

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Bonnie to Rich et al. re: Physician Practice Expense Transition Issue (4 pages)	10/13/1999	P5 AMS 4/6/15
002. memo	Bonnie to Rich et al. re: Physician Practice Expense Transition Issue (4 pages)	10/13/1999	P5 AMS 4/6/15

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Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

HEALTH CARE
FINANCING ADMINISTRATION



ADDRESSEE:

Chris Jennings
Dan Mendelson
Mark Miller

PHONE: _____

FROM:

Bonnie Washington

OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: 202-690-6726

FAX : 202-690-6262

TOTAL PAGES:

1

ADDRESSEE'S FAX MACHINE NUMBER:

DATE:

REMARKS:

Draft OPD letter to Sen Rockefeller
& others for your review. Please
let me know today if you have
Comments.



The Honorable John D. Rockefeller
United States Senate
Washington, D.C. 20510

Dear Senator Rockefeller:

Thank you for your letter to the Administrator concerning the proposed Medicare hospital outpatient prospective payment system. I am responding on her behalf, and I regret the delay in this response.

I am aware of the many concerns raised about the potential impact that this proposed system would have on hospitals. The estimated 5.7 percent overall reduction in payments to hospitals that would result from implementation of this new system is sizable. You advise that this reduction is an unintended decrease in payments to hospitals which "represents a misinterpretation of Congressional intent" that you believe can be resolved administratively.

I want to assure you that the Health Care Financing Administration is committed to ensuring that our payment policies are based upon an accurate reading of the law. In view of your concerns and similar ones raised by others, I have asked the Office of General Counsel to closely review the Balanced Budget Act provisions pertaining to the hospital outpatient prospective payment system and to advise us of areas where we may have some flexibility. Please be assured that this task will be completed in time to give full consideration to any such flexibility before the promulgation of the final rule.

I appreciate your bringing this matter to my attention and your interest in assuring appropriate payments to hospitals for outpatient services delivered to Medicare beneficiaries. My staff and I look forward to working together on this issue with you and the other Congressional Members who co-signed your letter.

A similar letter is being sent the other Members who co-signed your letter.

Sincerely,

Michael M. Hash
Deputy Administrator

June 18, 1999

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

Dear Madame Administrator:

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

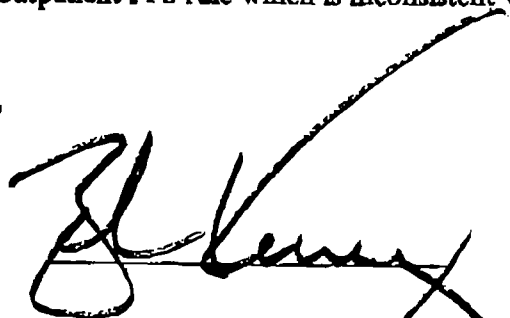
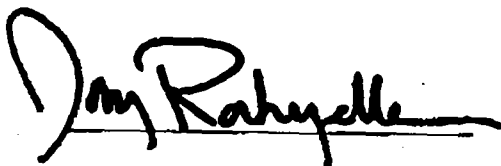
With the encouragement of Congress, HCFA, seniors' representatives and providers cooperatively developed the outpatient PPS policy. The new policy was designed to address a longstanding flaw in outpatient payment policy and to gradually rationalize Medicare's outpatient copayments, without imposing unmanageable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

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

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

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

Sincerely,



--more--

SEP 14 1999 14:00 HCFA LH 202 200 7837 P.04/05

United States Senate S/DCCM

WASHINGTON, DC 20510 1999 JUN 28 AM 11:23

June 18, 1999

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

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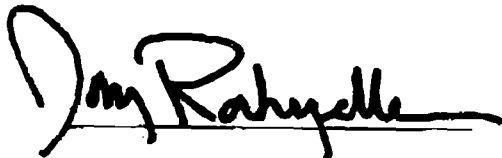
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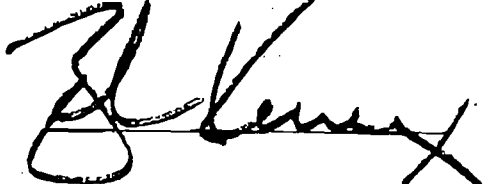
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Sincerely,









--more--

J. Wilson

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<u>John Breacy</u>	<u>Strom Thurmond</u>

<u>Richard Shelby</u>	<u>Jeff Sessions</u>
<u>Blanche R. Lincoln</u>	<u>John H. Chafee</u>
<u>Robt C. Inge</u>	<u>Ernie Boyd</u>
<u>Harry Reid</u>	<u>Carmie Mack</u>

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Office of Legislation



Number of Pages: _____

Date: 10/14/99

To:	From:
<i>Mark / Dan</i> <i>Chris / Jean</i>	Bonnie Washington
Fax: _____	Fax: _____
Phone: _____	Phone: _____

REMARKS: _____

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

October 13, 1999

Note to: Rich/Jane
Mark/Dan
Chris/Jeanne

Subject: Physician Practice Expense Transition Issue

The Administration's FY 2000 budget/legislative package contains a technical fix to the physician practice expense transition issue. The BBA language contains glitches and inconsistencies which has resulted in litigation about what BBA means and intends; certain specialties have argued for an atypical transition in which payments first increase before they decrease.

In submitting our legislative proposal, we indicated that we wanted a legislative correction regardless of the outcome of the Court case. A legislative correction is contained in the draft Senate Finance Chairman's mark.

We want you to be prepared on this issue. Attached is a short paper which discusses the issue. Justice has done a great job defending us in the lawsuit, but the outcome is uncertain. Justice has strongly urged a legislative correction.

We believe that this issue needs to be on a list of "must have" items for the forthcoming Medicare legislation. Without a legislative correction, if we were to lose the lawsuit, the plaintiffs could seek retroactive payments at least from Medicare which could involve taking money from primary care physicians.

Please call if you have any questions.


Bonnie

The Physician Practice Expense Transition

The BBA Provision: The Balanced Budget Act (BBA) enacted a transition to resource-based practice expenses under the Medicare physician fee schedule during 1999, 2000 and 2001. During these transition years only, practice expense payments are based on decreasing portions of prior charge-based values and increasing portions of resource-based values. The transition will be complete by January 1, 2002 at which point physician practice expenses are fully resource-based.

- o The purpose of a transition is to "soften the blow" for procedures and specialties where practice expense payments would be reduced under the resource-based system. The BBA softened the blow through a "normal" transition in which losing procedures are gradually reduced, during 1999, 2000 and 2001, to their full resource-based levels in 2002.
- o Prior to BBA, a resource-based practice expense system was scheduled to be implemented without any transition. Procedures would have increased and decreased from their charge-based levels to be completely resource-based in one step.

Implementation of the BBA Provision: The BBA transition language contains some glitches and inconsistencies. The Secretary's November 2, 1998 final regulation for the 1999 physician fee schedule implemented a "normal" transition, lowering practice expense payments in measured steps from their 1998 levels to their eventual 2002 levels (shown in the solid line in the attachment).

- o This "normal" transition was the purpose of the BBA provision, is a permissible reading of the ambiguous language, is consistent with the movement toward resource-based practice expenses since 1993 and is the only approach that makes policy sense.

The Lawsuit: Some physician specialties (including ophthalmologists, orthopedic surgeons, neurological surgeons, cardiologists, gastroenterologists and general surgeons) have sued the Secretary, arguing for a different, and highly unusual transition in which some practice expense payments first increase before they are reduced to their full resource-based level in 2002 (shown in the dotted line in the attachment).

- o These specialties have argued that an "atypical" transition is the only construction of the ambiguous language, though some of the litigating specialties urged still a different atypical transition in December 1997.
- o Moreover, these specialties argue that Congress explicitly intended that an atypical, up then down transition occur. They reject the "softening the blow" purpose of a normal transition.
- + Rather, they suggest that instead of gently moving procedures down to their resource-based level in measured steps, the purpose of the atypical transition is to provide additional compensation, in their words "to offset the significant long-term decrease those codes are scheduled to suffer under a resource-based PE-RVU

system”.

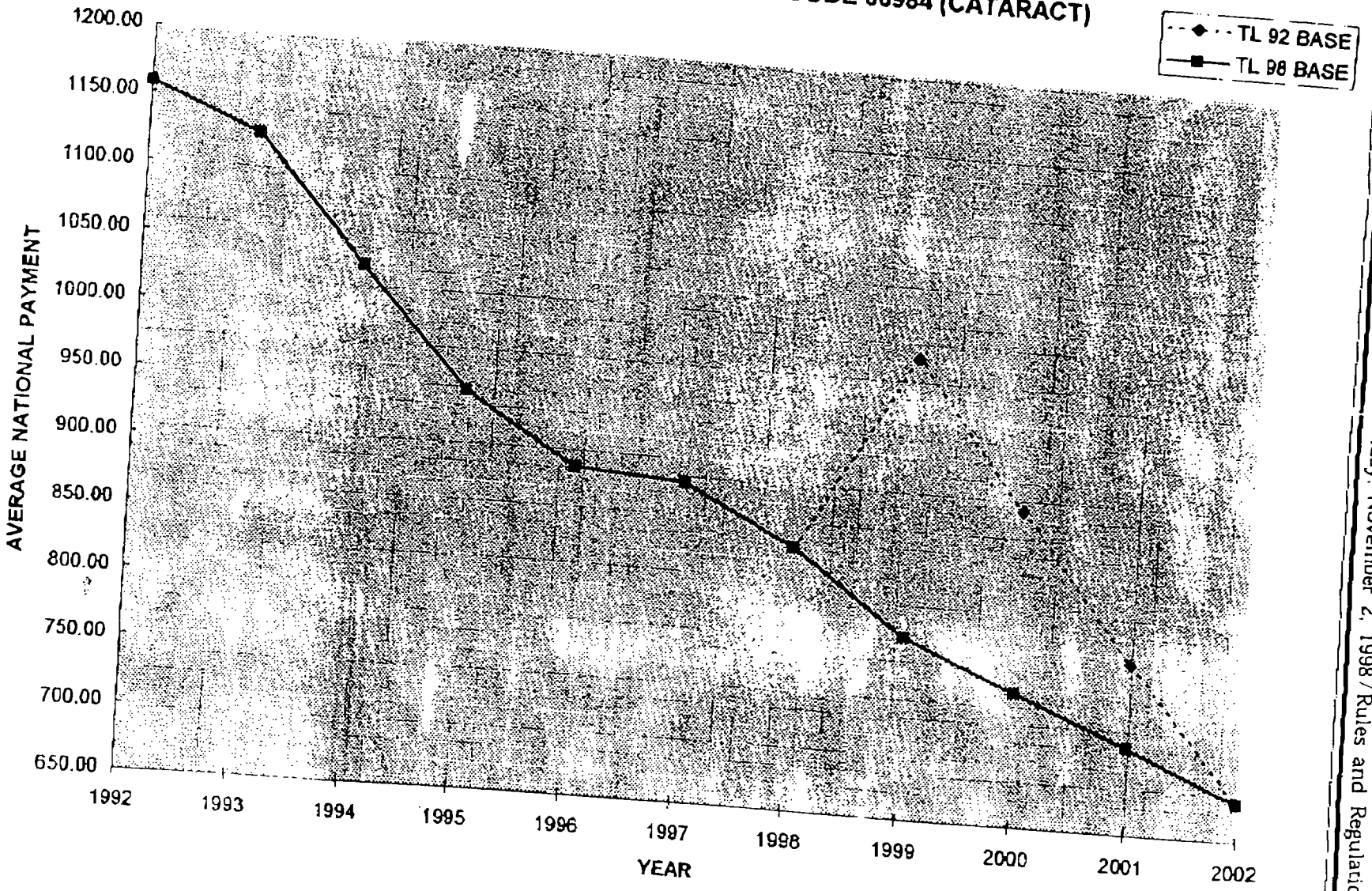
- + In effect, despite the fact that such an atypical transition has never been used for any type of service in Medicare, these specialties suggest that Congress explicitly rejected the “softening the blow” purpose of a normal transition, and explicitly intended that losing procedures, which were in excess of their resource-based levels, be given temporary payment increases during 1999, 2000 and 2001 to compensate for the fact the procedures will be at their resource-based levels beginning in 2002.
- + Such a contorted policy rationale is hard to believe in the context of the pre-BBA statute which had no transition and which had reduced payments for high-practice expense procedures in 1994, 1995 and 1996 (pursuant to OBRA-1993).
- + While these specialties do not challenge the resource-based levels to which losing procedures will be reduced beginning in 2002, their notion of resource-based levels providing for “suffering” is a unique perspective. Losing procedures are already being overcompensated under current charge-based payment levels compared to the resource-based levels. These specialties provide no rationale to justify why they assert that Congress explicitly would have provided for additional overcompensation for three years before getting to proper payment levels.
- + The real issue for these specialties seems to be that they don’t like resource-based payment levels since those proper payment levels will replace their currently overcompensated levels. A reduction in overpayments to proper levels does not constitute suffering.

Status of the Lawsuit: A lawsuit was filed last fall and the case is before the Court. There have been several rounds of filing of briefs. The case was referred to a Magistrate Judge who recently made recommendations to the Judge. The timing and ultimate resolution of the Court case cannot be predicted. Several primary care physician specialties have filed briefs in this case in support of the Secretary’s position.

Legislative Proposal: The Administration has submitted a legislative proposal to eliminate the glitches and clarify inconsistencies in the statutory language. In submitting the legislation, the Administration indicated that clarifying language was sought regardless of the outcome of the Court case. The clarification would resolve any ambiguities about achieving the softening the blow purpose of a “normal” transition that was the purpose of the BBA provision. The clarification would be the way the Secretary implemented the provision.

The transition to resource-based practice expenses is accomplished in a budget-neutral fashion. An atypical transition would increase payments for certain procedures and specialists and take money away from other procedures and specialists, typically primary care physicians. The legislative clarification has no budget effects.

AVERAGE NATIONAL PAYMENT FOR CPT CODE 66984 (CATARACT)



BILLING CODE 4120-01-C

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Senate Committee on Finance
Highlights of DRAFT Chairman's Mark
"Balanced Budget Adjustment Act of 1999"
October 12, 1999

Title I - Provisions Relating to Part A Only

- Skilled Nursing Facilities (SNFs): The mark would: adjust upward the new payment schedule to better accommodate medically complex patients by increasing by 7.5% the Special Care and Extensive Services RUGS; include the cost of Part B services in the facility-specific component of Medicare payments to SNFs participating in the Nursing Home Case Mix and Quality demo; and permit SNFs to elect to be paid according to the transition formula, or under the federal per diem rate, whichever is higher.
- Hospice Services: The mark would provide an upward adjustment in the market basket.

Title II - Provisions Relating to Part B Only

- Hospital Outpatient Departments: The draft mark would protect cancer and certain rural hospitals from the new payment system, and would limit the reductions in Medicare outpatient payments to other hospitals by establishing floors of 90%, 85%, and 80% over the first 3 years.
- Physicians: The mark includes a technical adjustment to stabilize payment rates for physicians, known as the sustainable growth rate. In addition, the mark resolves current pending litigation and applies a normal transition to the physician practice expense payment system.

Title III - Provisions Relating to Parts A and B

- Home Health Services: The mark would delay the 15% reduction in payments until PPS is implemented and would phase in the reduction over three years. The mark would raise the per visit limit to 108% of the national median; eliminate the 15 minute rule; and exclude durable medical equipment (DME) from consolidated billing. The mark would also allow overpayments to be repaid within 12 months without interest, and repayments made after 12 months and up to 5 years would require interest payments at rates consistent with those applied by the IRS to repayment of underpaid income taxes.
- Teaching Hospitals: The mark would delay the reduction in IME payments, by freezing the IME adjustment factor at 6.5% for fiscal years 2000 through 2003.

Title IV - Rural Initiatives

- In addition to protecting rural hospitals from the impact of the new outpatient payment system, the mark would provide a full payment update for Medicare Dependent Rural Hospitals and Sole Community Hospitals. The mark would also change the 96-hour restriction on individual inpatient hospital stays for Critical Access Hospitals to a requirement that the average inpatient stay of patients not exceed 96 hours; and directs the Secretary to set up a waiver process whereby certain hospitals currently treated as urban or large urban could be treated as rural.

Title V - Provisions Relating to Medicare+Choice

- The mark would lessen the impact of risk adjustment by providing a longer phase-in period. In addition, the mark would: ease the transition for beneficiaries affected by plan withdrawals or termination; extend waivers for social health maintenance organizations (S/HMOs); specify that notices regarding coverage of inpatient services be provided within 16-24 hours prior to discharge; and other provisions.

Title VI - Other Medicare Provisions

- Rehabilitative Therapy Caps: The mark would combine the rehabilitative therapy caps into a unified ceiling of \$3500.
- Dialysis: The mark would increase the composite payment amount for renal dialysis services furnished under the Medicare program.
- Recoupment of Certain DSH payments: The mark would suspend for one year the recoupment of certain disputed disproportionate share hospital (DSH) payments pending negotiations between the affected states, hospitals and HCFA; and would permit the recoupment of payments to be spread over 10 years at the discretion of the Secretary.

Title VII - Provisions Relating to Medicaid and CHIP

- Technical corrections to Medicaid DSH table for MN, WY, NM, DC.
- Lift sunset and 12 quarter limit on Medicaid-welfare transition fund.
- Correct the CHIP allotments for Puerto Rico and the territories.
- Technical adjustment to stabilize CHIP allocation formula and provide for improved data collection.

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SEP 22 99 (WED) 16:10

SENATE FINACE COMM

TEL: 202 228 0534

003/004
P. 004

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United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

FRANKLIN G. POLE, STAFF DIRECTOR AND CHIEF COUNSEL
DAVID PODOFF, MINORITY STAFF DIRECTOR AND CHIEF ECONOMIST

*Copies - Jane
Bonnie
Kurt to Chris J.
Dan M.*

September 22, 1999

The Honorable Trent Lott
Senate Majority Leader
S-207, The Capitol
Washington, D.C. 20510

Dear Trent:

As we continue to make progress on the appropriations bills for FY 2000, I wanted to alert you to several items that should be addressed this year with regard to the Finance Committee.

As you know, the CBO projected a \$14 billion on-budget surplus for fiscal year 2000. In the Taxpayer Refund and Relief Act of 1999, the FY 2000 revenue loss was approximately \$4 billion. It is important that this \$4 billion amount for FY 2000 be reserved for the following items this fall.

1. Tax Extenders - \$2.2 billion. Extension of tax provisions that expired in 1999 must be addressed. My preference is to pass the identical provisions that were included in the conference report to accompany H.R.2488, which included a five year extension of many of the provisions.
2. Alternative Minimum Tax (AMT) - \$1 billion. The AMT for individuals should be corrected in order for millions of Americans to take advantage of numerous tax credits such as the \$500 per child tax credit, HOPE scholarship credit, and the dependent care tax credit. We promised these benefits to middle income families and we should not let the AMT interfere with these credits. We provided AMT relief for one year in last year's omnibus appropriations bill. We need to extend this relief this year as well.

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SENATE FINACE COMM

TEL: 202 228 0554

P. 003

3. Medicare BBA 97 Changes - \$1 to \$1.5 billion. Several changes to the Balanced Budget Act of 1997 should be made this fall to alleviate the unintended consequences of certain Medicare provisions of the BBA 97.

I believe it is desirable that these three items be addressed before Congress adjourns for the year. In addition, several trade extenders should be addressed this year such as the GSP and TAA. Also, a minimum wage/small business tax package could be considered. As you may know, a limited number of non-controversial pay-fors are available to offset these additional items.

My staff and I are available to discuss any of these issues with you in our effort to resolve these Finance Committee matters with regard to trade, tax and Medicare needs.

Sincerely,



William V. Roth, Jr.
Chairman

WVR/jkw

WILLIAM V. ROTH, JR., DELAWARE, CHAIRMAN

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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

FRANKLIN G. FOLK, STAFF DIRECTOR AND CHIEF COUNSEL
DAVID PODOFF, MINDRITY STAFF DIRECTOR AND CHIEF ECONOMIST

October 14, 1999

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. President:

Thank you for the generous time you carved out of your schedule to discuss a number of issues with us last week. We wanted to share some additional thoughts on the matter of how we might work together to remedy some of the unintended consequences of the Balanced Budget Act of 1997 (BBA 97). As completion nears on a Chairman's mark developed in the Senate Finance Committee with bipartisan collaboration, we thought it would be best to revisit certain points.

As discussed in the Oval Office meeting, it would be extremely helpful and appropriate for the Administration to adjust downward its proposed 5.7 percent reduction in payments to hospital outpatient departments. We believe that the proposed reduction was an unexpected result of BBA 97 policies over which there is room for differences in interpretation. Of course, such an adjustment to the 5.7 percent reduction must be implemented in a way that protects the reduction in beneficiary coinsurance amounts scheduled to go into effect.

With the goal of achieving stability in the Medicare+Choice marketplace, we urge you to use your discretion to help ameliorate the negative impact of the Administration's current risk adjustment proposal on benefits and service areas offered by health plans. This is unequivocally within the Administration's authority and would demonstrate your commitment to the concepts of competition and choice in the Medicare program.

Our review of the skilled nursing facility prospective payment system suggests that treatment of medically-complex patients is inadequately reimbursed. Although the Chairman's mark would address certain aspects of this issue legislatively in the near future, we remain hopeful that you will commit to *specific* changes that could be made to ensure appropriate services for beneficiaries across the continuum of care.

Lastly, we understand an issue has very recently arisen with regard to the recovery of potential overpayments in the Medicare disproportionate share hospital program. We look forward to working with you to address this issue administratively. Thank you for your continued assistance as we work on the Senate Finance Committee to address these complex issues.

Sincerely,

A handwritten signature in cursive script, appearing to read "Bill", written over a horizontal line.

William V. Roth, Jr.

A handwritten signature in cursive script, appearing to read "DP Moynihan", written over a horizontal line.

Daniel Patrick Moynihan

American Medical Association

Physicians dedicated to the health of America



E. Ratcliffe Anderson, Jr., MD 515 North State Street 312 464-5000
Executive Vice President, CEO Chicago, Illinois 60610 312 464-4184 Fax

October 7, 1999

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
104 Hart Senate Office Building
Washington, DC 20510

Chris Rich really needs this. Barbara

Dear Mr. Chairman:

On behalf of the American Medical Association (AMA), I am writing to express our appreciation for including, in your September 24 letter to the President, correction of errors in the sustainable growth rate (SGR) among the list of items to be addressed by the Executive Branch administratively. Errors made by the Health Care Financing Administration (HCFA) have already shortchanged the SGR by \$3 billion. We appreciate your efforts to ensure that HCFA replaces these erroneous estimates with accurate data, and we hope these vital efforts continue.

Further, we have had discussions with your staff concerning several additional improvements in the SGR system that will require new legislation. We hope you will include the SGR refinements described below in your Committee's legislation to address the unintended consequences of the Balanced Budget Act of 1997. Our recommendations are compatible with those made by the Medicare Payment Advisory Commission (MedPAC) in its March 1999 Report to Congress.

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

As you noted in your letter to the President, the erroneous administrative projections used to set the SGR each year must be adjusted in order to avoid inappropriate payment reductions to physicians. Among several errors that HCFA has made in just the first two years of the SGR, the most serious was to underestimate by 1,000,000 beneficiaries the number of elderly and disabled patients enrolling in the Medicare fee-for-service program rather than managed care. For example, Delaware was one of the States where health plans abandoned Medicare in 1999, leaving fee-for-service as the only option for many patients. HCFA did not account for these plan withdrawals in the SGR; however, shortchanging Delaware physicians by nearly \$9 million, or nearly \$4,000 for each physician in the State.

To address this problem, we recommend that the Committee's legislation direct HCFA to replace its estimates with actual data for 2000 and each year thereafter. We further recommend that the Committee include report language expressing the Committee's concern about the erroneous projections in the 1998 and 1999 SGR and directing that they be corrected.

2. The SGR Must Be Increased to GDP+2 to Allow for Technological Advances and an Aging Population

The 1995 Republican budget plan, endorsed by the AMA, would have set the SGR factor for GDP growth at GDP plus two percentage points, but the Balanced Budget Act of 1997 sets this

Hon. William V. Roth, Jr.
Page 2 of 2

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

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

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

3. Steps Must Be Taken to Stabilize Future Payment Updates

As a result of design flaws in the SGR system, updates will alternate between steep increases and steep decreases, with physicians virtually guaranteed periods of several consecutive years with 5% payment cuts each year. It is inconceivable that Congress intended to create such intense volatility in Medicare payment rates, nor that Congress would condone such steep annual cuts for any other group. We recommend that several measures be enacted to prevent this volatility in Medicare physician payment rates:

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

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

The problems with the SGR system are augmented by the lack of timely, reliable information. Congress should require HCFA to provide previews for MedPAC's review of forthcoming payment updates and should share information on quarterly expenditures and changes in projections, as recommended by MedPAC.

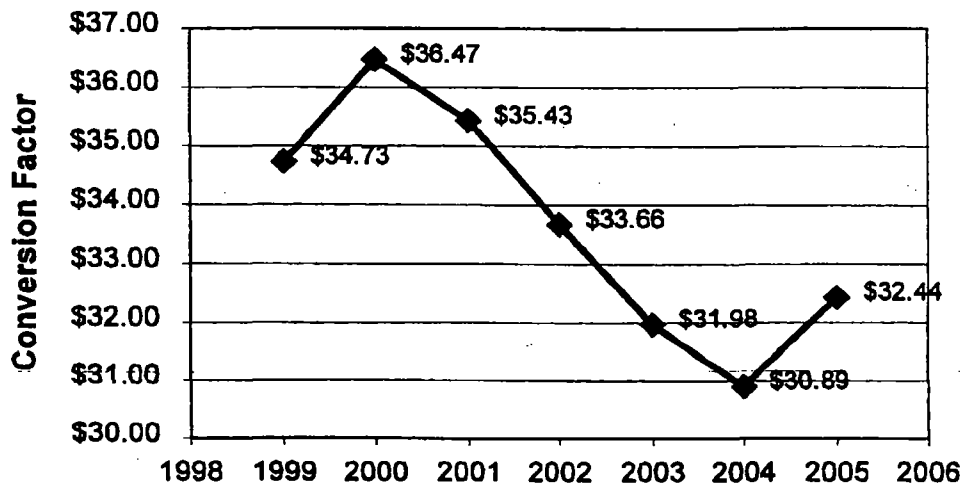
Thank you for your consideration, Mr. Chairman. We look forward to working with the Senate Committee on Finance to improve the SGR system. We would be happy to provide you with any additional information that you may need concerning our recommendations.

Respectfully,



E. Ratcliffe Anderson, Jr., MD

Medicare Physician Payment Rates Under HCFA's SGR Legislative Proposal



American Medical Association

Physicians dedicated to the health of America



Richard A. Deem
Vice President
Government Affairs

1101 Vermont Avenue, NW
Washington, DC 20005

202 789-7413
202 789-4692 Fax

October 5, 1999

Robert Berenson, MD
Acting Deputy Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Dear Bob:

Thank you for meeting with Mary Jo, Sandy, and me last week, and for calling me following our conference call with Ira and Marc to discuss HCFA's legislative proposal. We do appreciate your help in ensuring that the legislative language was shared with us. Unfortunately, the proposal is woefully inadequate.

Although we understand that HCFA agrees with us that the projection errors should be corrected, we still do not understand the HCFA concept of applying a budget neutrality adjustment to the error correction. That is why the list of questions we provided to you for last week's meeting included: "How exactly would such an adjustment be made? How would such an adjustment affect physician payment rates over the next 5 years? Alternatively, how would correction of the errors without such an adjustment affect payment rates?"

We still have not gotten an answer to these questions. As best we can tell without these answers, HCFA's legislative proposal would have no impact on physician payment updates until 2007, meaning physicians will continue to be shortchanged by the projection errors until then and payment updates will whipsaw between inflation-7% and inflation+3% until then. This is unacceptable. We appreciate your offer of a meeting with someone from the Office of the Actuary, and request that such a meeting be scheduled in the near future so that we can get these questions answered.

We also raised the question last week of how we can get Administration support for the entire package of fixes we have identified for the instability problem, including narrowing the limits on payments updates to inflation +/- 2% and use of 5-year rolling average GDP growth. We understand that it will be necessary to meet with Bonnie Washington on this issue and would appreciate your help in arranging for such a meeting.

The FY2000 SGR Final Notice

The AMA's concerns about the projection error issue and HCFA's management of the SGR system were significantly heightened last week with the publication of an FY2000 SGR of 2.1%. Although the HCFA projection of real per capita GDP growth seems more realistic than last year's estimate, the factors for enrollment and law and regulation changes are problematic.



Chris: 601 E Street, NW
Washington, DC 20049

This letter is going to members
of Ways & Means, Commerce, and
Senate Finance. We thought
it critical that members

~~thought you might be~~
interested in the attached.

understand the implications
of any further delay or
slow-down of the outpatient
census issue. *afix!!*

Patricia Smith
Sr. Coordinator/Health Issues
Federal Affairs

(202) 434-3770 phone
(202) 434-3758 fax



October 7, 1999

The Honorable William M. Thomas
U.S. House of Representatives
2208 Rayburn House Office Building
Washington, DC 20515

Dear Representative Thomas:

As Congress considers possible refinements to the Balanced Budget Act of 1997 (BBA 97), AARP urges you to keep in mind the implications of any changes for Medicare beneficiaries and for the solvency of the Medicare Trust Fund.

AARP is particularly concerned that the BBA 97 provision that began to reduce the beneficiary coinsurance for Medicare outpatient services is now in jeopardy. The phase-down enacted in the BBA remains the very minimum that must be done to begin to address the fact that, on average, beneficiaries today are paying about 50 percent of the total payment to hospitals for outpatient services.

If the scheduled phase-down of this provision is changed or delayed, beneficiaries will be forced to pay millions of dollars more out-of-pocket than they should for hospital outpatient services. AARP must oppose changes that further delay the phase-down of outpatient coinsurance for any beneficiary.

The extraordinarily high coinsurance for hospital outpatient services stemmed from a "glitch" in the law that allowed hospitals to base beneficiary coinsurance on the amount the hospital charged for the service rather than the amount Medicare approved. As a result, for years, Medicare beneficiaries have paid significantly higher coinsurance for hospital outpatient services than for other Part B services.

BBA 97 began to address the coinsurance problem by essentially "freezing" what beneficiaries now pay in coinsurance and slowly phasing it down, over many years, to the typical level of 20 percent of the total payment to hospitals. Medicare beneficiaries have already experienced one delay in the correction of the coinsurance problem due to Y2K concerns. This delay is estimated to have cost beneficiaries about \$600 million in additional coinsurance payments.



Page Two

Unfortunately, some groups are now raising concerns with Congress about how the new hospital outpatient prospective payment system (PPS) and the beneficiary coinsurance "fix" will be implemented. As a result, there is some discussion of delaying implementation of the hospital outpatient PPS system—either for all or some providers.

If Congress were to delay the new hospital outpatient payment system, the coinsurance "fix" would be delayed as well. Beneficiaries would then be forced to continue paying significantly higher coinsurance than they should. In fact, if the current phase-down does not go into effect, over the next ten years beneficiary coinsurance payments will grow, on average, to roughly 60 percent of the total payment to hospitals for outpatient services. By 2020, beneficiary coinsurance is estimated to rise to about 73 percent.

In addition to discussion about delaying the new hospital outpatient PPS system, some are considering whether Medicare should be required to make higher payments to hospitals for outpatient services. However, if Medicare were to increase spending to hospitals for outpatient services, this would also raise beneficiaries' Part B premiums because the amount of the monthly Medicare premium is tied directly to total Part B spending. The monthly beneficiary premium is already projected to more than double from \$45.50 a month in 1999 to \$94.60 by 2008. A significant portion of this increase is attributable to the changes made by the BBA.

AARP supported BBA 97. As is often the case with legislation of this magnitude, some "fine-tuning" may be required. However, we strongly believe that there should not be any further delay of the phase-down of the beneficiary coinsurance for hospital outpatient services. We urge you also to consider carefully whether changes to the hospital outpatient payment system will increase the monthly Medicare Part B premium that beneficiaries must pay.

If you or your staff have questions or need additional information about this issue, please contact Tricia Smith or Kirsten Sloan of our Federal Affairs staff at (202) 434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "Horace B. Deets". The signature is fluid and cursive, with the first name being the most prominent.

Horace B. Deets

October 12, 1999

MEMORANDUM RE. MEDICARE BBA GIVE-BACK LEGISLATION

TO: John Podesta
Steve Ricchetti
Gene Sperling
Bruce Reed
Jack Lew, Dan Mendelson
Larry Stein
Joel Johnson
David Beier
Melanne Verveer

FROM: Chris Jennings and Jeanne Lambrew

This afternoon, Senator Roth and Moynihan released their draft Medicare legislative give-back package. Thomas has indicated that he will release his mark tomorrow. Highlights of the Roth-Moynihan mark include:

- **Costs and scope:** The package includes provisions for virtually every provider that has raised concerns about the BBA and, as such, is likely to cost at least \$15 billion over 10 years. Provider concerns addressed include: teaching hospital IME payment freeze for 2000 through 2003; non-budget-neutral transition to the outpatient payment system; add-on for acute cases in skilled nursing facilities; and NY and PA DSH fix.
- **No offsets.** The mark did not mention offsets nor any transfer of surplus to the Medicare trust fund to protect solvency.
- **Does not include Medicare modernization provisions.** To the dismay of Senators Graham, Chafee, and possibly other members, Senators Roth and Moynihan did not include the traditional Medicare program modernization provisions in their mark. The reported reasons were that there was not bipartisan support and that the savings were too little to justify moving in this area. However, staff has quietly acknowledged that they hope to use the President's desire in this area as a chit in a broader Medicare reform debate next year.

There are reports that this mark is not necessarily supported by the Republican Leadership. Senator Lott may be meeting with Republican Finance Committee Members on Wednesday morning to discuss it.

Tomorrow, Bill Thomas will hold a press conference to unveil the Ways and Means Committee majority mark. He reports that it will be more modest, paid for (not through Medicare offsets but through an unspecified commitment from the Republican Leadership). He will also claim that he is carrying two-thirds of the costs of the BBA give-backs and will ask us to pick up one-third of the costs through the hospital OPD fix and the hospital transfer policy. Recognizing that we do not support the administrative fix for managed care, he will include it in his legislative package. The Ways and Means mark will not include traditional program modernization, for the stated reason that we have rejected movement towards a Medicare board and broader competition in the program. Thomas did not indicate exactly when he would mark up this bill.

The release of these two packages will increase pressure on the Administration to release its response on hospital outpatient department (OPD) policy. Mr. Thomas at his press conference will inevitably suggest that he is carrying more than his fair share of the costs and that the Administration should do its part. Both Roth and Thomas repeated that they would write letters stating their belief that the more generous interpretation for hospital payments is consistent with Congressional intent if we could act administratively.

We will need press guidance tomorrow as well as responses for the President for his press conference on Thursday.

P. 2

Senate Committee on Finance
Highlights of DRAFT Chairman's Mark
"Balanced Budget Adjustment Act of 1999"
October 12, 1999

Title I - Provisions Relating to Part A Only

- **Skilled Nursing Facilities (SNFs):** The mark would: adjust upward the new payment schedule to better accommodate medically complex patients by increasing by 7.5% the Special Care and Extensive Services RUGS; include the cost of Part B services in the facility-specific component of Medicare payments to SNFs participating in the Nursing Home Case Mix and Quality demo; and permit SNFs to elect to be paid according to the transition formula, or under the federal per diem rate, whichever is higher.
- **Hospice Services:** The mark would provide an upward adjustment in the market basket.

Title II - Provisions Relating to Part B Only

- **Hospital Outpatient Departments:** The draft mark would protect cancer and certain rural hospitals from the new payment system, and would limit the reductions in Medicare outpatient payments to other hospitals by establishing floors of 90%, 85%, and 80% over the first 3 years.
- **Physicians:** The mark includes a technical adjustment to stabilize payment rates for physicians, known as the sustainable growth rate. In addition, the mark resolves current pending litigation and applies a normal transition to the physician practice expense payment system.

Title III - Provisions Relating to Parts A and B

- **Home Health Services:** The mark would delay the 15% reduction in payments until PPS is implemented and would phase in the reduction over three years. The mark would raise the per visit limit to 108% of the national median; eliminate the 15 minute rule; and exclude durable medical equipment (DME) from consolidated billing. The mark would also allow overpayments to be repaid within 12 months without interest, and repayments made after 12 months and up to 5 years would require interest payments at rates consistent with those applied by the IRS to repayment of underpaid income taxes.
- **Teaching Hospitals:** The mark would delay the reduction in IME payments, by freezing the IMB adjustment factor at 6.5% for fiscal years 2000 through 2003.

Title IV - Rural Initiatives

- In addition to protecting rural hospitals from the impact of the new outpatient payment system, the mark would provide a full payment update for Medicare Dependent Rural Hospitals and Sole Community Hospitals. The mark would also change the 96-hour restriction on individual inpatient hospital stays for Critical Access Hospitals to a requirement that the *average* inpatient stay of patients not exceed 96 hours; and directs the Secretary to set up a waiver process whereby certain hospitals currently treated as urban or large urban could be treated as rural.

Title V - Provisions Relating to Medicare+Choice

- The mark would lessen the impact of risk adjustment by providing a longer phase-in period. In addition, the mark would: ease the transition for beneficiaries affected by plan withdrawals or termination; extend waivers for social health maintenance organizations (S/HMOs); specify that notices regarding coverage of inpatient services be provided within 16-24 hours prior to discharge; and other provisions.

Title VI - Other Medicare Provisions

- Rehabilitative Therapy Caps: The mark would combine the rehabilitative therapy caps into a unified ceiling of \$3500.
- Dialysis: The mark would increase the composite payment amount for renal dialysis services furnished under the Medicare program.
- Recoupment of Certain DSH payments: The mark would suspend for one year the recoupment of certain disputed disproportionate share hospital (DSH) payments pending negotiations between the affected states, hospitals and HCFA; and would permit the recoupment of payments to be spread over 10 years at the discretion of the Secretary.

Title VII - Provisions Relating to Medicaid and CHIP

- Technical corrections to Medicaid DSH table for MN, WY, NM, DC.
- Lift sunset and 12 quarter limit on Medicaid-welfare transition fund.
- Correct the CHIP allotments for Puerto Rico and the territories.
- Technical adjustment to stabilize CHIP allocation formula and provide for improved data collection.

American Medical Association

Physicians dedicated to the health of America



1101 Vermont Avenue, NW
Washington, DC 20005

FAX TRANSMISSION SHEET

Date: 10/4/99

To: Chris Jennings

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

Message:

See attached letter to President Clinton.

Total Pages (including cover sheet): 2

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

American Medical Association

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Thomas R. Reardon, MD
President

515 North State Street
Chicago, Illinois 60610

312 464-4887
312 464-5543 Fax
thomas_reardon@ama-assn.org

October 4, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President:

On a personal level and as president of the American Medical Association (AMA), I have enjoyed the privilege of working closely with you, Secretaries Shalala and Herman, others in your Administration, and the other members of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry to help design and enact a meaningful patients' bill of rights. Our work together, and especially your leadership and personal commitment to this issue, have clearly borne fruit. As I write this letter today, we are poised on the verge of a truly historic vote in the U.S. House of Representatives on patients' rights for all Americans.

While we have been focusing on patients' rights, however, actions by the Health Care Financing Administration (HCFA) have caused a serious problem in the Medicare physician payment schedule. I am writing to ask your help in solving this problem as you consider steps that you can take to repair the unintended consequences of the Balanced Budget Act (BBA).

The BBA established a system for annually updating Medicare physician payment rates called the sustainable growth rate (SGR). In its first two years, HCFA has already made \$3 billion in errors in its SGR calculations. As a result, physicians are caring for one million more patients than the Medicare budget allows. Despite HCFA's promise in a 1997 rule to fix its errors, it reneged one year later and now claims it lacks statutory authority to do so.

Mr. President, I understand that Senator Roth has written to you about this matter and will meet with you tomorrow. Senator Roth believes that the HCFA errors can be corrected without any new legislation. On behalf of the AMA, I urge you to direct HCFA to make the needed corrections. I also ask your support for an AMA legislative proposal addressing several other SGR improvements that do require congressional action.

Fixing the SGR is critical to ensuring that the 85% of elderly and disabled patients covered by fee-for-service Medicare continue to receive the access and benefits to which they are entitled. Thank you again, Mr. President, for your continued leadership on patients' rights and for your attention to this important matter.

Sincerely,

A handwritten signature in cursive script that reads "Thomas R. Reardon MD".

Thomas R. Reardon, MD

American Medical Association

Physicians dedicated to the health of America



1101 Vermont Avenue, NW
Washington, DC 20005

FAX TRANSMISSION SHEET

Date: 10/14/99
To: Chris Jennings

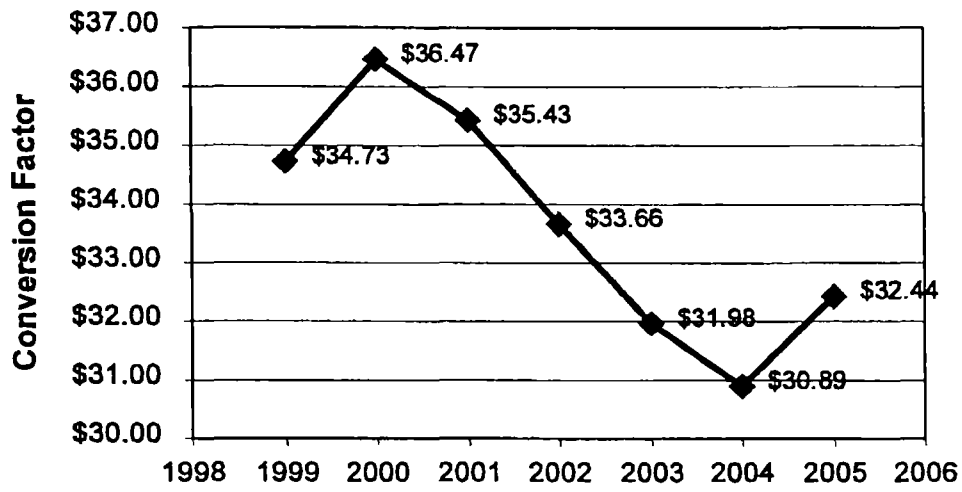
From: Richard A. Deem
Vice President
Government Affairs
Tel: (202)789-7413

Message:

Total Pages (including cover sheet): 2

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

Medicare Physician Payment Rates Under HCFA's SGR Legislative Proposal



October 13, 1999

Note to: Rich/Jane
Mark/Dan
Chris/Jeanne

Subject: Physician Practice Expense Transition Issue

The Administration's FY 2000 budget/legislative package contains a technical fix to the physician practice expense transition issue. The BBA language contains glitches and inconsistencies which has resulted in litigation about what BBA means and intends; certain specialties have argued for an atypical transition in which payments first increase before they decrease.

In submitting our legislative proposal, we indicated that we wanted a legislative correction regardless of the outcome of the Court case. A legislative correction is contained in the draft Senate Finance Chairman's mark.

We want you to be prepared on this issue. Attached is a short paper which discusses the issue. Justice has done a great job defending us in the lawsuit, but the outcome is uncertain. Justice has strongly urged a legislative correction.

We believe that this issue needs to be on a list of "must have" items for the forthcoming Medicare legislation. Without a legislative correction, if we were to lose the lawsuit, the plaintiffs could seek retroactive payments at least from Medicare which could involve taking money from primary care physicians.

Please call if you have any questions.


Bonnie

The Physician Practice Expense Transition

The BBA Provision: The Balanced Budget Act (BBA) enacted a transition to resource-based practice expenses under the Medicare physician fee schedule during 1999, 2000 and 2001. During these transition years only, practice expense payments are based on decreasing portions of prior charge-based values and increasing portions of resource-based values. The transition will be complete by January 1, 2002 at which point physician practice expenses are fully resource-based.

- o The purpose of a transition is to "soften the blow" for procedures and specialties where practice expense payments would be reduced under the resource-based system. The BBA softened the blow through a "normal" transition in which losing procedures are gradually reduced, during 1999, 2000 and 2001, to their full resource-based levels in 2002.
- o Prior to BBA, a resource-based practice expense system was scheduled to be implemented without any transition. Procedures would have increased and decreased from their charge-based levels to be completely resource-based in one step.

Implementation of the BBA Provision: The BBA transition language contains some glitches and inconsistencies. The Secretary's November 2, 1998 final regulation for the 1999 physician fee schedule implemented a "normal" transition, lowering practice expense payments in measured steps from their 1998 levels to their eventual 2002 levels (shown in the solid line in the attachment).

- o This "normal" transition was the purpose of the BBA provision, is a permissible reading of the ambiguous language, is consistent with the movement toward resource-based practice expenses since 1993 and is the only approach that makes policy sense.

The Lawsuit: Some physician specialties (including ophthalmologists, orthopedic surgeons, neurological surgeons, cardiologists, gastroenterologists and general surgeons) have sued the Secretary, arguing for a different, and highly unusual transition in which some practice expense payments first increase before they are reduced to their full resource-based level in 2002 (shown in the dotted line in the attachment).

- o These specialties have argued that an "atypical" transition is the only construction of the ambiguous language, though some of the litigating specialties urged still a different atypical transition in December 1997.
- o Moreover, these specialties argue that Congress explicitly intended that an atypical, up then down transition occur. They reject the "softening the blow" purpose of a normal transition.
- + Rather, they suggest that instead of gently moving procedures down to their resource-based level in measured steps, the purpose of the atypical transition is to provide additional compensation, in their words "to offset the significant long-term decrease those codes are scheduled to suffer under a resource-based PE-RVU

system”.

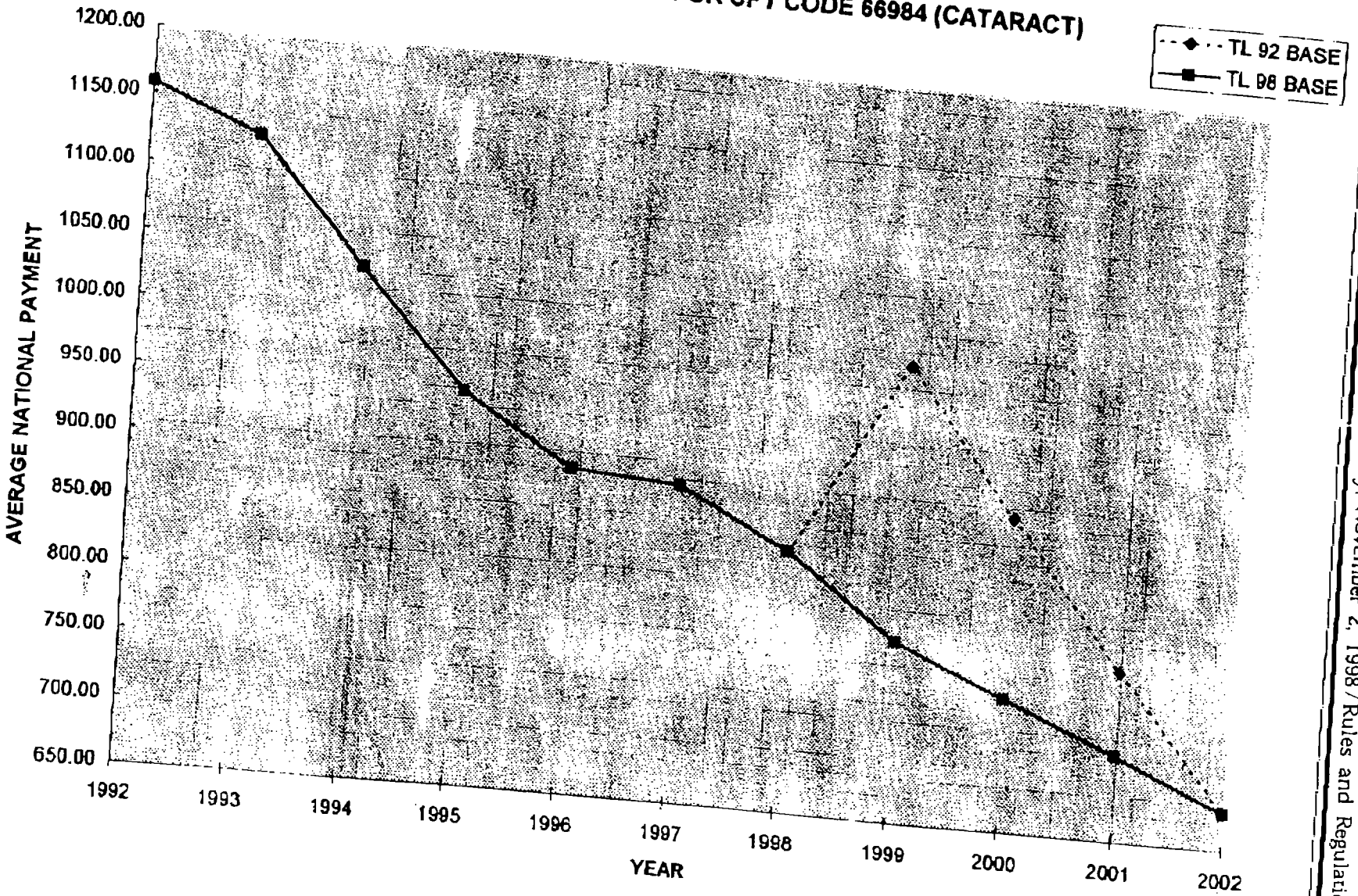
- + In effect, despite the fact that such an atypical transition has never been used for any type of service in Medicare, these specialties suggest that Congress explicitly rejected the “softening the blow” purpose of a normal transition, and explicitly intended that losing procedures, which were in excess of their resource-based levels, be given temporary payment increases during 1999, 2000 and 2001 to compensate for the fact the procedures will be at their resource-based levels beginning in 2002.
- + Such a contorted policy rationale is hard to believe in the context of the pre-BBA statute which had no transition and which had reduced payments for high-practice expense procedures in 1994, 1995 and 1996 (pursuant to OBRA-1993).
- + While these specialties do not challenge the resource-based levels to which losing procedures will be reduced beginning in 2002, their notion of resource-based levels providing for “suffering” is a unique perspective. Losing procedures are already being overcompensated under current charge-based payment levels compared to the resource-based levels. These specialties provide no rationale to justify why they assert that Congress explicitly would have provided for additional overcompensation for three years before getting to proper payment levels.
- + The real issue for these specialties seems to be that they don’t like resource-based payment levels since those proper payment levels will replace their currently overcompensated levels. A reduction in overpayments to proper levels does not constitute suffering.

Status of the Lawsuit: A lawsuit was filed last fall and the case is before the Court. There have been several rounds of filing of briefs. The case was referred to a Magistrate Judge who recently made recommendations to the Judge. The timing and ultimate resolution of the Court case cannot be predicted. Several primary care physician specialties have filed briefs in this case in support of the Secretary’s position.

Legislative Proposal: The Administration has submitted a legislative proposal to eliminate the glitches and clarify inconsistencies in the statutory language. In submitting the legislation, the Administration indicated that clarifying language was sought regardless of the outcome of the Court case. The clarification would resolve any ambiguities about achieving the softening the blow purpose of a “normal” transition that was the purpose of the BBA provision. The clarification would be the way the Secretary implemented the provision.

The transition to resource-based practice expenses is accomplished in a budget-neutral fashion. An atypical transition would increase payments for certain procedures and specialists and take money away from other procedures and specialists, typically primary care physicians. The legislative clarification has no budget effects.

AVERAGE NATIONAL PAYMENT FOR CPT CODE 66984 (CATARACT)



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Telephone: (202) 232-6200
Fax: (202) 232-1133
E-mail: dc@nrharural.org

Date: _____

To: Chris Jennings - WHA

Fax
Number: 456-5557

From: Darin Johnson, Government Affairs Director

Linda Rouse, Government Affairs Special Assistant

Subject: BTBA Rural Health

Issues - I started the
issues that could be done
administratively - Call if
you have questions

Pages (Including Cover Page): 11

Donna M. Williams
Executive
Vice President

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JOIN THE NATIONAL RURAL HEALTH ASSOCIATION IN GUARANTEEING ACCESS TO HEALTH CARE FOR RURAL AMERICANS

Pass Rural Targeted Balanced Budget Act of 1997 Reforms This Year

The NRHA's Rural Balanced Budget Act Relief Priorities

1. Protect Small, Rural Hospitals from the Impact of the Proposed Medicare Hospital Outpatient PPS System
2. Ensure Community Health Centers and Rural Health Clinics Continue to Receive Equitable Medical Reimbursement
3. Guarantee New HPSA Designation Promotes Access for Rural and Frontier Communities
4. Build Upon the Successful Medicare Rural Hospital Flexibility/Critical Access Hospital Program
5. Exempt National Health Service Corps Scholarships and Stipends from Federal Taxes
6. Require HHS To Conduct Rural Impact Statements
7. Promote Medical Residency Opportunities in Rural Settings
8. Require Specific Wage Indices Be Used for the New Skilled Nursing and Home Health PPS Systems
9. Allow Rural Providers in MSA Designated Counties to Participate in Rural Medicare Programs

Testimony of THE NATIONAL RURAL HEALTH ASSOCIATION

Hearing on
 Medicare Balanced Budget Act Refinements
 Ways and Means Health Subcommittee
 U.S. House of Representatives
 Friday, October 1, 1999

A real and imminent crisis is occurring in our country that threatens to shutout a vast number of our citizens from receiving health care as many rural and frontier providers are teetering on the brink of reducing and eliminating essential services. In that light, the National Rural Health Association (NRHA) would like to share its support for the rural targeted Balanced Budget Act of 1997 (BBA) relief priorities identified by our diverse, grassroots membership. We believe that collectively these priorities will secure access to vital health care services for rural Medicare and Medicaid beneficiaries and their families.

A report authored by the non-partisan Rural Policy Research Institute states, "Given low enrollment into managed care and limited use of any Medicare risk plans in rural areas for the foreseeable future, the impact of changes in traditional Medicare are of vital concern for the welfare of rural beneficiaries." Without rural targeted BBA reforms, the NRHA is gravely concerned that access to basic health care services will be jeopardized for those seniors living in rural and frontier America.

Recognizing the need for rural targeted BBA relief, both the House Rural Health Care Coalition and the Senate Rural Health Caucus introduced omnibus rural health care bills earlier this year, H.R. 1344 and S. 980, which include a number of important BBA relief provisions. Currently 95 members of the House of Representatives and 31 members of the Senate have cosponsored these rural health bills - a clear indication of the bipartisan support for rural targeted BBA relief. The NRHA's BBA relief priorities were taken directly from provisions included in both H.R. 1344 and S. 980, and are supported by both the House Rural Health Care Coalition and the Senate Rural Health Caucus.

In a recent letter to the Congress, thirty-nine of our nation's state office of rural health directors shared, "Over the past 10 years state and federal programs have encouraged our rural health providers to integrate their services. For many rural communities, it is the hospital that provides not only inpatient and outpatient care, but also services such as skilled nursing, home health and ambulatory care. Because the BBA reduces payments in each of these areas, rural hospitals are being financially punished for having done exactly what state and federal governments asked them to do - integrate services. As a result, these hospitals are reducing and eliminating services that rural beneficiaries and their families depend on daily."

If the BBA is fully implemented and rural hospitals, clinics and health centers are forced to reduce services or in some instances, close their doors, hard-to-recruit physicians and other health care providers will leave these communities. To reopen a rural health clinic or to recruit a primary care practitioner back into a rural or frontier community is an almost impossible task. That is why the Ways and Means Health Subcommittee and the Congress must be proactive in ensuring access to health care is not jeopardized for rural Americans.

Data from the Medicare Payment Advisory Commission illustrates that a greater percentage of rural hospitals experienced negative total Medicare operating margins in fiscal year 1995 than urban hospitals - 15.9 percent vs. 9.8 percent. Of concern to the NRHA is that these numbers reflect the financial condition of small, rural hospitals before any portion of the payment reductions in the BBA had been enacted and implemented.


The fact is rural hospitals and other providers depend more on Medicare reimbursement than their urban counterparts and are more vulnerable to payment reforms and reductions under the BBA, because rural America has a disproportionately higher percentage of Medicare beneficiaries. BBA relief targeted toward rural health care providers must be enacted this year so these providers can continue to ensure access to quality health care for the millions of Medicare and Medicaid beneficiaries living in rural and frontier America.

Of equal concern is the Congressional Budget Office has projected that Medicare spending for fiscal year 1999 will be \$88.5 billion less than was anticipated when the BBA was enacted. The result is our nation's rural hospitals, community health centers, rural health clinics and other providers are being asked to provide rural Medicare and Medicaid beneficiaries with a greater number of health care services and higher quality of care while their Medicare and Medicaid payments are being drastically reduced beyond what the Congress originally intended.

Because of the cumulative negative impact that reforms contained in the BBA are beginning to have on the rural health care delivery system, it is imperative that the rural targeted priorities outlined below be included in any BBA relief measure considered by your Subcommittee and the Congress this year. The NRHA stands ready to assist and support the Ways and Means Health Subcommittee and the Congress in guaranteeing access to health care services for rural and frontier Americans. If you have questions about the NRHA's BBA relief priorities or if the association and its membership can be of further assistance to you, please contact Darin E. Johnson, Vice President for Policy and Public Affairs, at (202) 232-6200.

THE NATIONAL RURAL HEALTH ASSOCIATION'S RURAL TARGETED BBA RELIEF PRIORITIES

1. Medicare Hospital Outpatient Prospective Payment System

 **Exempt Medicare Dependent Small Rural Hospitals and Sole Community Hospitals from the proposed Medicare hospital outpatient PPS system or at a minimum, establish a stop loss measure to protect low-volume, rural providers from the disproportionate effects of the PPS system.**

The NRHA is deeply concerned with the Health Care Financing Administration's (HCFA) proposed rule implementing a Medicare prospective payment system (PPS) for hospital outpatient services as defined by the BBA. New estimates prepared by HCFA demonstrate the grave impact the proposed PPS system will have on low-volume, rural hospitals.

The NRHA understands Congress may be considering, as part of a larger BBA relief measure, a phase-in of the proposed PPS payment methodology as a means of protecting small, rural hospitals from the severe impact of the proposed PPS system. The NRHA strongly opposes a phase-in because the impact on rural hospitals will ultimately be the same - small, rural hospitals will be placed in a financially vulnerable situation. A phase-in of the PPS system for hospital outpatient services would be nothing more than a band-aid fix to a very serious problem which merits a more viable and long-term solution.

HCFA's latest analysis on the impact of the proposed PPS system shows that Medicare payments for hospital outpatient services for small, rural hospitals with fewer than 50 beds would be reduced by 13.8 percent compared to 5.7 percent for all hospitals. In addition, total Medicare payments on average for rural hospitals would be reduced almost twice as much as for all hospitals (1.1 to 0.6 percent). The harsh reality is that access to care for Medicare beneficiaries in rural areas will be jeopardized as a result of this proposed PPS methodology, especially when combined with other payment reductions included in the BBA.

For some rural hospitals (25-100 beds), outpatient services total 45 percent of total revenue compared to less than 33 percent for their urban counterparts. Many of these hospitals already are experiencing negative operating margins, making them extremely vulnerable to the effects of outpatient payment reform. It appears the effect is greater on government owned hospitals and hospitals with less than 50 beds. It is these hospitals that are providing services to the most remote areas of our nation, and also generally serve communities with high Medicare populations.

2. Medicaid Reimbursement to Community Health Centers and Rural Health Clinics

Repeal the phase-out of Medicaid cost-based reimbursement to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) or as an alternative, implement a prospective payment system that guarantees rural centers and clinics receive equitable reimbursement.

Beginning October 1, 1999 the BBA permits state Medicaid agencies to pay FQHCs and RHCs less than it actually costs the rural health care provider to care for their Medicaid patients. Moreover, the phase-out methodology used by the BBA is flawed in that it automatically reduces reimbursement below the cost of providing services no matter how reasonable they may be. Such a drastic move will threaten the existence of these safety net providers and the role they play in ensuring access to quality health care for rural Medicaid and Medicare beneficiaries and the uninsured.

FQHCs and RHCs provide primary care services to our nation's most vulnerable and underserved rural populations. As a result, these providers are extremely dependent upon Medicaid payments to cover the cost of these services. The BBA forces community health centers to face revenue losses that are impossible to avoid or overcome through greater efficiencies or cost-cutting. In the year 2000 alone, these revenue losses will equal \$100 million nationally.

According to the HCFA's own analysis, the Medicaid per beneficiary cost is much lower in a RHC than in other provider settings by an average of \$500 per beneficiary. Such a reduction in Medicaid reimbursement penalizes RHCs for their efficiency in providing primary care services to rural Medicaid beneficiaries.

The House Rural Health Care Coalition's Triple-A Rural Health Improvement Act of 1999 (H.R. 1344) repeals the BBA's provision phasing-out reasonable cost reimbursement to FQHCs and RHCs. The Senate Rural Health Caucus' Promoting Health in Rural Areas Act of 1999 (S. 980) and two free-standing bills (S. 1277 and H.R. 2341) create an alternative Medicaid PPS system for FQHCs and RHCs.

The PPS system provides Medicaid payments in fiscal year 2000 that are equal to 100 percent of the per visit costs of furnishing services in 1999. Subsequent to 2000, the amount per visit would be increased by the percentage increase in the Medical Economic Index and adjusted for changes in scope of services. The Senate provision would also allow states to pay for services at rates above those provided by the Medicaid PPS system. The NRHA would support an alternative Medicaid PPS system if it is modified to reward cost efficient FQHCs and RHCs and contains a federal enhanced match to encourage states to continue paying cost-based reimbursement to these essential providers.

3. Health Professional Shortage Area and Medically Underserved Area Designations

 **Legislate the following as the Bureau of Primary Health Care (BPHC) considers changes to the methodologies used to define Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs):**

- Require consideration of pending physician retirements or resignations in designating HPSAs;
- Require revised standards for HPSA designation through expedited negotiated rule-making process;
- Require DHHS to consider the needs of medically underserved populations and individuals and the percentage of the population over age 65 in developing such standards; and
- Prohibit new methodology for HPSA designation if the methodology is detrimental to rural or frontier communities in that it results in the provision of fewer services.

Given the dramatic impact the BPHC's proposed rule to establish a new designation methodology for Medically Underserved Populations (MUPs) and HPSAs would have had on federal and state programs to serve rural and frontier underserved populations, the BPHC was recently forced to withdraw its proposed revision to the methodology for designating these areas.

While the current law establishing MUAs and HPSAs applies specifically to the National Health Service Corps and Federally Qualified Health Centers programs, a number of other important programs impacting underserved populations are affected by these designations. Federal programs impacted by changes in the designation methodology include eligibility for cost-based reimbursement to Rural Health Clinics, allocation of Health Professions Education and Training Grant programs (Titles VII and VIII) funding, Indian Health Professions Scholarship Grant program, Medicare bonus payments to physicians in underserved areas and eligibility for Medicare telehealth reimbursement. It is critically important to take into consideration the implication of any change in the MUA and HPSA methodologies on these programs, as well as state sponsored programs. The smallest change in these methodologies could put in jeopardy a number of federal and state programs and resources providing access to primary care services.

The BPHC's proposed methodology did not give considerable weight to the additional needs of the nation's elderly and Medicare population, a disproportionate number of whom reside in rural and frontier communities. While the proposed rule included a method for age-adjusting, several states reported that under the proposed methodology areas with higher percentages of elderly residents actually were disadvantaged. Any final underserved area designation must give separate consideration to the elderly population.

Additionally, the proposed designation did not take into account the special needs and characteristics of our nation's frontier population. It was likely that a number of frontier areas would not have met the requirements to be designated as a MUP, and therefore would not have been designated as a HPSA even though their population to primary care practitioner ratio was greater than 3000 to 1. The NRHA recommended in its formal comments to the BPHC that a separate frontier area designation process be established to take into account population density, distance in miles to the nearest service market and time in minutes to the nearest service market.

Given the many barriers to health care services the proposed MUA and HPSA designation methodology may have caused rural and frontier underserved areas, the Congress must direct the BPHC to initiate a negotiated rule-making process to facilitate the design of a new underserved designation that more appropriately and effectively recognizes medically underserved and health professional shortages areas in rural, frontier and urban areas.

4. Critical Access Hospital Reforms

Strengthen the Medicare Rural Hospital Flexibility Program by making the following important reforms to this program which is maintaining essential access to basic hospital and emergency room services for rural and frontier Americans:

- Allow hospitals that closed or downsized to a clinic within three years of enactment of this law to reopen as or convert to a Critical Access Hospital (CAH);
- * Allow CAHs to choose between two options for payment for outpatient services: (1) reasonable costs for facility services, or (2) an all-inclusive rate which combines facility and professional services;
- Require Medicaid programs to reimburse for services in CAHs;
- Change the 96 hour length of stay limit to a 96 hour average;
- Exempt CAH swing beds from PPS for skilled nursing facilities; and
- Grant CAHs deemed status that will allow for accreditation.

The NRHA urges the Congress to adopt reforms to the Medicare Rural Hospital Flexibility program that will further strengthen our nation's rural health care delivery system. This program, established by the BBA, creates an important alternative for small, rural hospitals by providing regulatory relief and more equitable financing options by assisting states in proactively responding to market changes, removing restrictive regulatory standards, and supporting network development and regional approaches to health care. It is vitally important the Subcommittee include the NRHA's CAH reforms in its BBA relief legislation so this program is able to reach its full potential.

To date, 36 state rural health plans have been approved by HCFA, and approximately half of the estimated 1,100 eligible small, rural hospitals nation-wide have indicated an interest in being designated a CAH.

Extremely crucial to encouraging maximum participation in the program is allowing CAHs to choose between two options for payment for outpatient services: (1) reasonable costs for facility services, or (2) an all-inclusive rate which combines facility and professional services. The all-inclusive payment allows hospitals to bundle physician payments into their CAH cost-based reimbursement, which is a key financial incentive to recruiting physicians to practice in CAHs. This option was an important component of the successful demonstration projects that this program is based upon – the Montana Medical Assistance Facility program and the Essential Access Critical Hospitals/Rural Primary Care Hospital program.

Permitting hospitals that have recently closed or downsized to reopen or convert to a CAH is also vital to the ultimate success of the program. This provision would allow those facilities that have already succumbed to the overwhelming financial pressures created by decreasing Medicare and Medicaid reimbursement payments to continue providing essential primary and emergency care services to their communities. Changing the current 96 hour length of stay limitation to a 96 hour average will also provide CAHs flexibility in caring for their patients. In addition, it will save money from unnecessary and costly patient transfers when only an additional day or two of inpatient care is needed.

5. National Health Service Corps Scholarships

Exempt the National Health Service Corps (NHSC) scholarships from federal taxation in any tax measure that moves through the Congress this year.

This tax provision was included in the tax measure recently approved by the Congress, but subsequently vetoed by the President. It was also part of a broader education bill passed last year that was again vetoed by the President because of unrelated provisions. As demonstrated by its passage by the Congress on two occasions, wide bipartisan and bicameral support for this issue exists – which is vital to the NHSC's mission of providing quality health care services to our nation's most vulnerable populations.

In testimony submitted earlier this year to the House Ways and Means Committee, a NHSC scholar and second year medical student spoke of how she was forced to take out two loans – one to cover a portion of her living expenses and the other to pay her federal taxes – because each month more than half of her stipend is withheld by the Internal Revenue Service (IRS) for tax purposes.

The NHSC program plays a critical role in providing primary health care services to rural and urban underserved populations. The scholarship program is one of the few incentives the NHSC has to recruit new clinicians to rural and inner-city communities. Currently 2,400 NHSC clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and mental and behavioral professionals, provide primary care services to over 4.6 million Americans who would otherwise lack access to quality health care.

6. Rural Impact Statements

Require the Department of Health and Human Services (DHHS), when promulgating or proposing a regulation related to a health care program, to include an analysis of the impact of implementation of the regulation on rural areas, including its impact on: (1) rural safety net providers; (2) rural primary care providers; (3) rural hospitals; (4) FQHCs and RHCs; (5) the economies in rural areas; and (6) rural residents.

While the NRHA recognizes the enormous burden that has been placed upon the DHHS, specifically HCFA, as it implements the Medicare and Medicaid reforms contained in the BBA, the association remains extremely concerned that the Department continues to consider, draft and implement policies that will put access to health care in jeopardy for rural beneficiaries. Recent regulations proposed and implemented by HCFA have not recognized the unique needs of our nation's rural health care delivery system.

On several occasions the BBA and members of the Senate Finance Committee and the House Ways and Means Committee were explicit in their intent to give special considerations to rural providers when implementing portions of the BBA. For example, the BBA gave specific instructions to the Secretary of HHS to give "special considerations" to rural residency programs when apply the BBA's Graduate Medical Education reforms. These special considerations were not included in the Department's final rule. On another occasion, members of the Senate Finance Committee responsible for drafting the telehealth portion of the BBA communicated that it was their intent that "store and forward" telemedicine be reimbursed by

Medicare - yet the Department refused to follow these instructions. Most recently HCFA's own analysis shows that its proposed PPS system for Medicare hospital outpatient services will have a disproportionate impact on low-volume rural hospitals. However, the Administration recently proposed in its fiscal year 2000 budget to move forward with applying the PPS system to small, rural hospitals with a transition period.

Given these reoccurring examples of how the interests of rural health care providers and beneficiaries are not being taken into consideration by the DHHS as important policies are developed, it is critical that Congress mandate that the implication of policies and rules on the rural health care delivery system be analyzed and receive the serious consideration they deserve by the Department.

7. Graduate Medical Education Reforms

Legislate the following rural Graduate Medical Education reforms to promote residency opportunities in rural and frontier communities:

- Require the Department of Health and Human Services to provide special consideration in apply the BBA provisions that reduced IME payments to providers and placed a ceiling on the number of Medicare funded residencies to rural residency programs, as well as facilities that are not located in an underserved rural area but have established separately accredited rural training tracks;
- Increase indirect GME payments to some hospitals by changing the way interns and residents are counted, from including those who were in the hospital during the most recent cost reporting period ending on or before December 31, 1996, to those who were appointed by the hospital's medical residency training programs for the same time period; and
- Allow a hospital that sponsors only one residency program to count one additional intern/resident for each calendar year up to a maximum of three more than the limit otherwise determined under this provision.

The BBA contained several Medicare GME provisions that were intended to promote residency opportunities in rural hospitals and ambulatory settings. The provisions were included by Congress because studies show that GME programs located in rural areas help to counteract persisting rural physician shortages by attracting medical residents and physicians to rural communities. Unfortunately, these rural specific GME provisions were not implemented by the Secretary of HHS in her final rule implementing the BBA.

The BBA called for the gradual reduction of IME payments to facilities training residents, and a ceiling to be phased-in on the number of residents for which a GME program will receive Medicare funding. For the purpose of determining both IME and DME payments, existing programs may not exceed the number of resident FTEs reported in their teaching hospital on or before December 31, 1996.

Understanding the cap on the number of residents would restrict new and expanded residency programs in general, the BBA recognized the importance of graduate medical training in rural areas by instructing the Secretary of HHS to "give special consideration to facilities that meet the needs of underserved rural areas." In addition, the Secretary was also given discretion to modify the ceiling for new GME programs (those established on or after January 1, 1995). Despite the Congress' explicit guidance, the Secretary did not make any special considerations for facilities providing rural and frontier residency opportunities in her final rule implementing the GME provisions.



8. Wage Indices for Skilled Nursing Facilities and Home Health Agencies

Require that area wage adjustments for the skilled nursing and home health care PPS systems be based on wage levels at Skilled Nursing Facilities and Home Health Agencies.

As part of the current Medicare hospital inpatient PPS system, HCFA uses a complex formula to determine the amount it reimburses hospitals for providing inpatient services to Medicare beneficiaries. About three-quarters of that payment is increased or decreased by applying a hospital wage index which is intended to adjust for the fact that market wage rates for nurses and other hospital employees vary somewhat across the country.

The current index actually goes well beyond its original intent in that it not only makes adjustments for differences in local wage rates, but it also rewards hospitals in areas, mostly urban, where a greater than average number of employees are hired. As a result of this methodology, the wage index varies greatly between urban and rural hospitals - the primary reason Medicare reimbursement to rural hospitals is lower and their resulting Medicare inpatient margins are less than half of urban hospitals (4.4 versus 9.7 percent in 1995).

The BBA mandated that HCFA develop new PPS systems for hospital outpatient services, skilled nursing and home health care. HCFA has signaled that it plans to apply the currently flawed wage index, which was created specifically for the hospital inpatient PPS system, to the payment systems for hospital outpatient services, home health care, and skilled nursing. The NRHA believes only wage rates relevant to the specific services providing in these settings should be used. In addition, the hospital wage index, as well as the wage indices used by the new PPS systems for hospital outpatient services, home health care and skilled nursing, should be changed to reflect only legitimate differences in area wage rates, not average per employee expenditures that are biased toward facilities in urban areas.

9. Medicare Rural Waiver

For purposes of Medicare payments, establish a waiver process to allow rural providers located in Metropolitan Statistical Areas (MSAs) to be classified as "rural" if they are located: (1) in a rural area as defined by the Goldsmith Modification published in the *Federal Register* on February 27, 1992; (2) outside of an urbanized area as defined by the U.S. Census Bureau; or (3) in an area designated by a State as rural.

The definition of a rural area currently used by HCFA for purposes of Medicare reimbursement does not recognize certain hospitals and other providers that are indeed located in rural and frontier areas. Because the federal definition of rural is based solely on whole-county urban or rural classification, some rural hospitals, community health centers and rural health clinics cannot participate in Medicare programs designed to help preserve access to care for rural Medicare beneficiaries and their families. These important programs include the Medicare Rural Hospital Flexibility/Critical Access Hospital program, the Medicare Dependent Hospital and Sole Community Hospital programs and the Rural Health Clinics program. The supplemental payments made to rural providers by these programs are frequently the primary reason for their continued viability and existence.

As defined by law, the Medicare program currently defines "rural" as any area that is outside of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget. MSAs are defined along county lines and may include one or more counties. This definition ignores such important factors as geography, demography, transportation, and economics in defining rural and urban areas.

For purposes of determining eligibility for federal grant programs, the Federal Office of Rural Health Policy uses the Census Bureau's rural census tracts which recognize rural areas within MSA counties. In addition, both the Department of Agriculture and the Federal Communications Commission have adopted this rural definition for their rural-focused programs. Rural hospitals, health centers and clinics that are currently located in MSA counties do not have the ability to obtain reclassification from urban to rural status.



Office of Legislation



Number of Pages: C+6

Date: 10/8

To: Dan Mendelson 395-5631	From:
Mark Miller 395-3910	Bonnie Washington / Paul Cotton
Chris Jennings - 456-5557	
Jean Lambrew 456-7431	
Fax: _____	Fax: <u>690 8168</u>
Phone: _____	Phone: <u>690-6277</u>

REMARKS: Comments to Paul Cotton
at 690-6277 - ASAP!

REVISED RUTH LETTER

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

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402

Dear Senator Roth:

The President and I are committed to working with you and other Members of Congress to strengthen and modernize the Medicare program for those who rely on it today and in future generations. This specifically includes addressing the unintended consequences of certain Balanced Budget Act of 1997 provisions. Our foremost concern is to ensure that Medicare beneficiaries continue to have access to the quality care they deserve. I am responding to your request that we review certain potential adjustments and advise you of our ability to address these issues administratively.

As you know, the President has included \$7.5 billion over 10 years in his comprehensive Medicare reform plan to fund legislative changes to help smooth the transition to BBA payment reforms and ensure access to care. The plan also includes a number of administrative actions that we are taking to ease the burden on providers. We are committed to affording providers maximum flexibility to ease the burden of the BBA within the limited discretion given to us in the law. We will continue to evaluate proposals and make appropriate additional changes administratively where we have discretion to do so under the law. We also will continue working with Congress, beneficiary groups, provider groups, and our colleagues at the General Accounting Office (GAO), the HHS Inspector General's Office, and the Medicare Payment Advisory Commission (MedPAC) to identify and address areas where there is evidence of adverse effects of the BBA on beneficiary access to quality care. You asked us to review and comment on our ability to take administrative steps to address a number of issues. The following is our assessment of those issues.

Hospitals

Proposal: Develop and administer a budget neutral multi-year transition method for implementation of the hospital outpatient prospective payment system (PPS -- scheduled for July 2000), including a policy to maintain the scheduled reductions in beneficiary cost-sharing liabilities for services received in hospital outpatient departments.

Obtain an expert and independent evaluation of the clinical soundness and payment equity implications of the proposed Ambulatory Patient Classification (APC) system, including its appropriateness for unique categories of providers, such as cancer hospitals. If a delay in implementation or exemption of certain classes of providers is warranted under the review, inform the Congressional Committees of jurisdiction by June 2000.

Comments: We expect to publish the final rule implementing the outpatient PPS system early next year. We are reviewing all of the many comments we received and working to address these comments in the final rule. In addition, I have asked the Office of Legislative Counsel at the Department of Justice to closely review the BBA provisions pertaining to the hospital outpatient PPS and to advise us of areas where we may have some flexibility.

Where we know we have administrative flexibility, we are taking advantage of it to help hospitals adjust to the new payment system required under the law. For example, as you have suggested, we are considering a 3-year transition to the new PPS by making budget-neutral adjustments that will increase payments to hospitals that would otherwise incur large payment reductions. These hospitals would include certain rural, inner city, cancer, and teaching hospitals. This transition policy would maintain the scheduled reductions in beneficiary cost sharing for services furnished at these hospitals.

In addition to the transition policy, we are also considering a delay in implementing the proposed "volume control mechanism." The statute requires the agency to develop a volume control mechanism. In the proposed rule, we suggested use of a mechanism that might lead to a downward adjustment in the payment rates as early as 2002 (to reflect volume increases in 2000). Delaying this mechanism would provide time for providers to adjust to the new system. The proposed rule also uses the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

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

Proposal: Freeze the payment policy for hospital transfers at the current set of 10 Diagnosis Related Group categories.

Comments: As you have suggested, and as the President announced as part of his Medicare reform plan, we are planning to postpone for two years the extension of the hospital transfer policy to additional diagnoses beyond the current set of 10 Diagnosis Related Group Categories. We also will consider whether further postponement of extension to additional diagnoses is warranted.

Skilled Nursing Facilities

Proposal: Establish payment refinements to selected Resource Utilization Groups as the Skilled Nursing Facility (SNF) PPS is implemented. These changes should be targeted to improve reimbursement for medically complex cases, with special attention to the unique problems of patients requiring complex treatments and prosthetics.

Comments: As you have suggested, we will use administrative flexibility to increase payment for high acuity patients under the skilled nursing facility prospective payment system where data indicate such changes are warranted. However, we are able to make such administrative changes only in a budget neutral manner. We have research underway now on how we should make such refinements. We expect to have the research completed by the end of this year and to then propose refinements in a proposed rule next Spring for implementation in October 2000.

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

Physicians

Proposal: Provide immediate advice on administrative options for improving annual updates in payments for physicians' services to correct for erroneous projections.

Comments: The HHS General Counsel advises that we do not have the ability under the existing law to correct the Sustainable Growth Rate (SGR) for projection errors. However, the Administration has submitted, as part of the President's FY 2000 budget, a budget neutral legislative proposal to require that revisions be made to correct estimation errors in calculation of the SGR and to fix other technical aspects of the SGR.

Home Health

Proposal: Relieve home health agencies of the inappropriate responsibility for tracking patients that secure services from more than one agency in order to prorate payments.

Comments: This is required by statute and cannot be addressed administratively. However, due to systems complications and Y2K constraints, we have not instructed claims processing contractors to make systems changes to automatically track the implementation of this provision. If claims processing contractors learn of situations where patients are receiving services inappropriately, they will take appropriate action to ensure proper payment. We are concerned that eliminating proration altogether may create incentives for agencies to re-direct patients to another agency after the agency provided services equal to their per beneficiary limit.

Proposal: Provide for extended repayment schedules for agencies that incurred significant Medicare overpayments due to difficulties adjusting to major BBA 97 payment system changes.

Comments: As part of the President's Plan, we are allowing agencies an automatic 36 months to repay excess interim overpayments. The first year is interest-free.

Ambulatory Surgical Centers

Proposal: Do not implement payment policy changes for ASCs until 1999 industry survey data are analyzed and properly incorporated into any proposed changes.

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

implementing payment changes until the 1999 survey data are incorporated, we would have to delay the payment policy changes planned for July 2000 for an additional three years.

Medicare +Choice

Proposal: Revise phase-in schedule for risk-adjusted payment to extend the transition by at least two years and to prevent any single plan from experiencing more than a 5-10% shift in Medicare payment rates attributable to the risk adjuster in any single year.

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

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



October 5, 1999

STATEMENT BY THE PRESS SECRETARY

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release
5, 1999

October

STATEMENT BY THE PRESS SECRETARY

President Clinton Meets With Senate Finance Committee Chairman Roth And Ranking Member Moynihan To Discuss Medicare Reform

Senate Finance Committee Chairman William V. Roth Jr. (R-DE), and ranking Democrat Daniel Patrick Moynihan (D-NY) met this morning with President Clinton to discuss the outlook for Medicare reform legislation.

The President, as well as Chairman Roth and Senator Moynihan, reiterated their intention to strengthen and modernize the Medicare program. The Senators conveyed their mutual desire to work towards the goal of passing broad-based Medicare reform in this Congress.

Chairman Roth and Senator Moynihan urged that administrative and legislative action be taken this fall to moderate the impact of Medicare provider payment reductions included in the Balanced Budget Act of 1997 (BBA). The President indicated his openness to such initiatives, but in the context of providing additional statutory authority to modernize the purchasing practices of the Medicare fee-for-service program. The President pointed out that initiatives to modernize the traditional Medicare program were included in both the Breaux-Thomas recommendations and the Administration's broader Medicare reform proposal released earlier this year.

The President indicated that Administration representatives will work with the Finance Committee, as well as the House Ways and Means and House Commerce Committees, on a package of provisions that moderate the impact of the BBA and modernize the fee-for-service program. The President also agreed to provide an expeditious response regarding the administrative actions the Department of Health and Human Services can take independent of the legislative process so that the Committees can construct their legislative packages to reflect these changes. The President reaffirmed his commitment that any provider payment reforms should not harm the success we have had in extending the life of the Medicare trust fund.

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FOR IMMEDIATE RELEASE
October 5, 1999

Press Release #106-215
Contact: Senator Roth:
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ROTH, MOYNIHAN MEET WITH PRESIDENT ON MEDICARE

WASHINGTON - Senate Finance Committee Chairman William V. Roth, Jr. (R-DE) and ranking Democrat Daniel Patrick Moynihan (D-NY) met this morning with President Clinton to discuss the outlook for Medicare legislation. Senators Roth and Moynihan informed the President of their intention to continue working toward a consensus within the Committee and with the President on legislation to reform Medicare over the long-term, including adding a prescription drug benefit, while protecting the solvency of the Medicare trust fund.

Senators Roth and Moynihan also discussed with the President the need to act immediately, before the end of the first session of this Congress, to restore some of the Medicare funding cuts under the Balanced Budget Act of 1997 (BBA).

In response to inquiries from Chairman Roth and Senator Moynihan regarding possible administrative adjustments to the BBA, the President agreed to provide a quick answer so that the Committee could fashion legislation that takes into account any administrative changes.

President Clinton recommended, as an offset to part of the costs in the BBA package, that the package include a proposal sent to Congress in June to modernize the fee-for-service program. Senators Roth and Moynihan agreed to consider the President's recommendation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
THE GENERAL COUNSEL
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TO: CHRIS TEWINGS / DEVORAH ADLER

DATE: 10/5/99

DEPARTMENT/OFFICE: WH / DPC

PHONE: 202 456-5560

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FROM: HARRIET S. RABB
GENERAL COUNSEL

COMMENTS: The attached page sets out
HHS' view of the proposed
Crime Bill language re: Controlled
Substances Act.

PAGES INCLUDING COVER: 2

I. Background

HHS and DOJ have already agreed to the following expansions of DOJ's emergency scheduling authority:

- DOJ can emergency schedule and reschedule drugs under IND.
- FDA will periodically certify to DEA that an IND is being actively pursued.
- Researchers will periodically certify that they can account for all drug product.
- DEA can bring criminal charges against IND holders if FDA finds that they have violated the terms of their IND.

The following issues remain:

- DOJ wants parallel, independent authority to promulgate recordkeeping and reporting requirements mirroring FDA requirements, and to investigate and prosecute violations.
- HHS is concerned that DOJ will impose on IND researchers the security requirements that apply to drug manufacturers who handle large amounts of drug substance.

II. What problem are we trying to fix?

- The problem DOJ seeks to address with this legislation is "street" abuse of substances that are being researched under INDs. The provisions already agreed to are fully adequate to address this abuse.
- There has never been evidence, or even allegations, of diversion of IND drugs by an IND researcher. Legitimate researchers and drug suppliers have a strong interest in preventing diversion to preserve their ongoing relationships with FDA, DEA, and the scientific and medical research community.
- Imposing additional regulatory burdens decreases the incentive to conduct this essential scientific and medical research. One of the core principles of this administration is that we do not impose regulatory burdens unless there is a demonstrated need for additional regulation. There is no demonstrated need in this area.

III. What are the problems with DOJ's proposed legislation?

Record Keeping and Reporting Requirements

- Duplicate regulations will result in confusion and impose excessive regulatory burdens on researchers who will be required to comply with two sets of regulations governing the same activity.
- Interpretation and enforcement of regulations by two different agencies could result in confusion and inconsistent enforcement since the same conduct could be determined to be violative by one agency, but not the other. Such inconsistency would undercut the authority of both agencies.

Security Requirements

- Compliance with extensive security requirements will be excessively costly for researchers who are producing small amounts of a drug substance for research purposes only, and are generally not realizing a profit from the sale of substances under IND.
- Existing FDA regulations address the security and accountability of controlled substances and permit DEA to inspect a researcher's records and facility.

To: COURTNEY & DEVORATH



United States Senate Committee on Finance

219 Dirksen Senate Office Building
Washington, D.C. 20510
Phone: (202) 224-4515
Fax: (202) 228-0578

Date:

9/27/99

To:

BROOME

Fax Number:

456-6220

From:

ALEC THOMPSON

Re:

LETTER FROM FRIDAY + ENCLOSURE

No. of Pages (Including Cover Sheet):

6

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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-8200

FRANKLIN G. HOLT, STAFF DIRECTOR AND CHIEF COUNSEL
 DAVID PODOFF, MINORITY STAFF DIRECTOR AND CHIEF ECONOMIST

September 24, 1999

The Honorable William Jefferson Clinton
 The White House
 1600 Pennsylvania Avenue, NW
 Washington, D.C. 20500

Dear Mr. President:

During the 105th Congress, you provided leadership and worked successfully with Congressional leaders to enact the Balanced Budget Act of 1997 (BBA 97). That law helped put the federal government on a course of fiscal discipline that is resulting in major economic dividends benefitting all Americans. With respect to the Medicare program, we collaborated on the most significant set of reforms in payments to providers and private health plans that has occurred since the program was first enacted. These changes had the salutary effect of temporarily stabilizing the rates of growth in Medicare spending and extending the solvency of the Part A Hospital Insurance Trust Fund.

As is occasionally the case with major legislation, we have learned that there are some unintended consequences. As a result, certain provider and health plan payment adjustments may be required under Medicare in order to protect beneficiaries' access to quality health care services and plans. It is my intention to propose shortly a package of legislative adjustments in areas where steps must be taken to improve payment equity to providers and to protect the availability of privately offered Medicare+Choice plans. In this regard, although you did not specify policies, it was helpful that the Administration's recently released Medicare reform proposal set aside \$7.5 billion over 10 years to address concerns in these areas.

Our review indicates that several areas of legitimate concern could clearly be addressed by the Executive Branch administratively, thereby freeing the Congress to concentrate on those matters which can only be addressed legislatively. I urge you to review the enclosed list of

The Honorable William Jefferson Clinton

September 24, 1999

Page 2

administrative adjustments and advise me of your willingness to take steps within the Administration to address these matters. As necessary, the Congress can and will act on other related matters. However, I am confident that in the spirit of the BBA 97 agreements, including a shared concern for fiscal responsibility, you will want to collaborate with us in resolving these concerns. Thank you for your consideration.

Sincerely,



William V. Roth, Jr.
Chairman

Enclosure

Administrative Adjustments to Improve Medicare Provider Payment Equity, and to Stabilize the Medicare+Choice Program

Hospitals

Proposal -- Fair Transition for Outpatient Payment Changes: Develop and administer a budget neutral, multi-year transition method for implementation of the hospital outpatient prospective payment system (scheduled for July, 2000), including a policy to maintain the scheduled reductions in beneficiary cost-sharing liabilities for services received in hospital outpatient departments.

Obtain an expert and independent evaluation of the clinical soundness and payment equity implications of the proposed Ambulatory Payment Category (APC) system, including its appropriateness for unique categories of providers, such as cancer hospitals. If a delay in implementation or exemption of certain classes of providers is warranted under the review, inform the Congressional Committees of jurisdiction by June, 2000.

Explanation: The Balanced Budget Act of 1997 (BBA) required the Secretary to implement a prospective payment system (PPS) for hospital outpatient department services by January 1, 1999. The proposal issued by the Administration represents a major change in Medicare payment policy for outpatient services and may result in significant changes in hospital payments. This requested adjustment is needed to provide hospitals a reasonable period to adjust operations to meet these funding changes, while maintaining corrections to the amount that beneficiaries are required to pay in coinsurance for hospital outpatient services.

There is also concern about the methodology of the proposed APC classification system. Before such drastic changes to current payment policy are implemented, an independent review of the proposal is appropriate.

Proposal -- Limit Scope of Hospital Transfer Policy: Freeze the payment policy for hospital transfers at the current set of 10 Diagnosis Related Group categories.

Explanation: The BBA gave the Secretary of HHS authority to classify discharges from acute-care hospitals to post-acute care facilities within a group of 10 Diagnostic Related Groups (DRGs) as "transfers." Beginning in 2001, the Secretary would have authority to expand this policy to more than the initial 10 DRGs. As other payment policy changes from the BBA continue to be monitored, it is unnecessary to expand the transfer policy in the foreseeable future.

Skilled Nursing Facilities

Proposal -- Higher Payments for Complex Cases: Establish payment refinements to selected Resource Utilization Groups as the Skilled Nursing Facility (SNF) PPS is implemented. These changes should be targeted to improve reimbursement for medically complex cases, with special attention to the unique problems of patients requiring complex treatments and prosthetics.

Explanation: The BBA phases in a PPS that pays for covered SNF services on a per diem rate. The General Accounting Office has indicated that the current rate may not adequately reimburse for services provided to medically complex patients.

Physician Payments

Proposal -- Corrections Due to Erroneous Spending Projections: Provide immediate advice on administrative options for improving annual updates in payment for physician services to correct for erroneous projections.

Explanation: Implementation of new payment methodologies established in the BBA produced inappropriate payment reductions to physicians due to failures to adjust for erroneous administrative projections used to set rates. This particular problem could be remedied through changes in the year-to-year administrative payment projection and adjustment process.

Home Health Agencies

Proposal -- Proration of Payments: Relieve home health agencies of the inappropriate responsibility for tracking patients that secure services from more than one agency in order to prorate payments.

Explanation: New home health payment systems created by the BBA called for tracking the number of home health services beneficiaries receive from different facilities, so that payment amounts could be prorated. However, the BBA does not specify that this tracking is the responsibility of the agencies. Such responsibility would be more appropriately assigned to the fiscal intermediaries.

Proposal -- Equitable Recovery Schedules for Overpayments: Provide for extended repayment schedules for agencies that incurred significant Medicare overpayments due to difficulties in adjusting to major BBA 97 payment system changes.

Explanation: There is recognition of the need for more flexible overpayment schedules for certain home health agencies facing large overpayment amounts due to the changes in payment systems contained in the BBA.

Ambulatory Surgical Centers (ASCs)

Proposal -- Fair Payment for ASCs: Do not implement payment policy changes for ASCs until 1999 industry survey data is analyzed and properly incorporated into any proposed changes.

Explanation: In a proposed rule, the Administration is proposing changes to the payment policy for ASCs based upon 1994 survey data. It would be more appropriate to implement proposed changes after the 1999 survey data is complete.

Medicare+Choice

Proposal -- Fair Transition for Health Plans: Revise phase-in schedule for risk-adjusted payments to extend the transition by at least two years and to prevent any single plan from experiencing more than a 5-10% shift in Medicare payment rates attributable to the risk-adjuster in any single year.

Explanation: The BBA required HCFA to develop and implement a health-based risk-adjustment system by January 2000 to increase payments to plans that enroll sicker patients and to decrease payments to plans that enroll healthier patients. The implementation may cause significant changes in the annual payments to plans and thus the premiums beneficiaries would be charged. This proposal would provide for a more gradual transition to risk adjustment and protections for both beneficiaries and plans.



FILE ID:

TWELFTH FLOOR
 1875 EYE STREET, NW
 WASHINGTON, DC 20006-5409
 PHONE: (202) 466-6550 FAX: (202) 785-1756

FAX COVER SHEET

To: Chris Jennings Special Assistant to the President for Health Policy Development	From: Jim Pyles
Fax: 456-7431	Pages: 9
Phone: 456-5560	Date: September 29, 1999
Re:	

Urgent
 For Review
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PYLES
SUTTER &
VERVILLE PC**
ATTORNEYS AT LAW

Twelfth Floor
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Washington, DC 20006-5409
Phone: (202) 466-6550 Fax: (202) 785-1756

MEMORANDUM

To: Chris Jennings
From: Jim Pyles
On behalf of the Home Health Services and Staffing Association
Date: September 27, 1999
Re: President's Statement on the Budget Surplus

I was struck by the President's statement this morning concerning the budget surplus as compared to the growing crisis in home health as described by a study released on September 14 by the George Washington University Center for Health Services Research and Policy. See An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care (September 1999).

The President stated that this year's budget surplus will be at least \$115 billion which is "larger than last year's, and larger, in fact, than any dollar surplus in the history of the United States".

The George Washington University study found that cuts in Medicare reimbursement for home health services are

- 1) eliminating access to covered home health services for the sickest, most frail Medicare beneficiaries;
- 2) eliminating access to covered specialty services for those beneficiaries that can still obtain services; and
- 3) deleting information concerning the higher cost patients from the data base that will be used for a prospective payment system.

Chris Jennings
September 27, 1999
Page 2

The question that must be asked is: **How can the Administration, at a time of unprecedented budget surpluses, fail to fund covered home health for sickest, most frail Medicare beneficiaries?**

I am attaching a copy of the executive summary of the George Washington University study for your review.

Attachment

Executive Summary

Introduction

The Medicare home health provisions of the Balanced Budget Act of 1997 (BBA) were designed to convert home health payment methodology to a prospective payment system (PPS) that would end cost-based reimbursement considered to create incentives to increase utilization. As a transition to PPS, the BBA mandated an interim payment system (IPS) designed to constrain substantially the growth in Medicare home health expenditures. In this report, we present the results of a descriptive study of home health agency responses to the changes in payment methodology. Major findings from this research are:

- **The majority of agencies participating in the study have altered their case mix and/or their practice patterns to conform utilization to reimbursement. Diabetics, particularly complex diabetics, appear to be the most affected by changes in admission practices and reductions in the level of care. Other beneficiaries with more intensive care needs also appear to be affected significantly by these changes.**
- **Southern agencies in the study do not appear to have the same capabilities to alter their case mix as agencies in other regions. Nor do their case mixes contain as much variety. Accordingly, beneficiaries in the South may experience more reductions in their levels of care, while sicker beneficiaries in other regions may experience more difficulty gaining access to home care services. The findings indicate that IPS may be exacerbating regional variations in the health status characteristics of home care beneficiaries, even as utilization and payment becomes more nationally uniform without regard to the health status of beneficiaries.**
- **Chronically ill beneficiaries may experience greater fragmentation of care among providers and more disruptions in care as a result of payment changes.**
- **Administrative constraints on utilization may affect access by sicker beneficiaries to appropriate levels of home care.**

Approximately 3 million acutely and chronically ill elderly and disabled Medicare beneficiaries depend on home health services as an element of their medical care. As would be expected from their homebound status, Medicare home care beneficiaries generally are sicker, older, and poorer than Medicare beneficiaries in general.

While initially limited to post-hospital acute care of defined duration, the Medicare home health benefit was expanded in 1980 to include those beneficiaries who had not experienced a prior hospital stay and to provide services for as long as medically necessary. As a result, the number of Medicare home care beneficiaries increased dramatically, marked by the inclusion of

people with disabling chronic diseases who require ongoing medical management.

Other factors contributed to the large growth in home care services including the growth of managed care, changes in Medicare hospital reimbursement, and technological changes enabling more complex care to be delivered at home. These factors, in combination with the growing supply of home health providers, led to sharp increases in home care utilization from 1989 to 1993, after which time the growth in home care began to abate. The rapid rise in home care spending from 1989 to 1993 led to the inclusion in the BBA of changes in payment methodology designed to reduce substantially payments for and utilization of home health services.

This report will describe the Medicare home health care changes in the BBA, the scope of the underlying study, previous research, the study findings, and their implications. In addition, it will provide recommendations designed to address issues concerning beneficiary access to care.

Overview of BBA Changes in Medicare Home Health Reimbursement

The ultimate goal of the BBA was to convert home care reimbursement to a case-mix adjusted prospective payment system (PPS) and end the cost-based reimbursement considered to create incentives to increase utilization. Because HCFA had not developed a home care PPS methodology, the BBA mandated an interim payment system (IPS) to be in effect for two years. However, IPS is expected to be in place until at least October, 2000.

The IPS contains a number of elements designed to constrain growth in home care costs substantially. It excluded increases in market basket costs from 1994 to 1996 in calculating IPS. Then, IPS reduced the per-visit cost limits from 112 percent of the national mean to 105 percent of the national median. The IPS also imposed payment limits on the aggregate amount of Medicare reimbursement a home health agency may receive based on its average per beneficiary costs in FY 1994, regardless of its current case mix or the cost of care of any individual beneficiary. It is the operation of these payment limits that has created the most controversy. Finally, IPS imposed an additional across-the-board 15 percent reduction in home health payments to go into effect on October 1, 1999.

According to the Congressional Budget Office (CBO) in 1997, these changes were designed to achieve savings of \$16.2 billion over five years. The most recent projections by CBO indicate that in fact IPS spending reductions for home health services will amount to \$47.9 billion over the same period. As a result of concerns that the magnitude of the payment reductions in home health were having an adverse effect on services, the Omnibus Consolidated and Emergency Supplemental Appropriations Act (P.L. 105-277) modified somewhat the payment methodology. The per-visit limits were raised from 105 percent to 106 percent of the national median. Low-cost agencies (those that provided services below the level of the national median in FY 1994) regardless of case-mix were provided additional payments. The 15 percent across-the-board reduction was delayed for one year.

Previous studies of the IPS raised the concern that this payment methodology would create incentives to deny care to the sickest and frailest beneficiaries and would result in substantial regional variation in access to services and in quality of care. The 1998 changes in the BBA which provide additional funds to low-cost agencies without regard to patient mix did not address those concerns because they did not direct additional funds to the care of higher cost beneficiaries. This study examines the specific responses to the BBA payment reforms made by home health agencies since 1997.

Study Methods

The goals of this descriptive case study are 1) to explore and document the effect of IPS on the service delivery patterns of home health agencies; 2) to examine whether these effects have led to a reduction in the availability of services; and 3) to assess whether a reduction in services will likely affect disproportionately the sickest, most costly Medicare beneficiaries.

The experiences of home health agencies in nine states were examined: California, Florida, Indiana, Iowa, Louisiana, Massachusetts, Mississippi, Pennsylvania, and Texas. States were selected for geographic diversity and urban/rural mix. In addition, states were selected to enable comparisons in their historic utilization patterns and demographic composition.

Interview protocols consisting of 60 questions were mailed to agencies who responded to a solicitation through state home health associations. Structured interviews were conducted with all agencies who responded to protocol. This protocol was designed to collect information from 1994, 1996, and 1998 about the types of patients admitted to care, patient mix over time, patterns of referrals and discharges, clinical practice patterns, and changes in demand for alternative services and financing. The study also examined financial and operational factors affecting agency stability and access to care. Participating agencies were assured of confidentiality, and all agency identifiers were deleted from completed protocols.

The data on which this report is based were collected from twenty-eight home health agencies. The respondents included nine free-standing for-profit agencies, 11 free-standing non-profit agencies, and eight hospital-based or affiliated agencies from all nine states and reflect a mix of urban and rural agencies. Interviews were completed with all of the agencies who responded to the protocol. While based on a self-selected sample of agencies, we believe the sample reflects a good cross-section of agency experience since it represents a mix of respondents by type, geography, and utilization history.

Previous Research

Findings from recent studies suggest that patients with similar health status and underlying conditions who have unconstrained access to home health services have better health outcomes than those who do not receive home health services or those whose access is tightly

controlled through managed care. In addition, two major studies funded by the Health Care Financing Administration (HCFA) examined the relationship between intensity of utilization and outcomes and regional variation in utilization and outcomes. These studies are referenced at Footnotes 21 and 23. Taken together, these studies' findings indicate that higher utilization is associated with poorer underlying health status which triggers the need for more intensive or longer term services. Moreover, beneficiaries who use more intensive services tend to experience measurable improvements in health status as they receive more care. On the basis of these studies, it appears that those beneficiaries with poor underlying health status and more intensive needs will be more susceptible to adverse consequences as a result of changes in patterns of care. These more vulnerable beneficiaries appear to be more concentrated in the southern states.

Findings

The study results show changes in clinical practice patterns and patient case-mix and selection by responding agencies that may have implications for access to or quality of care. Home health agency interview data indicate that most of the responding agencies have adjusted their case mixes and/or their practice patterns to conform utilization to reimbursement. While fiscal intermediary practices have clearly had an effect on both case mix and practice patterns, agency responses indicate that payment levels appear to be the dominant driver of these changes. Moreover, the data show substantial regional variation in the types of adaptations made by home health agencies. In general, southern agencies appear more likely to rely on reducing level of services and less able to change their case mix characterized by more chronic illness. Agencies in other regions are more likely to rely on screening admission of patients or altering marketing patterns to control case mix of their patients as well as reducing the number of visits. Interview findings indicate that diabetics, particularly complex diabetics, appear to be affected significantly by both exclusions from care and reductions in the level of services. Other patients who present predictably high-costs also appear to be experiencing some displacement, although not to the same degree. By contrast, study data indicate that patients with predictably low-costs may be experiencing improved access to care, regardless of amount of time in care.

The majority of agencies report that the financial need to limit the level of services provided has created greater fragmentation of care between different types of providers. Agencies report that this fragmentation of care for individual beneficiaries is related in part to shorter stabilization periods in care. The data suggest that this pattern of fragmentation affects sicker, more chronically ill beneficiaries since they are the ones who require more ongoing and intensive services. Agency reports also suggest that the effects of intermediary review, changed staffing patterns within agencies to reduce costs, and changed physician referral patterns may compound this fragmentation and create additional barriers to access to care.

Overall, the number of Medicare beneficiaries admitted to care in the study agencies as a percentage of all patients has declined 21 percent since 1996. Medicare 1998 revenues in the study agencies have declined by 25 percent from 1994 levels reflecting lower payments and

utilization for Medicare beneficiaries. Agencies report cross-subsidization from other entities or charitable sources to pay for care delivered to Medicare beneficiaries.

Notwithstanding the evidence of substantial problems, some agencies report that IPS has triggered some efficiencies and quality enhancements. These include more case management, higher levels of nursing supervision, more goal and outcomes orientation with patients, encouragement of greater patient independence, and reduction of administrative costs.

Discussion and Implications

The reported screening of high cost patients as well as significant reductions in the number of visits suggest that some beneficiaries may have difficulty receiving home health services or maintaining a consistent level of services. The reductions in care to high cost beneficiaries potentially could affect their health status. The decline of the relative percentage of Medicare beneficiaries compared to other patients served by the study agencies suggests that Medicare beneficiaries may be experiencing greater access problems than non-Medicare patients and that agencies may be retrenching their participation in the Medicare market. The extent of the decline in diabetic patient census in particular as reported by home health providers as well as the reductions in care apparently targeted to complex diabetics raise more pronounced concerns about the long-term health status of this population. Evidence that home health agencies and physicians may be arbitrarily limiting care to avoid increased administrative scrutiny may compound potential problems by sicker beneficiaries to maintain a consistent level of services, even as this greater involvement provides utilization oversight.

The reported responses by agencies in non-southern regions reflecting a tendency to favor healthier case mix while southern agencies maintain historic case mix characterized by more chronic illness may exacerbate regional variations in the health status characteristics of home health beneficiaries, even as utilization becomes more nationally homogenized to meet reimbursement requirements. This uniformity of utilization in the face of increasingly regionally diverse case-mix could create even greater regional disparities in health outcomes among Medicare beneficiaries.

These effects appear to be magnified by changes in other parts of the health care system. Evidence of greater movement of patients between providers of all types may reflect greater fragmentation of care for the sickest population. This fragmentation suggests that providers at all levels may be experiencing difficulty providing sustained care to high cost patients, carving out a sector of patients with chronic illness and medical instability who may experience increasing difficulty obtaining care in any health sector. The adverse effects of chronically ill beneficiaries rotating in and out of the health care delivery system and experiencing more disruptions in care on the effective management of chronic disease may be significant.

Many adaptations to the BBA as reported by home health agencies expose significant gaps in clinical and beneficiary information against which these changes should be measured.

The decline in the total number of beneficiaries in the study agencies receiving home care services or experiencing reductions in services must raise serious concerns both for access to care and its quality and effectiveness. The apparent increase among almost all of the respondents in patient/staff ratios, the increased patient load for skilled services, and the reduction or elimination of specialty services including mental health services by some agencies underscore concerns regarding quality of care. The fact that these changes are occurring in the absence of organized patient tracking and outcomes analysis magnifies these concerns.

The data from the study agencies suggest that many of the sicker beneficiaries may no longer be in the Medicare home care system as a result of screening and exclusion by some agencies. Moreover, reimbursement-based changes in utilization may not reflect the clinical needs of the patient. Accordingly, any permanent PPS system that is based on utilization data from 1998 may fail to address the service needs of the eligible population. This could result in the long-term exclusion of sicker populations from Medicare home care services or the standardization of levels of care that are ineffective.

Recommendations

The findings of this study taken together with previously published studies, raise significant policy questions that should be addressed. Specifically, additional studies must be conducted to track beneficiaries' experiences obtaining home health care and to evaluate the effects of changed patterns of care on beneficiary health status and the degree and cost-effectiveness of greater fragmentation of care. Because of findings indicating that IPS and the BBA have created distortions in utilization data, PPS should not rely on utilization data from 1998-99. Given the evidence that agencies exclude or limit the amount of care to sicker beneficiaries, the IPS should be modified to adequately account for the costs of medically necessary care for these beneficiaries. Guidelines to fiscal intermediaries and physicians should be clarified to mitigate administrative barriers to beneficiary access to care. Finally, any additional reductions in payments for home health services should be postponed until definitive data on the effects of the current reductions can be assessed.

Conclusion

The challenge for policy-makers is to develop payment methodologies that create efficiencies while maintaining incentives to provide effective care to the sickest populations. The failure to meet this challenge could produce a systemic failure to appropriately manage chronic disease, generating higher health care costs in other sectors or adverse consequences on beneficiary health.

TO: CHRIS / DEVAR AW

FROM: JAW

THE WHITE HOUSE

Office of the Press Secretary
(New York, New York)

Internal Transcript

October 7, 1999

INTERVIEW OF THE PRESIDENT
BY
JOHN ROBERTS OF CBS~~Sheraton New York Hotel and Tower~~
New York, New York

3:40 P.M. EDT

Q Mr. President, sir. Good to meet you; how are you?

THE PRESIDENT: Good to see you.

Q So, you know the issue, sir. You've been trying to address it, the idea that there are 15 million senior citizens in this country who don't have Medicaid coverage for prescription drugs, Medicare coverage. What does it say about a country, sir, where many people have to go outside of the country to buy drugs that they can afford?

THE PRESIDENT: Well, it's wrong. And it happens because we have about three-quarters of our senior citizens need prescription drugs that they simply can't afford. They don't have access to any coverage, or the coverage they have is too expensive and too limited. And in Canada and in many places, drugs made in America are cheaper than they are here because bigger units can buy discounts.

Now, this proposal I made to reform Medicare is totally voluntary -- no senior has to buy a prescription drug coverage if he or she doesn't want it. But if they do buy it, then a private group -- not the government -- would be able to get the drugs at a lower cost because they would be buying them in bulk. And I think it's fair. It will not adversely affect the drug companies. It will increase their volume, even though the drugs, individually, will be cheaper. They will still come out way ahead. And our people will be treated more fairly and they won't have to depend upon whether they're on the Canadian border to run across the line to buy drugs they can afford.

-MORE-

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Q What do you think about the idea of allowing pharmacies to re-import drugs, parallel importing for senior citizens and allow them access to the cheaper prices that they would pay in Canada?

THE PRESIDENT: You're the first person that ever asked me that. I don't know. But I'll look into it. It's an interesting idea. I never thought about it.

Q That's Congressman Sanders' idea. He has proposed to allow pharmacies to re-import drugs from Canada or Mexico. There has been some question as to whether or not that would be legal because of FDA regulations. But that's the idea that he is proposing.

THE PRESIDENT: Well, if you could preserve their safety and quality, that there were some assurance of that, I would think it could be done. And it might work well along the Canadian border for Vermont, where Congressman Sanders lives, and for the other states along the border.

Then the further you get away from the border, the question is will the transportation cost back more than offset the money that you would otherwise save. I don't know the answer. You're the first person that's ever asked me that. But I'll look into it.

Q Now, the drug companies have been saying that even under your plan, which would allow Medicare to buy drugs in bulk, it would decrease the revenue stream to the point where research and development would be stifled. I mean, would you look at the profits they've been making in the last few years -- is that a legitimate argument?

THE PRESIDENT: No. No, you know, they said that over and over and over again. American drug companies charge American citizens far more money for the same pharmaceuticals than they charge Europeans, Canadians, Mexicans, anyone else.

Q Does that seem right?

THE PRESIDENT: No. They say they do it because we bear the full cost of -- the research and development cost -- and they can't put it off on any of the others because the government controls the prices. That's what they say.

So I think if that's true, then the United States and its people have been awfully good to our drug companies. They've been willing to pay higher prices for drugs made in America than

-MORE-

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people in other countries do, and I think they owe it to the seniors to get off this high horse and stop trying to beat this attempt to extend medical coverage to seniors for prescription drugs.

People that live on fixed incomes ought to be able to get the benefit of discounts you get when you buy in bulk. This is not government regulation, this is market power. A lot of these drugs they have long since recovered the research and developments cost, long since. And I just think it's wrong for our people either not to be able to get them at all or to pay so much more than others do. And this is one way to sort of split the difference between their position that they need higher profits to invest in research and development, and the very low cost that they can get if they happen to live close enough to the Canadian border to cross it.

So I would like to see Medicare cover prescription drugs on a voluntary basis so our seniors can get discount prices. It's very important.

Q The ideas that have been floated in the Senate, which ostensibly are voucher systems, would you agree with that type of system to pay for prescription drugs?

THE PRESIDENT: Well, it wouldn't be as effective as the proposal we've made because it would be more difficult to get the benefit of discounts. And, therefore, over a few years it would be harder to keep the premiums down.

But, as I said, I would like to see the members of Congress in both parties engage with us on this, let's work it through, let's come up with something -- you've got three-quarters of our seniors in trouble out there and we ought to do something about it.

Q In terms of national priorities, how important is this?

THE PRESIDENT: Oh, I think it's very important. The big challenges facing our country right now, at the top of those challenges are what to do about the aging of America as more of us live longer -- that means we have to save Social Security and reform and modernize Medicare; and the children of America -- we have to give all of our kids a world-class education with the most diverse student population ever.

Those are the big challenges we face. And to me this is a big part of it. You're going to have -- the average 65 year old person today has a life expectancy of 82. The people being born today, if the human genome project works out right, might have a

-MORE-

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life expectancy of 100. But if that's true, in order to maintain their quality of life and their health and not bankrupt the hospitals, we'll have to keep more and more of them well with the proper kind of drug treatment programs.

So you want the drug companies to be able to continue to pioneer new drugs, but they've got to be affordable and they have to be accessible.

Q Thank you for your time, sir, I appreciate it.

THE PRESIDENT: Thank you.

END

3:46 P.M. EDT

-MORE-

An Initial Report
on
The Impact of the Balanced Budget Act
On Small Rural Hospitals

WWAMI Rural Health Research Center, University of Washington ¹

September 1999

Funded by the Office of Rural Health Policy, HRSA, DHHS

¹ Funded by the Office of Rural Health Policy, HRSA, DHHS. Grant #CSURC0001-03.

Executive Summary

A report on case studies of six well-managed, small rural hospitals. The hospitals selected were among the best managed and stable rural facilities in their states, and had all suddenly experienced financial difficulty in the last few years. These hospitals are in six different states, representing the diversity of rural America: Iowa, Kentucky, Mississippi, Montana, Pennsylvania and Texas. The Office of Rural Health Policy asked the University of Washington's Rural Health Research Center to make an initial rapid assessment of the impact of the BBA by conducting intensive site visits to six rural hospitals. This study is an investigation of the reasons for and effects of their financial downturns.

Financial downturns. In just two years (1997 to 1999) the financial condition of five of the six case study hospitals has worsened. The Balanced Budget Act is already eroding the financial stability of these small rural hospitals. Four are in the red; the other two are scarcely in the black (Table 1). Their worsening financial condition is the combined result of the Balanced Budget Act and the increasing presence in rural areas of Medicaid and commercial managed care programs. Managed care reduces inpatient days, and commercial plans demand discounted fees.

BBA payment impacts. The Balanced Budget Act's provisions have already made significant cuts to rural hospitals' Medicare payments. The largest impact -- on outpatient revenues -- is yet to come.

- **Diversified hospitals hit hardest.** These forward-looking hospitals had worked hard to expand and diversify -- all have outpatient services, five have home health agencies, and two have skilled nursing facilities. The Medicare revenues for all of these services will decline as the new prospective payment systems come on line. (Tables 2 and 3)
- **Home health.** Five of the hospitals have experienced large losses in their home health programs, directly attributable to BBA cutbacks and rule changes. Large home health losses have undermined the financial stability of three of the hospitals visited.

- **Skilled nursing facilities.** The Pennsylvania hospital started a SNF in 1995. Medicare reimbursement rates per day have fallen from \$407 in FY 98 to \$288 in FY 2000, and are anticipated to fall to \$221 when the BBA rate is fully phased in. Although this unit operates at capacity, it is already losing money at current reimbursement rates and likely will be closed to stem the losses.
- **Outpatient services.** Effects of the Medicare outpatient payment reductions are yet to come. They will be the largest. (Table 3)

Impact on access and quality of care

- Home health agencies are selecting patients based on the agency's ability to afford caring for them within BBA limits.
- The Texas hospital closed two outlying federally certified rural health clinics because reimbursements had fallen.
- The Pennsylvania hospital closed and the Mississippi hospital sharply reduced partial hospitalization programs for elderly psychiatric patients.
- The Texas and Kentucky hospitals laid off half their home health nurses
- One hospital used an employee buyout strategy to reduce its staffing level and costs. The highest paid, most skilled nurses took the buyout. This hospital's managers voiced concerns about 'being on the edge' of their ability to maintain quality of care.

Background

Initial reviews of the 1997 Balanced Budget Act provisions by rural policy experts (RUPRI, 1997; RUPRI, 1999) predicted negative financial impact on many rural hospitals. Earlier this year, some evidence of detrimental effects began to surface (NRHA Annual Meeting, 1999; Capital Area Rural Health Roundtable, July 1999). Rural hospitals' first experience with Medicare prospective payment systems -- DRGs in the 1980s -- had been negative. Medicare inpatient PPS was a major contributor to the closing of several hundred rural hospitals. Now three additional Medicare prospective payment systems are coming on line -- for skilled nursing facilities, home health agencies, and hospital outpatient services. Most rural hospitals will be affected by at least two of the new prospective payment systems (21% will be affected by all 3; 72% will be affected by 2 of them) as well as numerous other BBA reductions in hospital payments (Univ. of Minn., 1999).

The Office of Rural Health Policy asked the University of Washington's Rural Health Research Center to make a rapid assessment of the impact of the BBA by conducting intensive site visits to six rural hospitals. This largely qualitative study of a limited number of case studies was designed to identify the types of changes that are occurring to the financial and institutional foundations of rural hospitals. There is no claim to representativeness of the results. Hospitals in six different states were selected representing the diversity of rural America: Iowa, Kentucky, Mississippi, Montana, Pennsylvania and Texas. These six hospitals were selected because they 1) have reputations as being well-managed, 2) have stability in their boards, physician supply and administrators, and 3) suddenly began experiencing financial stress. Selecting relatively well-run facilities allowed the study team to focus on the effect of changes in environment and payment policy. This paper is the first report of findings from this study; a more detailed report will be published later in 1999.

General Deterioration in Financial Condition

In 1997, our six study hospitals were in reasonable financial condition, but half had negative operating margins. As illustrated in Table 1, two years later, five of the six have seen their margins decline substantially. Four are actually in the red and the other two are scarcely in the black. The Balanced Budget Act is a major contributing factor to this trend since it is directed at those sectors rural hospitals have worked hardest to expand. Similar to many rural hospitals, they had sought to diversify -- they opened home health agencies.

Table 1
Changes in Hospital Profitability
in Six Study Hospitals
FY 1997-1999

Location of Study Hospital	Total Operating Revenue Received FY99	Net Revenues After Expenses		
		1997 Profitability	1999 Profitability	Percent Change
Iowa	\$ 9,268,575	\$342,249	\$ 22,982	- 93.3%
Kentucky	18,494,600	- 373,990	126,038	+133.6
Mississippi	7,946,652	- 617,522	- 774,642	- 25.4
Montana	9,217,618	321,383	- 364,821	- 213.5
Pennsylvania	22,579,649	- 131,971	- 812,633	- 515.8
Texas	4,548,900	706,360	-521,000	- 173.8

Source: Calculated by the University of Washington's WWAMI Rural Health Research Center using the hospital Medicare Cost Reports for FY 1997 and FY 1999.

Notes: "Profitability" is measured by subtracting total operating expenses from total operating revenue from patient care, but excluding non-operating income such as income on investments, gifts, and tax revenues. Starting dates for fiscal years differ among hospitals. Data for Mississippi are for Fiscal years 1996-1998. Data for the Pennsylvania hospital are for one year 1998-1999 only.

started skilled nursing units, expanded outpatient departments, initiated geriatric psychiatry programs, and increased rehabilitation units. However, this diversification in no way decreased the heavy reliance of rural hospitals on Medicare. (U. Minn., Ch. 4)

Medicaid and commercial managed care programs are also part of the explanation. Managed care plans, both commercial and Medicaid, are becoming a significant presence in the rural markets visited, particularly those bordering on metropolitan areas. All the case study sites reported significant cuts in commercial insurance rates. Indeed they

reported that commercial plans are beginning to adopt Medicare fee schedules and payment plans wholesale. In addition, most states have now extended Medicaid managed care into rural counties and have effectively reduced inpatient days and payment for ER visits. All six hospitals reported a higher incidence of denials and delays in the processing of claims by managed care and commercial carriers. The effect of these developments is to exacerbate the impact of the BBA reductions.

The Balanced Budget Act and Rural Hospitals

The provisions in the Balanced Budget Act have made significant cuts to rural hospitals' Medicare payments that will sharply escalate in intensity and affect a wide range of the services they provide to Medicare beneficiaries. Table 2 summarizes the results of a simulation comparing a baseline of FY 1998 with the same data applied to fully phased-in BBA payment rules. (c. 2002). Note that the simulation model developed by the American Hospital Association projects only modest cuts in total patient revenue, but these are enough to wreak havoc with the bottom line of hospitals, even including subsidies and interest income. A key finding is that these projections, based on a widely disseminated model, appear to be underestimating the actual changes displayed in Table 1.

Many rural hospitals may be able, over time, to adapt to these reduced revenues, if they are able to survive that long. However, the declining or negative margins on which the study hospitals now operate require significant cost cutting and place some of the facilities in a race against time. This statement is not hyperbole. One hospital, an active, busy facility offering a wide spectrum of services, currently has \$250,000 in cash and in November faces well over \$1 million in paybacks to HCFA and to bond holders. While it has a plan to meet this crisis, the facility will be left with absolutely no financial reserves and further projected steep declines in Medicare revenues.

These hospitals will have to cut services to survive as their ability to further cut staffing is limited. Indeed, the site visit team considered that two of the hospitals had already made too deep a set of cuts in staff.

Table 2
Projected Changes in Revenue And Net Income of Hospitals
With Fully Phased-in BBA Changes To Medicare Payments
(in \$1,000's)

Location of Study Hospital	Total Patient Revenue			All Income Net of Expenses		
	Baseline FY 1998	With BBA	Percent Change	Baseline FY 1998	With BBA	Change
Montana	\$9,216	\$8,775	-5.3%	\$51	\$ -436	\$ -486
Mississippi	7,840	7,441	-5.1%	96	-303	-399
Pennsylvania	21,941	20,662	-5.8%	631	-647	-1,278
Texas	4,982	4,544	-8.8%	571	132	-438

Source: Projections calculated by the University of Washington's WWAMI Rural Health Research Center using hospital FY 1998 Cost Reports, an average payment impact model developed by the American Hospital Association, and hospital-specific projections of APC outpatient payment impact from the Health Care Financing Administration.

Notes: Patient Revenue is total revenue actually received and defined as total charges for all patient care net of discounts and allowances for charges not received. All Income Net of Expenses is patient revenue plus other sources of non-patient care income minus operating costs. Cost report data for two of the six study hospitals is not yet available. In the simulation there are no changes in costs; hence the difference in patient revenue (columns 1 and 2) is equal to the change in net income (column 6)

Specific Impacts of the BBA on Six Rural Hospitals

What services will have their revenues most affected by the BBA payment cuts? The BBA mandates a complex, far-reaching series of changes in Medicare payment policy. Table 3 examines the results of the simulations by type of hospital service. A key finding suggested by this table is that most of our study hospitals have not yet seen the largest impact of the phasing in of the BBA provisions. While much attention has been paid to the effects on home health, the forthcoming reductions in payments for outpatient departments will generate much larger reductions in total revenue.

Table 3
Distribution by Hospital Service of Projected Cuts
in Medicare Payments FY 1998-2002

Location of Study Hospital	Total Annual Reduction (\$1000s)	Payment Reductions by Major Hospital Service Area						
		Total	Acute Inpatient	OPD	SNF	Home Health	Capital	Bad Debt
Mississippi	-\$ 399	100%	39.9%	47.8%	-2.0%	--	8.2%	6.1%
Montana	-\$486	100%	24.9	56.8	--	12.2	5.7	0.4
Pennsylvania	-\$1,278	100%	26.7	26.3	31.9	4.6	6.2	4.3
Texas	-\$438	100%	13.9	66.2	--	13.5	3.1	3.2

Source: See Table 2

Note: Rows add to 100%. SNF includes skilled nursing facilities, a geriatric psychiatry unit, and limitation of payments for contracted physical therapy services.

Outpatient Department Payments

All six of these hospitals provide extensive outpatient services. In 3 of the 4 case study hospitals on which we had data to project BBA cuts by service area, the outpatient payment reductions will be the largest single amount. Hardest hit will be the Texas hospital; its outpatient payment reduction is projected to be two-thirds of all its BBA cuts. For the other three hospitals, it will be a smaller but still substantial proportion of their projected BBA cuts: 48%, 57% and 26% respectively. Although the estimates in Table 3 for outpatient payment reductions are speculative, they were developed by HCFA, and are the best available numbers of potential level of impact. The rural hospitals visited were so involved in trying to manage the current downward financial spiral that they have given very little attention to preparing for these large outpatient payment cutbacks which are still to come.

Home Health

Five of the hospitals we studied experienced large losses in their home health programs, directly attributable to BBA cutbacks and rule changes. Even the two hospitals (Texas, Kentucky) which anticipated large cutbacks and adjusted early by laying off staff and

reducing visits were forced to make significant repayments to HCFA. These home health losses have been of a magnitude to undermine the financial stability of three of the hospitals visited.

Implementation of the home health agency interim payment system was as flawed as the policy itself, in the eyes of the administrators with whom we spoke. The new per-case cost limits were not communicated to the hospitals for months after they were in effect. Our Kentucky hospital had guessed the cutback would be no worse than 25%, cut back its costs accordingly, and was only told by its fiscal intermediary six months after the fiscal year began that the cutbacks would total 50%. It has to write a check for about \$500,000 to HCFA, a particularly difficult development since the hospital used the interim payments to deliver the services and had held none of it in reserve.

Perhaps even more disturbing, home health agencies are having to both refuse patients who need care and deny visits to patients who need them because of the BBA cutbacks. Two hospital-based home health agencies stated that they now have to screen new cases and turn down those which appear to be high cost. Two respondents also stated that their nurses are seeing particularly needy patients on their own time without hope of reimbursement.

Skilled Nursing Facilities (long-term care)

The Pennsylvania hospital started a SNF in 1995 that was designed as a post-acute unit for stays of two weeks or less. Responding to its own difficulties finding an appropriate setting for high-need discharges, the initiative has proven popular and has a waiting list of patients awaiting discharge from other, often tertiary care, hospitals. It is now difficult to see how this unit can be preserved. Effective reimbursement rates per day have fallen from \$407 in FY 98 to \$288 in FY 2000. Given its current case mix the fully phased-in BBA rate will be \$221. The escalating financial losses for this SNF pose a challenge for the hospital as a whole. However, its demise also raises the problem the unit was designed to solve. Retaining patients will increase lengths of stay in the inpatient unit and exacerbate increasing losses there.

Moreover, the hospital reports that the BBA cuts have increased the unwillingness of free-standing nursing homes to accept high-need patients. These nursing homes increasingly keep RN staffing at a minimum and avoid patients who need IVS, cardiac medications, daily lab tests, extensive physical therapy or diabetic care. In addition, the hospital has lost over \$125 thousand in billings from three local nursing homes that canceled their contracts for respiratory therapy in favor of in-house nurse-delivered oxygen. The change may not be trivial given the community's coal economy and the elevated incidence of lung disease among older people. Increasingly, when nursing home

patients are hospitalized, the hospital is having a harder time persuading the originating nursing home to take them back. The hospital social worker told us, "Things started to get really bad only in the last year or two. Nursing homes' decisions are now based on financing. Medicaid patients are really at risk for discrimination, especially if they have high acuity and expensive meds."

Bad Debt and Co-payments

Medicare beneficiaries who have limited or no supplemental insurance may have difficulty paying the hospital deductibles and copayments. Several study hospitals reported that the problem of bad debt for both Medicare and non-Medicare patients was increasing -- doubling in two years in the case of the Iowa hospital. Previously, Medicare beneficiary bad debt was reimbursable by including it as an allowable cost. This is being eliminated over a four year transition period.

Access to Care and Quality of Care

Are the BBA payment reductions and revenue losses from other payers affecting access to care and quality of care for rural Medicare beneficiaries? In four of the six hospitals visited, the scale of the cost cutting necessary to bring the hospital within range of the ever-deepening revenue reductions is so large that the only feasible solution is to cut back on services. And for many hospitals the largest reductions are yet to hit. Here are some the changes in service capacity and access that the site visit team was told about:

- Home health agencies are selecting patients based on the agency's ability to afford caring for them within BBA limits;
- The Texas hospital closed two outlying certified rural health clinics because reimbursements had fallen;
- The Mississippi hospital has decided to not even open its brand new Rural Health Clinic;
- The Pennsylvania hospital closed and the Mississippi hospital sharply reduced partial hospitalization programs for elderly psychiatric patients;
- Access to physical therapy, occupational therapy and speech therapy has declined in all the sites;
- The Iowa hospital had just raised the money to remodel its surgery facilities and is stopping the project mid-construction because of declining financial resources;
- The Texas and Kentucky hospitals laid off half their home health nurses;
- Ironically all sites are having to employ additional people on the paperwork side while reducing patient care in order to keep up with the new "fraud and abuse" rules under BBA;

- Labs are struggling with new rules requiring certain diagnoses to justify a Medicare reimbursement, while physicians cannot be told what the rules are.
- Three sites reported that physicians had become very reluctant to refer patients to home health or long term care because of a perception that they could be risking fraud and abuse charges.
- One hospital used an employee buyout strategy to reduce its staffing level and costs. The highest paid, most skilled nurses took the buyout. This hospital's managers voiced concerns about now 'being on the edge' of their ability to maintain quality of care.

Critical Access Hospital Program

The CAH program will help many rural hospitals, especially in that large group which averages fewer than 10 inpatients a day. However, the intent of the CAH legislation was never to help all rural hospitals. Some of our hospitals were too large to be downsized. For others (e.g. Iowa) the nearest larger hospital was so far away that the community required obstetrics and surgery -- services incompatible with restricted lengths of stay. The Mississippi hospital had high hopes for the program, but the results of a financial simulation showed they would actually lose money by converting to a CAH. (It was already exempt from PPS through its designation as a Sole Community Hospital and its inpatient relative to outpatient revenue was unusually large.) Finally, cost-based reimbursement means that Medicare will cover the direct costs of treating Medicare patients only. If the hospital is also experiencing losses serving its non-elderly population, where will the revenue come from to cover these shortfalls?

References

Rural Policy Research Institute. 1997. Rural Implications of the Balanced Budget Act of 1997, Report P97-10.

_____ 1999. Implications of the Provisions of the Balanced Budget Act of 1997: Critical Issues for Rural Health Care Delivery, Report P99-5

University of Minnesota Rural Health Research Center, 1999. *Rural Hospitals: Accomplishments and Present Challenges*. July 1999

September 24, 1999

ROTH URGES PRESIDENT CLINTON TO ADDRESS BBA 97 MEDICARE CHANGES THROUGH ADMINISTRATIVE ADJUSTMENTS

WASHINGTON -- Senate Finance Committee Chairman William V. Roth, Jr. (R-DE) today said that the Executive Branch has the authority to make needed adjustments to the Medicare program reforms enacted in the Balanced Budget Act of 1997, and urged the White House to go forward with them.

In a meeting today with representatives from the White House, Finance Chairman Roth suggested that the Clinton Administration address a number of areas of concern in the Medicare program administratively. He outlined his suggestions in a document entitled, "Administrative Adjustments to Improve Medicare Provider Payment Equity, and to Stabilize the Medicare + Choice Program." The document lists administrative changes for hospitals, skilled nursing facilities, physician payments, home health agencies, ambulatory surgical centers and Medicare + Choice.

"Our review indicates that several areas of legitimate concern could clearly be addressed by the Executive Branch administratively, thereby freeing the Congress to concentrate on those matters which can only be addressed legislatively," Roth stated in a letter to President Clinton.

"It is my intention to propose shortly a package of legislative adjustments in areas where steps must be taken to improve payment equity to providers and to protect the availability of privately offered Medicare + Choice plans."

A copy of the letter and enclosure are attached.

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September 24, 1999

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. President:

During the 105th Congress, you provided leadership and worked successfully with Congressional leaders to enact the Balanced Budget Act of 1997 (BBA 97). That law helped put the federal government on a course of fiscal discipline that is resulting in major economic dividends benefiting all Americans. With respect to the Medicare program, we collaborated on the most significant set of reforms in payments to providers and private health plans that has occurred since the program was first enacted. These changes had the salutary effect of temporarily stabilizing the rates of growth in Medicare spending and extending the solvency of the Part A Hospital Insurance Trust Fund.

As is occasionally the case with major legislation, we have learned that there are some unintended consequences. As a result, certain provider and health plan payment adjustments may be required under Medicare in order to protect beneficiaries' access to quality health care services and plans. It is my intention to propose shortly a package of legislative adjustments in areas where steps must be taken to improve payment equity to providers and to protect the availability of privately offered Medicare+Choice plans. In this regard, although you did not specify policies, it was helpful that the Administration's recently released Medicare reform proposal set aside \$7.5 billion over 10 years to address concerns in these areas.

Our review indicates that several areas of legitimate concern could clearly be addressed by the Executive Branch administratively, thereby freeing the Congress to concentrate on those matters which can only be addressed legislatively. I urge you to review the enclosed list of administrative adjustments and advise me of your willingness to take steps within the Administration to address these matters. As necessary, the Congress can and will act on other related matters. However, I am confident that in the spirit of the BBA 97 agreements, including a shared concern for fiscal responsibility, you will want to collaborate with us in resolving these concerns. Thank you for your consideration.

Sincerely,

William V. Roth, Jr.
Chairman

Enclosure

Administrative Adjustments to Improve Medicare Provider Payment Equity, and to Stabilize the Medicare+Choice Program

Hospitals

Proposal -- Fair Transition for Outpatient Payment Changes: Develop and administer a budget neutral, multi-year transition method for implementation of the hospital outpatient prospective payment system (scheduled for July, 2000), including a policy to maintain the scheduled reductions in beneficiary cost-sharing liabilities for services received in hospital outpatient departments.

Obtain an expert and independent evaluation of the clinical soundness and payment equity implications of the proposed Ambulatory Payment Category (APC) system, including its appropriateness for unique categories of providers, such as cancer hospitals. If a delay in implementation or exemption of certain classes of providers is warranted under the review, inform the Congressional Committees of jurisdiction by June, 2000.

Explanation: The Balanced Budget Act of 1997 (BBA) required the Secretary to implement a prospective payment system (PPS) for hospital outpatient department services by January 1, 1999. The proposal issued by the Administration represents a major change in Medicare payment policy for outpatient services and may result in significant changes in hospital payments. This requested adjustment is needed to provide hospitals a reasonable period to adjust operations to meet these funding changes, while maintaining corrections to the amount that beneficiaries are required to pay in coinsurance for hospital outpatient services.

There is also concern about the methodology of the proposed APC classification system. Before such drastic changes to current payment policy are implemented, an independent review of the proposal is appropriate.

Proposal -- Limit Scope of Hospital Transfer Policy: Freeze the payment policy for hospital transfers at the current set of 10 Diagnosis Related Group categories.

Explanation: The BBA gave the Secretary of HHS authority to classify discharges from acute-care hospitals to post-acute care facilities within a group of 10 Diagnostic Related Groups (DRGs) as "transfers." Beginning in 2001, the Secretary would have authority to expand this policy to more than the initial 10 DRGs. As other payment policy changes from the BBA continue to be monitored, it is unnecessary to expand the transfer policy in the foreseeable future.

Skilled Nursing Facilities

Proposal -- Higher Payments for Complex Cases: Establish payment refinements to selected Resource Utilization Groups as the Skilled Nursing Facility (SNF) PPS is implemented. These

changes should be targeted to improve reimbursement for medically complex cases, with special attention to the unique problems of patients requiring complex treatments and prosthetics.

Explanation: The BBA phases in a PPS that pays for covered SNF services on a per diem rate. The General Accounting Office has indicated that the current rate may not adequately reimburse for services provided to medically complex patients.

Physician Payments

Proposal -- Corrections Due to Erroneous Spending Projections: Provide immediate advice on administrative options for improving annual updates in payment for physician services to correct for erroneous projections.

Explanation: Implementation of new payment methodologies established in the BBA produced inappropriate payment reductions to physicians due to failures to adjust for erroneous administrative projections used to set rates. This particular problem could be remedied through changes in the year-to-year administrative payment projection and adjustment process.

Home Health Agencies

Proposal -- Proration of Payments: Relieve home health agencies of the inappropriate responsibility for tracking patients that secure services from more than one agency in order to prorate payments.

Explanation: New home health payment systems created by the BBA called for tracking the number of home health services beneficiaries receive from different facilities, so that payment amounts could be prorated. However, the BBA does not specify that this tracking is the responsibility of the agencies. Such responsibility would be more appropriately assigned to the fiscal intermediaries.

Proposal -- Equitable Recovery Schedules for Overpayments: Provide for extended repayment schedules for agencies that incurred significant Medicare overpayments due to difficulties in adjusting to major BBA 97 payment system changes.

Explanation: There is recognition of the need for more flexible overpayment schedules for certain home health agencies facing large overpayment amounts due to the changes in payment systems contained in the BBA.

Ambulatory Surgical Centers (ASCs)

Proposal -- Fair Payment for ASCs: Do not implement payment policy changes for ASCs until 1999 industry survey data is analyzed and properly incorporated into any proposed changes.

Explanation: In a proposed rule, the Administration is proposing changes to the payment policy for ASCs based upon 1994 survey data. It would be more appropriate to implement proposed changes after the 1999 survey data is complete.

Medicare+Choice

Proposal -- Fair Transition for Health Plans: Revise phase-in schedule for risk-adjusted payments to extend the transition by at least two years and to prevent any single plan from experiencing more than a 5-10% shift in Medicare payment rates attributable to the risk-adjuster in any single year.

Explanation: The BBA required HCFA to develop and implement a health-based risk-adjustment system by January 2000 to increase payments to plans that enroll sicker patients and to decrease payments to plans that enroll healthier patients. The implementation may cause significant changes in the annual payments to plans and thus the premiums beneficiaries would be charged. This proposal would provide for a more gradual transition to risk adjustment and protections for both beneficiaries and plans.