a portion of reduced beneficiary coinsurance costs. In addition, we have also enclosed for your review a legal analysis reinforcing our position and urging HCFA to follow congressional intent by having Medicare program funds offset reductions in beneficiary coinsurance.

As Rick may have discussed with you, we are requesting a meeting with HCFA so that this inequity can be fixed administratively in an expeditious manner. We would certainly appreciate it if you would provide your input on this issue. Thank you for your prompt attention to this critical issue for our members.

Sincerely,

Mary Beth Savary Taylor

Mary Beth Savary Taylor
Director
Executive Branch Relations

Enclosure

Washington, DC Center for Government and 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

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.

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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

Dan El 55178-238
Chris J
OVP
views — Sarah B

Hospitals

Proposal Title: Do Not Expand the Hospital Transfer Provision Included in the BBA

Current Law: The transfer provision requires Medicare to reduce payments to hospitals that transfer patients to another hospital or unit, skilled nursing facility or home health agency after a shorter than average stay. The transfer policy applies to only ten diagnosis-related groups (DRGs). In fiscal year 2001 and thereafter, the Secretary may include additional DRGs and post-discharge services in the Medicare transfer policy. HCFA is planning to include additional DRGs in FY 2001.

Description of Proposal: This proposal would state that the Secretary will not add, or would delay adding, additional DRGs or post-discharge services to the Medicare transfer policy. This proposal could be implemented administratively under Sec. 1886.

Implementation: As soon as possible through a Federal Register Notice without comment.

Costs: $ 4 -5 billion over five years.

Pros and Cons

Pros: Repeal of the transfer provision is one of the hospital association's top legislative priorities. The association is also concerned that if the transfer provision is not repealed, the Secretary may expand this policy to include additional DRGs in FY 2001. This proposal will alleviate the association's concern by stating publicly that we do not plan to expand the proposal to additional DRGs and at the same time still applying the policy to the ten DRGs with the highest percentage of post acute care use.

Cons: The transfer policy was implemented because of concern that Medicare was overpaying hospitals that transfer patients to post acute care after a very short acute care stay. Medicare may be paying twice for the same care -- once in the hospital and again in the post acute care setting or home health visit. The transfer policy addresses the Medicare double payment concern by adjusting a hospital's payment if the hospital discharges a patient to a post acute setting before the average length of stay. Although the transfer policy targets the DRGs with the highest percentage of post acute care use, this provision will prevent expansion to other DRGs.

Yes lets do some thing for hospitals

Hospitals

Proposal Title: Encourage Managed Care Plans to Make DSH Payments to Hospitals

Current Law: DSH payments are currently included in Medicare's payments to Medicare Plus Choice managed care organizations.

Description of Proposal: This proposal would encourage managed care plans to make DSH payments to hospitals when a managed care enrollee receives services in a DSH hospital.

Vehicle for Promulgation: Notice letter to managed care organizations encouraging them to make DSH payments to hospitals. The DSH adjustment for each hospital would be included in the notice.

Costs: To be determined

Pros and Cons

Pros: Carving out DSH payments from Medicare plus Choice plans is a top priority for the AAMC and the AHA. The AAMC and AHA believe that the DSH payments should go to hospitals serving low-income populations.

Cons: Managed care organizations would find this provision extremely burdensome.

Outpatient Department Services

Proposal Title: Require beneficiaries to pay the full amount of coinsurance on multiple procedures.

Current Law: Copayment amounts for outpatient department (OPD) services under the prospective payment system (PPS) are based on median charges. Since median charges are considerably lower than mean charges, this results in a substantial reduction in hospital revenue (5.7 percent) from beneficiary copayments. The law is clear, we cannot change from median to mean.

Description of Proposal: Reduce the impact of the outpatient department PPS on hospitals from 5.7% to 4.4% by changing the payment policy for coinsurance on multiple procedures. When multiple procedures are performed on the same day, beneficiaries would be required to pay the full copayment amount on procedures furnished after the initial procedure. The Medicare payment amount, however, would be reduced by one-half for such procedures.

When can it be implemented? Can it be implemented without major systems changes? This can be implemented at the same time that the OPD prospective payment system is implemented in July 2000.

Costs: This would be budget neutral to Medicare, but would result in increasing total beneficiary copayments annually between $150 million and $200 million, and increasing payments to hospitals by the same amount.

Pros and Cons

Pros:

- Hospitals are very unhappy about the large reduction in revenue resulting from the statutory requirement to calculate coinsurance based on median charges rather than mean charges. Our recent increase in the estimate of the impact of this policy from a 3.8 percent reduction to a 5.7 percent reduction has created even more discontent. This proposal would mitigate the impact slightly.

Cons:

- Results in increasing beneficiary coinsurance. Perpetuates the longstanding problem with beneficiaries paying a disproportionate share of coinsurance in hospital outpatient departments. (Last year, Representative Thomas was extremely critical about our decision to delay the OPD PPS because it would maintain the current coinsurance methodology for an additional year and a half and result in a loss of coinsurance savings.)

- It is inequitable to have a policy whereby Medicare would only pay half on the multiple procedures and beneficiaries would pay the full amount.

Note: The technical feasibility of this proposal still needs to be worked out.

Outpatient Department Services

Proposal Title: Implement a transition policy to the full outpatient department (OPD) prospective payment system (PPS) for certain hospitals that will receive a large reduction.

Description of Proposal: During a transition period of three years, provide increased payments to reduce the impact of the OPD PPS for hospitals that would otherwise receive a large reduction. These increased payments would be provided in a budget neutral way and could be made in either of the following ways:

- Increases would be made for certain classes of hospitals that HCFA's impact analyses indicate would experience a relatively large negative impact under the new payment system. (The hospitals that we anticipate will receive the largest reductions are: low-volume rural hospitals, low-volume urban hospitals, teaching hospitals with more than 100 residents, cancer hospitals, rehabilitation hospitals, psychiatric hospitals, and childrens' hospitals.)

- Increases would be given on a hospital-specific basis to those individual hospitals that we estimate would receive a large negative impact.

When can it be implemented? Can it be implemented without major systems changes? This can be implemented at the same time that the OPD prospective payment system is implemented in July 2000.

Costs: This could only be implemented in a budget neutral fashion under current law.

Pros and Cons

Pros:

- The proposal would help some hospitals that are estimated to receive a large reduction in payment under the OPD PPS.

- Making adjustments on a hospital-specific basis, if we determine that it is technically feasible to do, would target assistance to those hospitals that we estimate need it the most.

Cons:

- Making these adjustments in a budget neutral way results in reducing payments to those hospitals that would not otherwise receive a reduction.

- Adjustments for classes of hospitals, although the most administratively feasible to do, will result in making additional payments to certain hospitals that might not be negatively effected. They would receive an adjustment, however, merely because

they fall in the class.

- For some hospitals, the data available to determine the estimated impact of the new system is very poor, making it difficult to determine with precision whether an adjustment is warranted.

Proposal Title: Delay implementation of volume control mechanism.

Current Law: The law requires that the Secretary develop a method for controlling unnecessary increases in the volume of covered OPD services under the prospective payment system. In the proposed rule, HCFA proposed that in the first year, hospital spending for OPD services would be measured against our estimate of what they otherwise would have been paid. If actual payments exceeded that amount, the update would be reduced in the year following such a determination (e.g., the 2002 update would be reduced for spending exceeding the target in 2000). For subsequent years, a variety of options were mentioned in the rule, and comments were solicited on them.

Description of Proposal: A volume control mechanism would not be implemented in the first few years of the outpatient department prospective payment system.

When can it be implemented? Can it be implemented without major systems changes? This could be announced when the final rule is published. No implementation required.

Costs: To be determined.

Pros and Cons

Pros:

- The delay would provide an adjustment period while providers accustom themselves to the new system.

Cons:

- With any new payment system, there is a risk that the conversion factor for calculating the new rates is either too high or too low. This will only be known when hospitals actually begin to bill using the new APC codes. Thus, the volume control target in the first year would be a safeguard against overestimation of the conversion factor.

Home Health

Proposal Title: Reimburse HHAs for their costs of implementing OASIS through a national demonstration project.

Current Law: Under the interim payment system, those HHAs whose costs are below the aggregate per-visit and per-beneficiary cost limits are currently receiving full-cost reimbursement for OASIS activities. Those subject to the per-visit limit will receive both a startup and ongoing adjustment to their visit limit cap to account for OASIS costs. However, we cannot make similar adjustments to the per-beneficiary limits under the law. If a home health agency is subject to the per-beneficiary limit (the majority of providers), it will not be reimbursed for the additional costs of OASIS.

Description of Proposal: The General Medicare Demonstration Authority, section 402 of the Social Security Amendment of 1967, allows HCFA to conduct demonstrations that test different methods of payment to "increase the efficiency of economy of health service...through the creation of additional incentives." Using this authority, HCFA could reimburse HHAs that are subject to the per-beneficiary limits on a per capita or flat rate, and therefore, not reimburse for OASIS through the IPS.

Arguably, this demonstration authority would allow us to test a change in payment that would include the OASIS-related cost, provided we meet the conditions for demonstration authority. There is no precedent for such a national demonstration project.

Implementation: There may be significant operational issues with this demonstration that we're examining. In addition, to determine which HHAs are subject to the per-beneficiary limit, cost reports must be settled. Cost reports are usually settled approximately a year after the end of their cost reporting periods.

Costs: TBD

Pros and Cons:

Pro

- Reimbursing HHAs for the cost of OASIS may mitigate agencies' complaints about implementing the instrument. This proposal could help HCFA implement PPS on time.

Con

- We would be stretching the definition of a national demonstration project since it is unclear what we are actually demonstrating. GC advised that while we have the technical legal authority, this may not be possible to operationalize or be justified as a demonstration.

- This demonstration could be a costly precedent. Other providers who have reporting burdens will likely want similar treatment.

- Any payment we would propose other than the actual cost would be disputed by the industry as insufficient. If we reimburse at cost, it would be difficult to verify whether costs are reasonable. Also, this would also set HHAs at odds with those that are currently being reimbursed under th per-visit cap.

Home Health

David Some concerns but can be examined

Proposal Title: Provide extended repayment schedules for HH IPS overpayments.

Current Law/Regulations: HCFA regulations specify that, in general, debts collected through installment payments will be collected in 3 years or less. The regulations permit exceptions to the 3 years in the case of "unusual circumstances...such as the possibility of debtor insolvency...". The Administrator has the authority to provide extended repayment schedules depending upon the financial circumstances of the debtor.

Last August, HCFA instructed the contractors to 12-month grant extended repayment schedules for all HHAs facing interim payment system overpayments. Agencies are able to request additional time, if necessary, and must lay out their plans and abilities to repay the debt. The regional offices have the authority to grant up to 3-year extended repayment schedules. Anything beyond 3 years must be approved by central office.

Description of Proposal: Permit 3 years for home health agencies to repay interim payment system overpayments.

When can it be implemented? Immediately, no system implications.

Costs: TBD

Pros and Cons

Pros:

- Provides immediate assistance to HHAs that are facing interim payment system overpayments.

Cons:

- Delays recovery of IPS overpayments.
- To the extent that a provider continues to receive Medicare payments but is ultimately unable to repay the overpayment, could result in losses to the Trust Funds.

Home Health

Proposal Title: Decline collection of interest on HH-IPS overpayments

Current Law/Regulations: Title XVIII requires that interest be accrued on determinations of debt that are not repaid within 30 days. The Administrator of HCFA has delegated authority under the Federal Claims Collection Act on the collection of claims. Under the various regulations implementing this Act, the Administrator has the authority to not collect all or part of the interest accrued.

Currently, interest is assessed following the submission and review of an agency's cost report. Most of the IPS overpayments have been assessed when interim rates were calculated -- not when the cost report is submitted. Because of this, HCFA was able to provide, interest free, 12 months to repay the IPS overpayments.

Description of Proposal: On a case-by-case basis, determine whether to collect all or part of the interest due on HH IPS overpayments. (While the Administrator has the authority to decline to collect interest in all cases, doing so would undermine the Agency's ability to ever collect interest in the future.)

When can it be implemented? Immediately, no systems implications.

Costs: TBD

Pros and Cons

Pros:

- Provides immediate assistance to HHAs that are facing interim payment system overpayments.

Cons:

- Has the potential to erode HCFA's ability to collect interest on any overpayments.
- Is a cost to the Treasury. (Interest collections do not go into the Trust Funds.)

SNF

Proposal Title: Use Department of Labor Producer Price Index (PPI) in place of the SNF market basket to update the SNF rates.

Current Law: Current law stipulates that HCFA "establish a market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services". HCFA uses a SNF market basket index to update the rates. The market basket includes wages and salaries, utilities, and capital-related expenses.

Description of Proposal: Begin using BLS Producer Price Index (PPI) for nursing homes in lieu of the SNF market basket to update SNF rates. The PPI is calculated from billing information.

Authority Under Which HCFA Can Promulgate Proposal: Under the BBA, HCFA has some flexibility in establishing a market basket as long as it meets the criteria of reflecting changes over time in the goods and services used to produce SNF care. HCFA could do this administratively.

Vehicle for Promulgation: Regulation. HCFA could only waive notice and comment rulemaking thereby publishing an interim final rule with comment if it can show good cause for doing so. The Administrative Procedure Act defines "good cause" as when notice and comment rulemaking is "unnecessary or contrary to the public interest". According to OGC, HCFA would have great difficulty in showing this.

When can it be implemented? Assuming HCFA could waive notice and comment rulemaking, an interim final rule with comment would have to be published by July 1, 1999 in order for the change to be made October 1, 1999. If, however, HCFA must follow the procedure for notice and comment rulemaking (and develop PPI projections for 2000), the earliest the change could be made is April 2000, after the Y2K window reopens.

Costs: (leave this blank for now)

What are the policy/strategy Pros and Cons? PRO: Because the three years of the PPI is higher than the market basket, SNFs may receive increased payment. CON: Because the PPI includes price information, we would essentially be giving SNFs payment updates based on their own pricing decisions. This creates an incentive for SNFs to inflate prices. CON: The PPI for SNFs is a relatively new index and, thus, movement in the future is unknown. The PPI could dip below the market basket (as it has recently for hospitals), in

which case switching to the PPI could cause industry discontent. The other possibility, as we've seen recently with the prescription drug PPI, is that the index dramatically increase (20%) because of the pricing decisions of one part of the sector. This occurs because the PPI reflects prices and not underlying costs and is, therefore, vulnerable to variations in the pricing decisions of the market. CON: The PPI will have an adverse effect on the Part A trust funds. CON: Although the BLS tracks the PPI, it does not do any projections of future rates. HCFA would have to forecast the rates.

Therapy Caps

Proposal Title: Delay implementation of per beneficiary caps until January 1, 2001.

Current Law: The $1500 caps on physical therapy/speech therapy and occupational therapy are currently being implemented on a per provider basis rather than a per beneficiary basis for all providers except for skilled nursing facilities. That is, each provider is responsible for billing Medicare no more than $1500 for each cap for each beneficiary. A beneficiary, however, may go to another provider and receive services after the $1500 cap is reached.

HCFA currently plans to implement the caps on a per beneficiary basis beginning on July 1, 2000.

Description of Proposal: This proposal would further delay the implementation of the caps on a per beneficiary basis until January 1, 2001.

When can it be implemented? Can it be implemented without major systems changes? Results in further delaying the systems changes needed to implement the per beneficiary caps.

Costs: To be determined.

Pros and Cons

Pros:

- Would further delay the impact of the caps on beneficiaries in non-SNF settings.
- It would be administratively complicated to implement the caps on a per beneficiary basis in the middle of the year. It would also be difficult to explain to beneficiaries who had received services in the first half of the year how the policy would affect them beginning in July.

Cons:

- Is only an incremental improvement. Doesn't address the serious access problems people have raised. Doesn't address the problem in skilled nursing facilities at all, which has been the focus of attention since this is where the caps are currently being fully implemented.
- Is contrary to the policy in the law

Proposal Title: Lengthen the Current Phase-In Schedule for M+C Risk Adjustment

Current Law: The BBA mandated that M+C payments be adjusted for the risk associated with enrollee health status beginning in 2000. Although the law did not mandate a phase-in of risk adjustment, the Administration decided to phase it in over a 5-year period, from 2000-2004. Initially, from 2000-2003, an inpatient model is being used; if fully implemented, this model would recoup an estimated one half of the overpayment attributable to favorable selection in M+C plans. Beginning in 2004, a comprehensive model, which uses both inpatient and outpatient data, will be used.

Description of Proposal: Modify the current phase-in schedule for years beginning in 2001 to increase the length of the phase in from 5 years to 6, 7, or 8 years, as follows:

(a) 6-year option (including current policy in 2000):

2001: 80 percent demographic and 20 percent inpatient only (PIP-DCG),
2002: 60 percent demographic and 40 percent inpatient only (PIP-DCG),
2003: 30 percent demographic and 70 percent inpatient only (PIP-DCG),
2004: 35 percent demographic and 65 percent comprehensive risk adjustor (HCC), and
2005: 100 percent comprehensive risk adjustor (HCC).

(b) 7-year option (including current policy in 2000):

2001: 80 percent demographic and 20 percent inpatient only (PIP-DCG),
2002: 60 percent demographic and 40 percent inpatient only (PIP-DCG),
2003: 40 percent demographic and 60 percent inpatient only (PIP-DCG),
2004: 50 percent demographic and 50 percent comprehensive risk adjustor (HCC),
2005: 25 percent demographic and 75 percent comprehensive risk adjustor (HCC), and
2006: 100 percent comprehensive risk adjustor (HCC).

(c) 8-year option (including current policy in 2000):

2001: 90 percent demographic and 10 percent inpatient only (PIP-DCG),
2002: 80 percent demographic and 20 percent inpatient only (PIP-DCG),
2003: 70 percent demographic and 30 percent inpatient only (PIP-DCG),
2004: 60 percent demographic and 40 percent comprehensive risk adjustor (HCC),
2005: 40 percent demographic and 60 percent comprehensive risk adjustor (HCC), and

2006: 20 percent demographic and 80 percent comprehensive risk adjustor (HCC), and
2007: 100 percent comprehensive risk adjustor (HCC).

NOTE that there is also informal discussion of 2 diagnosis-specific "give backs". One would pay M+C plans more for HIV-positive patients on drug regimens by increasing the PIPDCG payment for hospitalized AIDS patients. The other would pay more for hospitalized patients with congestive heart failure, in order to compensate plans more for the costs they assert they have from keeping other CHF patients out the hospital. See policy concerns below.

How this be implemented without major systems changes? When can it be implemented? This change can not happen until 2001.

The year 2000 rates were published in March 1999 as required in the BBA and the Administration's planned phase-in for 2000 (90% demographic/10% PIPDCG) was announced prior to that time. Plans need to know both the 2000 rates and the demographic/PIPDCG proportions for 2000 in order to complete their adjusted community rate proposals (ACRPs), which are due July 1. If either the 2000 rates or the phase-in proportions were to change, the ACRPs would have to be changed. The timing for preparing **Medicare and You** would be impossible if ACRPs are submitted after July 1.

Costs: 10-year costs (in Billions):

6-year option:	$ 3.9
7-year option:	$ 7.3
8-year option:	$13.8

Pros and Cons

Pros

- Increasing the length of the transition would be viewed favorably by plans and could reduce the number that may otherwise drop out of the program.

Cons

- For many years, HCFA, CBO, MedPAC and its predecessor commissions, the GAO, and the OIG have pointed out that Medicare overpays HMOs because they enroll a healthier-than-average subset of Medicare beneficiaries. Estimates of

overpayments range from about 5-10 or more percent of payments under the AAPCC methodology. The inpatient hospital data received from plans in connection with the BBA's mandate to risk adjust payments documents overpayments of 7 percent. HCFA actuaries believe that more complete data to be gathered in future years will show overpayments of 10-15 percent. HCFA's current phase-in strategy results on foregone savings of over $4 billion. Delaying the phase-in will result in greater foregone savings.

- CBO did not score any savings for the BBA's risk adjustment provision. After our announcement of the risk adjustment methodology they modified their baseline to reflect savings attributable to risk adjustment. They would score any legislation which would delay or "liberalize" the current transition schedule as a cost.

- Paying substantial sums to plans for non-hospitalized HIV-positive patients raises concerns about Medicare paying for outpatient prescription drugs for these beneficiaries when it does not cover other outpatient drugs nor would this proposal cover drugs for HIV-positive individuals who do not enroll in an M+C plan. It also raises questions about documenting that no other payer (e.g., Medicaid) covered their prescription drugs and, because payment levels are very high, that plan lists of covered beneficiaries are accurate.

- Similarly, paying substantially more (twice the current PIPDCG amount) for hospitalized CHF patients would create twice the incentive for plans to inappropriately hospitalize such patients.

Medicare+Choice

Proposal Title: Implement M+C Risk Adjustment on a Budget Neutral Basis

Current Law: Current law mandates implementation of risk adjustment of M+C payments in 2000. It does not explicitly address whether the policy should be implemented on a budget neutral basis, however, HCFA's current system assumes additional savings based on risk adjustment.

Description of Proposal: The risk adjustment system would be implemented by redistributing amounts attributable to selection bias to plans based on the health status of their enrollees. Thus, total overpayments due to selection bias in the Medicare+Choice program would continue at present levels, though funds would be redistributed. Moving forward with this proposal would require a reinterpretation of the law and the rationale for doing risk adjustment.

How this be implemented without major systems changes? When can it be implemented? As with the modification to the transition schedule this proposal could not be implemented in 2000 without disrupting the fall education campaign. The resulting switch from a non-budget neutral implementation in 2000 to budget neutral implementation in 2001 would be difficult to defend.

Costs: TBD

Pros and Cons

Pros

- Implementing risk adjustment on a budget neutral basis would be viewed favorably by plans and could reduce the number that may otherwise drop out of the program.

Cons

- For many years, HCFA, CBO, MedPAC and its predecessor commissions, the GAO, and the OIG have pointed out that Medicare overpays HMOs because they enroll a healthier-than-average subset of Medicare beneficiaries. Estimates of overpayments range from about 5-10 or more percent of payments under the AAPCC methodology. The inpatient hospital data received from plans in connection with the BBA's mandate to risk adjust payments documents

overpayments of 7 percent. HCFA actuaries believe that more complete data, to be gathered in future years, will show overpayments of 10-15 percent. HCFA's current estimate of full implementation of risk adjustment from 2000-2004 is $15.7 billion. Making risk adjustment budget neutral will result in additional payments over the next 5 years to managed care plans of $15.7 billion.

- In view of all of the research indicating that Medicare overpays managed care plans because of selection bias and the Administration's proposal to reduce the base by 5% because of selection bias, it would be difficult to defend a reversal of policy. It would also be very difficult to undo this decision at a future time, when an even larger proportion of the Medicare population may be enrolled in an M+C plan. Note that the AAHP's documents on a "fairness gap" in 2004 appear to assume that Medicare HMOs will continue to have the same risk selection they had in 1998.

- The law has always provided authority for risk adjustment. There is nothing in the law, past or present, the supports implementing risk adjustment on a budget neutral basis. For other payments systems, where Congress had desired budget neutral implementation explicit statutory mandate was included.

- CBO did not score any savings for the BBA's risk adjustment provision. After our announcement of the risk adjustment methodology they modified their baseline to reflect savings attributable to risk adjustment. They would score any legislation which would mandate budget neutrality as a cost.

Hospitals

Proposal Title: HHS/DOL Study on Collecting and Using Occupational Mix Data

Current Law: The American Hospital Association (AHA) used to provide occupational mix data which allowed HCFA to adjust the hospital wage index for occupational mix. Because the AHA is no longer providing this data to hospitals, the wage index cannot be adjusted for occupational mix.

Description of Proposal: This proposal calls for a joint HHS/DOL study on collecting and using occupational mix data.

Costs: To be determined

Pros and Cons

Pros: This study would report on the feasibility of collecting and using occupational mix data. In addition, this study is included in Senator Daschle's rural health care bill.

Cons: Many people currently believe that collecting and using occupational mix data is extremely burdensome and not worth the effort since it would not have an impact on too many providers.

Hospitals

Proposal Title: Ease Restrictions for Hospital Reclassification

Current Law: Under current regulation, a hospital must meet certain requirements to apply for reclassification from a rural area to an urban area or an urban area to another urban area. Among these requirements, a hospital must demonstrate that (1) its average hourly wage is equal to at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation and (2) its average hourly wage is at least 108 percent of the average hourly wage in which it is located.

Description of Proposal: This proposal would ease restrictions for hospital reclassification by lowering the average hourly wage percents (84 and 108) needed for reclassification. This can be implemented administratively under Sec. 1886(d).

Vehicle for Promulgation: Notice with comment - Could be included in the FY 2001 Inpatient Hospital Regulation.

Costs: To be determined

Pros and Cons

Pros: This proposal would allow more hospitals to reclassify, specifically rural hospitals.

Cons: Medicare Geographic Classification Review Board (MGCRB) reclassifications are budget neutral and therefore other hospitals pay for the additional reclassifications.

Outpatient Department Services

Proposal Title: Use of Inpatient Wage Index for Outpatient PPS

Current Law: Hospitals in areas classified as rural currently can apply to use an urban wage index if they can show that their wages are more similar to the prevailing wages in the urban area.

Description of Proposal: This proposal would incorporate the hospital inpatient PPS wage index into the hospital outpatient department PPS and therefore allow hospitals that reclassify to use the urban rate for both inpatient and outpatient services. This proposal, included in Senator Daschle's rural health care bill, was proposed by HCFA in the September 8, 1998, PPS Outpatient Department Proposed Rule.

Vehicle for Promulgation: This proposal will be finalized in the OPD Final Rule in December.

Costs: To be determined

Pros and Cons

Pros: Allows rural hospitals that reclassify to not only use the urban rate for inpatient care, but also for outpatient services.

Cons: None

Lee Like This

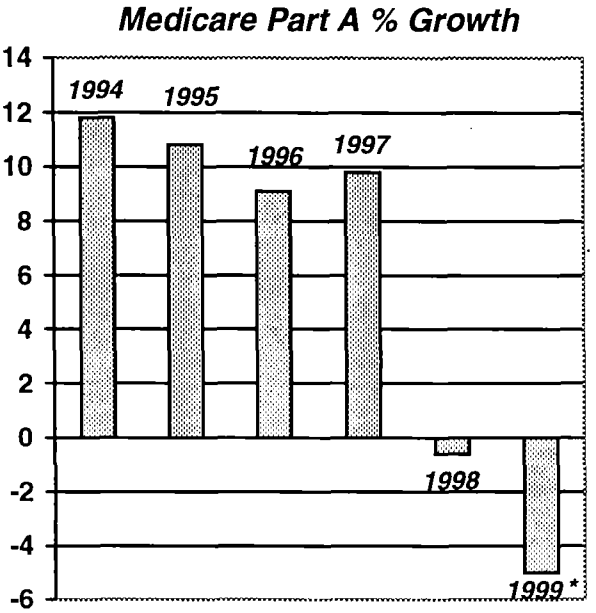
THE BALANCED BUDGET ACT OF 1997 CUT MEDICARE $92 BILLION MORE THAN EXPECTED!

UNANTICIPATED MEDICARE CUTS

- **$103 billion in savings projected – more than $195 billion actually saved.** When the Balanced Budget Act of 1997 (BBA '97) passed, the Congressional Budget Office (CBO) projected the bill would cut Medicare spending by about $103 billion over five years (FYs 1998-2002). However, CBO now estimates that Medicare will be cut $195 billion during fiscal years 1998-2002, over $90 billion more than anticipated.

- **5.8% Medicare growth was projected for FY '99 – negative 2% Medicare reduction realized.** When BBA '97 passed, total Medicare spending inflation was expected to drop from almost 10% in FY97 to about 5% and the out years. However, in April, the Treasury Department reported that total Medicare spending in the first half of FY1999 fell over 2%, just 17 months after BBA '97's enactment.

- **Medicare hospital spending plummeting.** In FY '98, Medicare Part A spending fell by almost 1%. For FY '99, CBO had projected a 2.5% increase for FY '99 when BBA '97 passed, but spending actually fell almost 5% during the first half of FY '99.



* = *First half of FY '99*

THE IMPACT ON HOSPITALS

Hospital Margins Are Falling Rapidly --

- Total hospital margins are projected to plunge almost one-half in five years, from 7% in FY '98 to 3.6 % in FY '02.

- Total hospital Medicare margins are expected to decline from 4.3% in FY '97 to only 0.1% this year (FY '99).

- Total hospital margins for rural hospitals are expected to fall from 4.2% in FY '98 to negative 5.6% in FY '02.

- Hospital outpatient Medicare margins are already negative 17 percent with FY '02 projections of negative 28%.

Financial Stability of Hospitals Shaken --

- **Not-for-profit hospital credit is deteriorating**. "At nearly $4 billion, the total amount of debt downgraded in the first quarter (1999) has already exceeded the total cumulative debt downgraded for all of 1997 as well as any prior year." (*Moody's Investors Service*)

- **Privately-owned hospital stocks are falling**. As of April 1999, stocks across the hospital management sector are down an average of 40% since the beginning of 1998, while the overall market is up some 40% over the same period.

Congress Must Revisit the BBA '97 to Address These Payment Issues!

REVISITING THE EXCESSIVE HOSPITAL CUTS IN THE BALANCED BUDGET ACT OF 1997

Background

In passing the Balanced Budget Act of 1997 (BBA), Congress intended to reduce Medicare spending by $103 billion over five years (FYs 1998-2002). According to recent Congressional Budget Office estimates of Medicare spending, Congress overshot its mark by almost $92 billion.

In FY1999 alone, the Balanced Budget Act of 1997 was projected to cut Medicare spending by $15.5 billion. Instead, FY1999 Medicare spending has been cut by $35 billion – $19.5 billion more than expected – reducing projected spending by an additional 9%. **Medicare Part A spending actually fell 5% for the first half of FY '99.**

Congress Must Address the Following Hospital Issues This Year to ensure Medicare recipients continued access to high-quality hospital-based care.

- **Reverse Proposed Reduction in Outpatient Payments.**

  The Balanced Budget Act of 1997 directed HCFA to implement a budget-neutral prospective payment system for hospital outpatient department services. FAHS supported such a change. The proposed regulation published by HCFA on September 8, 1998, however, was not budget neutral and would result in a 5.7% spending reduction aimed at hospitals. This policy adds an unintended $4.5 billion cut on top of the $7.2 billion outpatient reduction contained in the BBA.

  This reduction runs counter to congressional intent and was never "scored" by CBO. If implemented, as proposed by HCFA, the rule would reduce hospital outpatient payments by more than $850 million each year. The result: Medicare outpatient margins are projected to fall dramatically to negative 28% by FY2002.

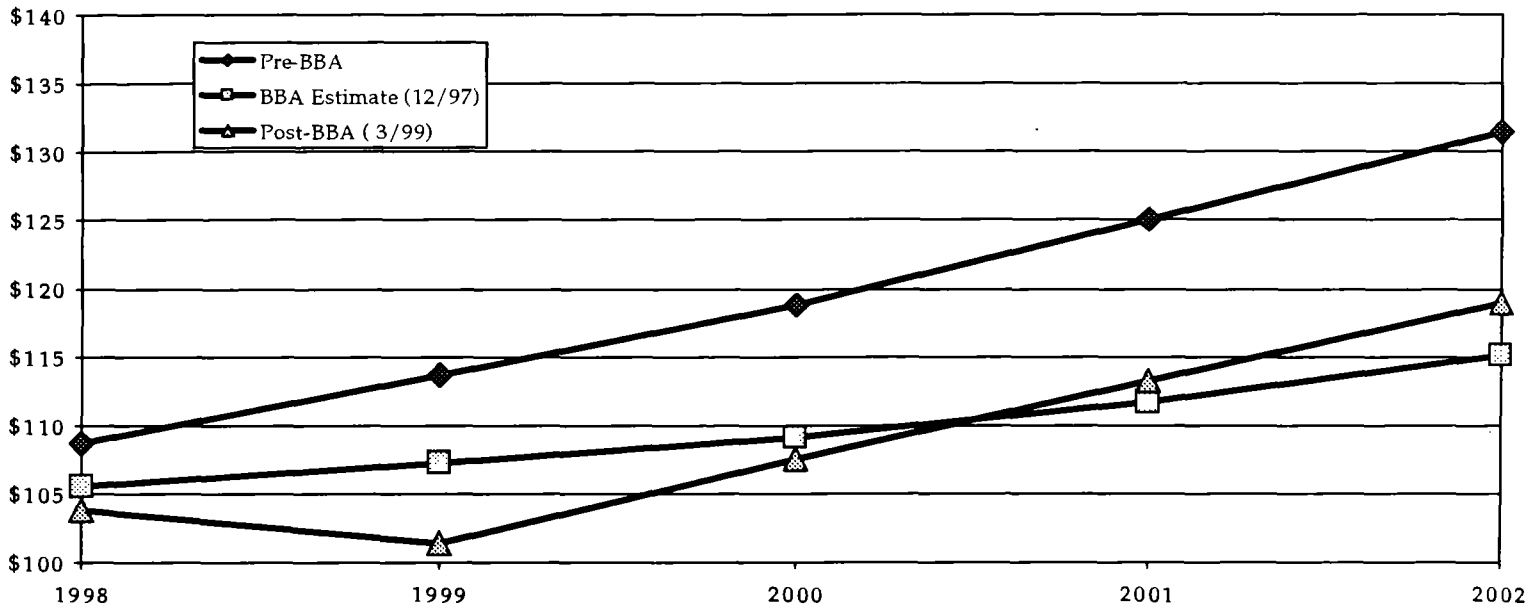
- **Repeal the Transfer Policy.**

  The Balanced Budget Act of 1997 significantly changed the way hospitals are reimbursed for patients who are discharged to a more appropriate setting for needed post-acute care. This so-called "transfer policy" reduces, on a pro rata basis, payments for inpatient hospital care if the patient is discharged to a post-acute setting before staying the average number of days associated with that patient's condition. This is bad policy, and bad medicine. The transfer policy ignores advances in integrating patient care. It is also fundamentally inconsistent with the premise that the prospective payment system is built on providing quality care in the most efficient setting, and that prospective payment systems are, or will soon be, in place in virtually every post-acute care setting. Tracking patients after discharge creates an administrative and liability nightmare for hospitals. This policy must be repealed.

- **Restore Federal Bad Debt Payments.**

  There are millions of low-income seniors who do not have Medigap coverage, do not qualify for Medicaid and cannot afford Medicare's hospital deductible. When a Medicare recipient cannot pay, the hospital assumes the cost as a "bad debt." The federal government had paid 100% of bad debt after due diligence to recover costs, but the Balanced Budget Act of 1997 reduced the federal share to 55%. Hospitals that treat a high proportion of poor seniors are particularly hard hit, and are simply absorbing the remainder as a loss. This provision is particularly unfair to hospitals because other health care providers still receive full reimbursement of bad debt costs.

Medicare Hospital Spending Reductions 92% More Than Expected Under BBA



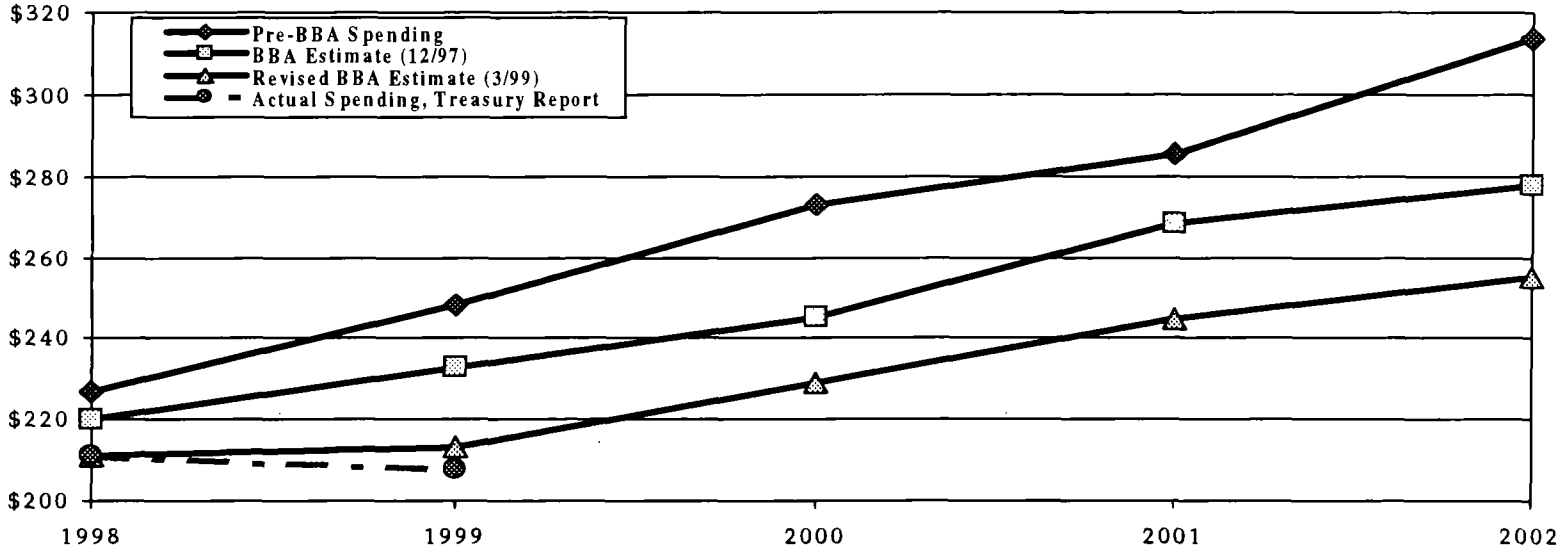
	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
Pre-BBA Spending	$108.7	**$113.7**	$118.8	$125.0	$131.4
Estimated Spending reductions under BBA (12/97)	(3.2)	**(6.4)**	(9.7)	(13.3)	(16.3)
Estimated Spending under BBA (12/97)	105.5	**107.3**	109.1	111.7	115.1
Additional Spending reductions per revised estimate	(1.7)	**(5.9)**	(1.5)	1.6	3.8
Revised Estimated Spending under BBA (3/99)	103.8	**101.4**	107.6	113.3	118.9

Sources: CBO, "An Analysis of the President's Budgetary Proposals for FY 2000: A Preliminary Report," March 3, 1999; CBO, "Budgetary Implications of the Balanced Balanced Act of 1997, "December 1997; CBO, "The Economic and Budget Outlook: Fiscal Years 1998-2007, January 1997

Medicare Spending $91.7 Billion Less Than Projected (FYs 1998-02)

Medicare Spending Estimates (in Billions)

BBA Savings Nearly Double Original Estimate

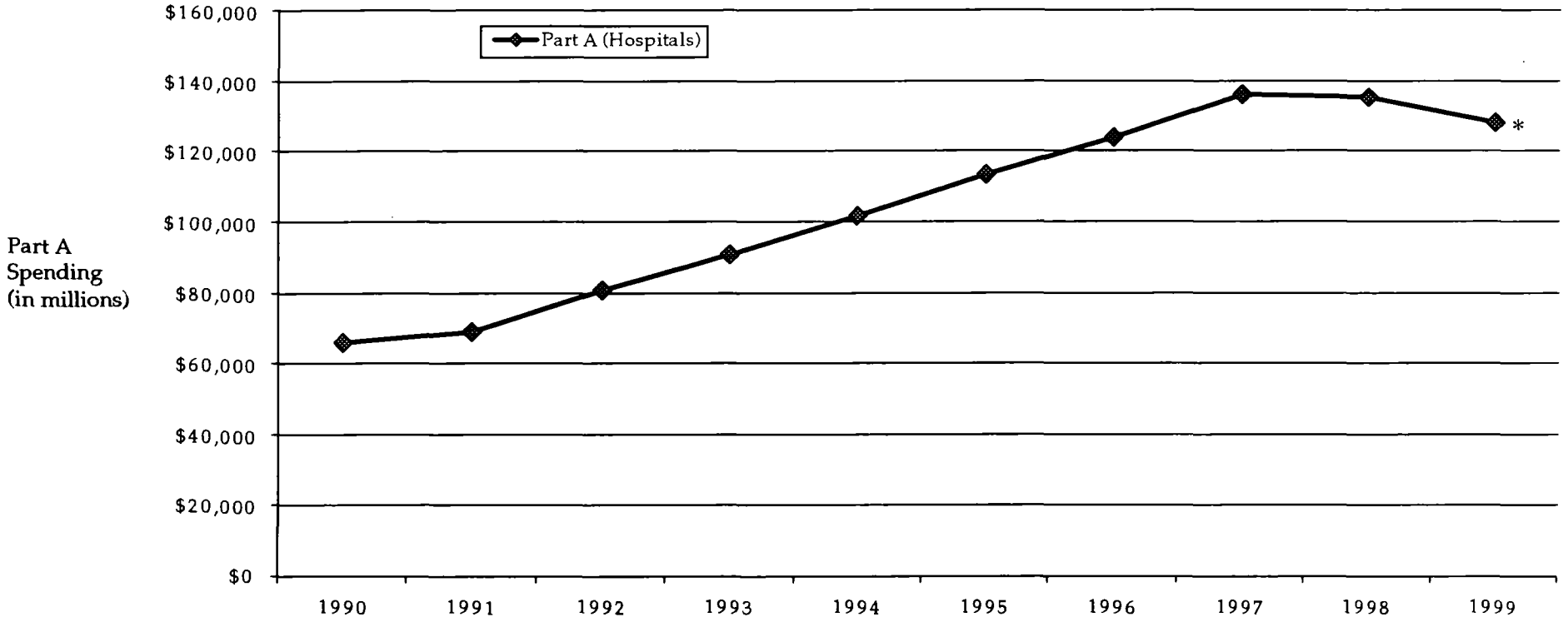


Projections Pre- and Post-BBA (in billions)	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	Five -Year Difference
Pre-BBA spending estimated	$227.0	**$248.2**	$273.0	$285.6	$313.7	-
Estimated spending reductions under BBA (12/97)	(6.9)	**(15.5)**	(27.6)	(17.1)	(35.9)	($103.0)
Estimated spending under BBA (12/97)	220.1	**232.7**	245.4	268.5	277.8	-
Additional spending reductions per revised estimate	(9.1)	**(19.4)**	(16.5)	(23.8)	(22.9)	(91.7)
Revised estimated spending under BBA (3/99)	211.0	**213.3**	228.9	244.7	254.9	-
Actual Spending Treasury * Report	211.0	**207.7**	-	-	-	-
Real Additional Spending Reduction	0.0	**(5.6)**	-	-	-	-

*Sources: CBO, "An Analysis of the President's Budgetary Proposals for FY 2000: A Preliminary Report", March 3, 1999; CBO, "Budgetary Implications of the Balanced Budget Act of 1997, "December 1997. *Treasury 3/31/99 Estimates Projected to Entire Year.*

Medicare Part A Spending Fell In '98

First Reductions In Program History



Part A	1990	1991	1992	1993	1994	1995	1996	1997	1998	* 1999
Spending (in millions)	65,912	68,705	80,787	90,730	101,535	113,583	124,009	136,175	135,406	128,274
Percent Increase		4.2	17.5	12.3	11.8	10.8	9.1	9.8	-0.6	-5.2

Source: Administration's Proposed Budget of the United States Government, Fiscal Year 2000, Table 11.3, Historical Tables, January 1999; Monthly Treasury Statement of Receipts and Outlays of the United States Government for FY 1999 through March 31, 1999, Table 5.

* Annualized estimate based on 6 month actual outlays reported by Treasury

HELMSIN & YARWOOD ASSOCIATES

Bob Beverson

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 2000, 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.

California Office: 200 P Street, Suite F-31, Sacramento, California, 95814, Tel (916) 441-5134 Fax (916) 441-5134
Washington DC Office: 2637 N. Marcey Road, Arlington, Virginia 22207 Tel (202) 898-2858 Fax (202) 842-3860

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.

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

Clinical Success Stories Submitted by Site

Baltimore Site

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.

The EverCare Story
Clinical Success Stories Submitted by Site

Baltimore Site

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.

EVERCARE®

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 Kelth:

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.

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.

California Office: 200 P Street, Suite F-31, Sacramento, California, 95814, Tel (916) 441-5134 Fax (916) 441-5134
Washington DC Office: 2637 N. Marcey Road, Arlington, Virginia 22207 Tel (202) 898-2858 Fax (202) 842-3860

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 St

Clinical Success Stories Subn

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.

Here are examples

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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

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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.

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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

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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.

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

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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

AMERICAN HOSPITAL ASSOCIATION WHITE PAPER

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

By

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3/ H.R. Rep. No 105-149, 105th Cong., 724 (1997); S. Rep No. 105-29, 105th Cong., 58 (1997); H.R. Rep. No. 105-217, 105th Cong., 784 (1997).

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

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

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

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

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

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

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

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

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

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

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

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7/ *Id.* at § 4152(b).

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

9/ *Id.*

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

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

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

12/ H.R. Rep. No 105-149, 105th Cong., 724 (1997); S. Rep No. 105-29, 105th Cong., 58 (1997); H.R. Rep. No. 105-217, 105th Cong., 784 (1997).

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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 concerns 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.

May 19, 1999
Page 2

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.

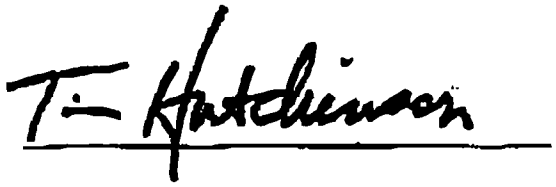
Sincerely,

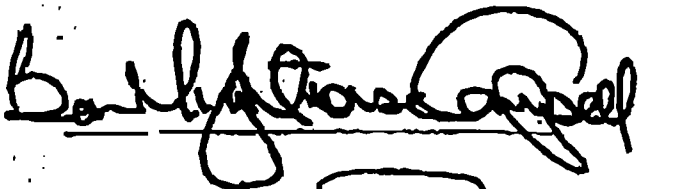
Pete V. Domenici

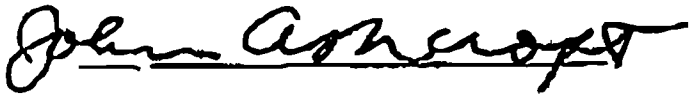
Jeff Bingaman

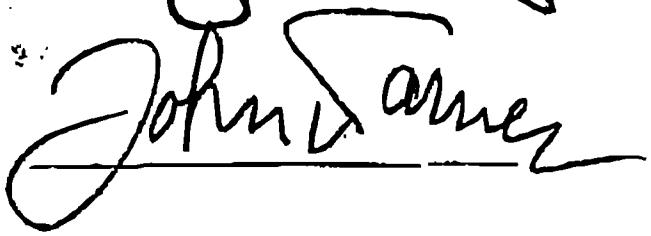
May 19, 1999
Page 3

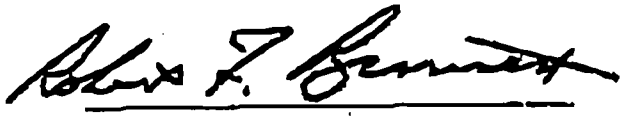
May 19, 1999
Page 4

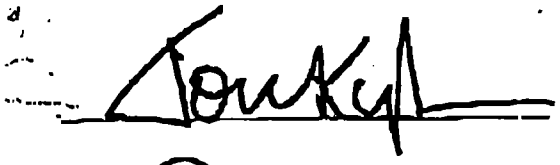


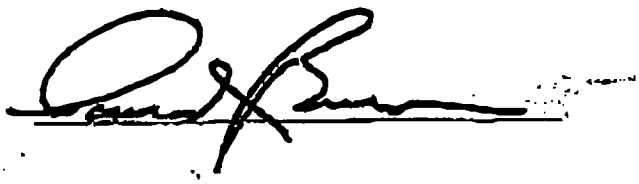


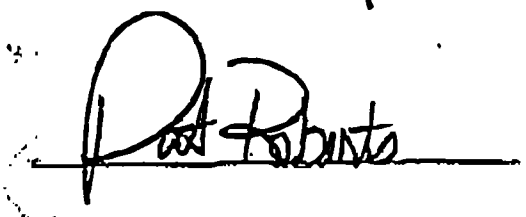


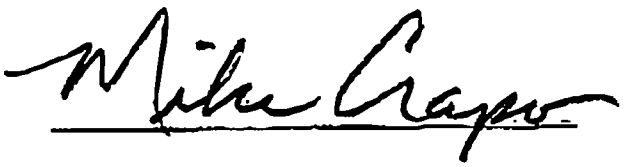


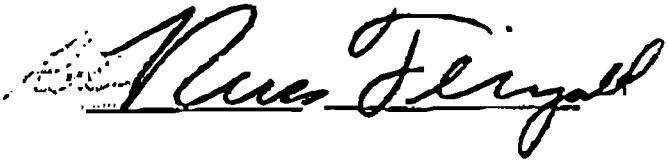


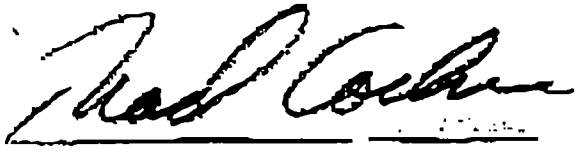


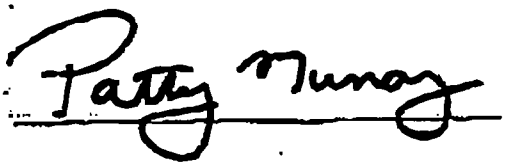


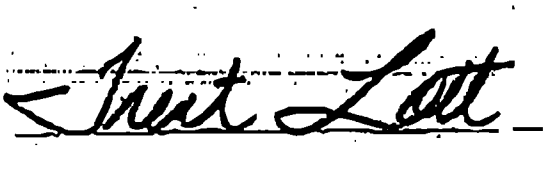


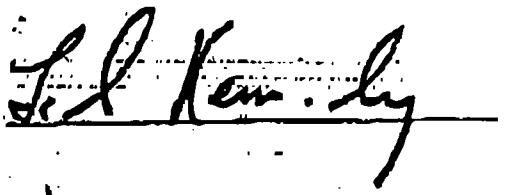


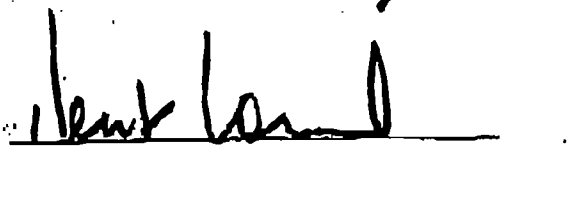


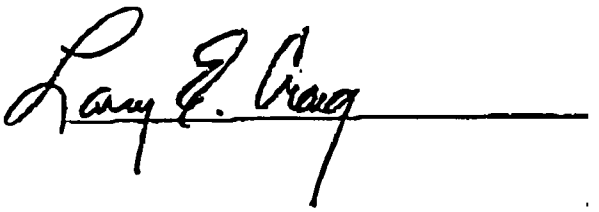


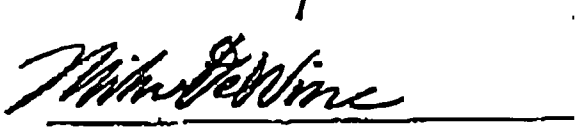


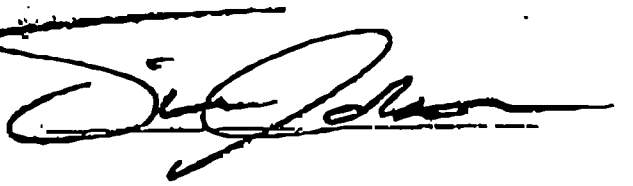


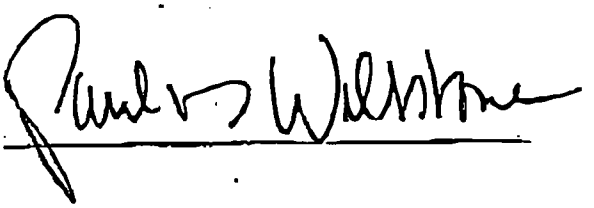


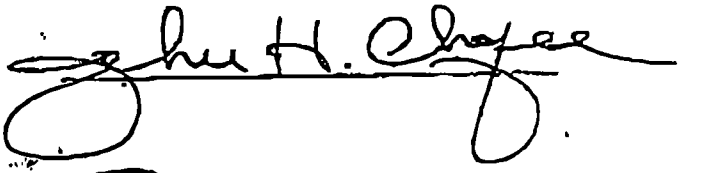


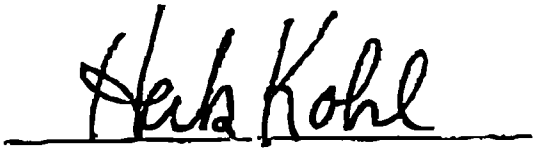


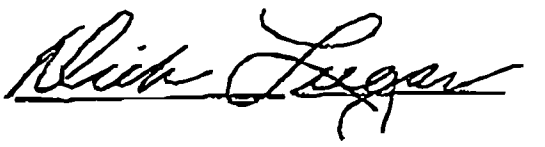












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Chafee	
Lugar	
McCain	

May 28, 1999

Mr. Chris Jennings
Deputy Assistant to the President
for Health Policy Development
Old Executive Office Building, Room 216
17th Street & Pennsylvania Avenue, NW
Washington, D.C. 20503

Dear Chris:

Per your conversation with Rick Pollack, enclosed please find a copy of a letter we sent to HCFA Administrator Nancy-Ann DeParle on the outpatient PPS issue strongly objecting to HCFA's interpretation of the 1997 Balanced Budget Act requiring hospitals to fund a portion of reduced beneficiary coinsurance costs. In addition, we have also enclosed for your review a legal analysis reinforcing our position and urging HCFA to follow congressional intent by having Medicare program funds offset reductions in beneficiary coinsurance.

As Rick may have discussed with you, we are requesting a meeting with HCFA so that this inequity can be fixed administratively in an expeditious manner. We would certainly appreciate it if you would provide your input on this issue. Thank you for your prompt attention to this critical issue for our members.

Sincerely,

Mary Beth Savary Taylor
Director
Executive Branch Relations

Enclosure

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

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Washington, DC 20004-2802
(202) 638-1100

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

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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

AMERICAN HOSPITAL ASSOCIATION WHITE PAPER

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

By

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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7/ *Id.* at § 4152(b).

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

9/ *Id.*

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

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

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

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