THE WHITE HOUSE
WASHINGTON
January 6, 1983

TO: JAMES A. BAKER, III

FROM: *CRAIG L. FULLER*

☐ **FYI**

☐ **Comment**

☒ **Action**

Attached are papers for Secretary Schweiker's briefing this afternoon (3:15 pm - Roosevelt Room) on Rates of Reimbursement Under the Medicare End-Stage Renal Disease Program

f HHS memos

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

DISCUSSION MEMORANDUM

Final Rule to Set Rates of Reimbursement Under the Medicare End-Stage Renal Disease Program

Background:

In 1972 Congress extended Medicare benefits to individuals of all ages suffering from end-stage renal disease (ESRD). The treatment for this serious disease is regular kidney dialysis, typically three times a week for the duration of the patient's life, or kidney transplantation. The program was relatively small at the outset--11,000 patients and total 1974 payments of about $229 million. Currently, however, the program serves 63,500 patients at an annual cost to Medicare of over $1.8 billion (FY 1982).

The industry providing dialysis services consists of two basic segments: (1) 691 facilities that are part of hospitals and (2) 514 independent, free-standing facilities that provide only dialysis services. Over three-fourths of all independent facilities are private, for-profit entities, while only 5 percent of hospital units falls into this category.

The current Medicare reimbursement rules have contributed to the enormous growth in ESRD program expenditures. Hospitals are reimbursed for their reasonable costs and have little incentive to make their operations more efficient, since they are not allowed to retain any surpluses that result from cost reductions. This leads to high cost operations and unnecessarily large Federal expenditures. By contrast, independent facilities are reimbursed on the basis of reasonable charges (up to a current cap of $138 per treatment) and may retain any difference between those charges and actual costs. Department of Health and Human Services audits revealed that the median costs of hospital-based dialysis facilities were $135 per treatment compared to $108 for independent facilities. Indeed, these low costs of independent facilities have raised concern that the current $138 allowable charge may also be resulting in unnecessary Federal expenditures.

HHS audit data also showed that the most economical type of dialysis is dialysis in the patient's own home, where the median cost is $97 per treatment. Only about 17 percent of dialysis patients are currently treated at home, although home dialysis is believed to be suitable for 30-40 percent.

In March 1981, the Administration's budget for FY 1982 included development of a prospective, single rate system designed to maximize the benefits of marketplace competition by paying the same rate to all types of facilities. The Omnibus Budget Reconciliation Act of 1981, however, forced HHS to abandon the single rate concept. Instead, the Act requires rates that differentiate between hospital-based and independent facilities, as well as encourage the increased use of home dialysis. The Act specifies a preference for dual composite rates, which would be determined by considering the respective costs of in-facility and home dialysis. Composite rates are expected to yield a substantial return to a facility for each patient who is dialyzed at home and a lesser margin for those served in the facility, thus inducing the facility to shift patients to home dialysis where medically appropriate.

HHS Recommendation

In February 1982, the Department proposed a dual composite rate methodology for public comment. Although the rates to be paid to individual facilities would vary with local labor costs, the average rate for hospital-based facilities would be $131 per treatment and the average rate for independent facilities would be $127. The same rate would be paid for both home and in-facility dialysis. An exceptions process would be available to allow higher rates for facilities with justifiably higher costs (e.g., pediatric facilities or sole providers in isolated communities). Projected budget savings in FY 1983 depend on how quickly the new rates are implemented, but estimated savings for FY 1984 are $150 million.

The Department determined that the Reconciliation Act requirement for differentiation of hospital from nonhospital facilities should be carried out by adjusting the hospital rate to account only for legitimate higher costs incurred by hospitals as a class. The hospital rate was therefore raised to reflect excess hospital overhead costs resulting from Medicare cost accounting principles that apply only to hospitals. No adjustment was made to recognize the hospitals' generally higher labor and supplies costs, since these have not been shown to be justifiable.

Nonselected Option

An alternative considered but not adopted would be to base the rate for hospitals on all costs incurred by hospitals, whether or not justifiable, and to base the rate for independent facilities on the costs incurred by independents alone. Under

this methodology, there would be a wide spread between the two rates, e.g., $141 for hospitals and $116 for independents. This option was rejected because the large differential rewards hospital inefficiencies instead of maximizing the potential for the marketplace to reward efficient operation.

Changes in the Final Regulation

The Department is not proposing any major revisions in the final regulations. However, in response to some comments received, the Department has proposed a few key changes as follows:

- Delayed Effective Date. There will be a 90-day delayed effective date after publication of the final regulation to allow high cost providers an opportunity to adjust to the new lower rates.

- Adjustment of Rates for Regional Wage Differences. In the NPRM, the Department proposed to adjust the base rate using the data on variation in hospital wages in States and SMSAs developed by the Bureau of Labor Statistics. Based on the variation in wage levels, hospital dialysis rates would vary from $114 to $146 per treatment. Independent rates would vary from $109 to $143. Commentors objected that the proposed rates overstated the difference in labor costs for dialysis facilities. Specifically, the low rural rates might cause rural facilities to close. Also, GAO and the Inspector General noted that some dialysis facilities now operate at less than the current limit of $138 per treatment and such facilities in high wage areas might receive an unearned "windfall."

  In the final rule the Department has provided a two-year transition period, during which Medicare would pay no less than $118 per independent and $122 per hospital treatment to either type of facility. The added payments for rural facilities will cost about $5 million more per year and the reduced payments in high wage areas will save about $5 million per year. During the two-year "transition" period, HCFA will try to develop wage data specific to ESRD facilities.

- Exceptions to the Rates. The final rule includes specific procedures and criteria under which a renal dialysis facility with justifiable costs above its prospective payment rate could apply for an exception.

Exceptions must be related to the following specific conditions: (1) the facility is essential and geographically isolated; (2) has an atypical patient mix; (3) incurs educational costs; (4) extraordinary circumstances such as a fire or natural disaster; (5) provides self-dialysis training which exceeds allowable costs ($20); or (6) a frequency of dialysis exception for a facility with patients that do not require dialysis three times a week. The Department will consider exceptions only if a facility is able to provide adequate documentation that all of its costs are reasonable and it has excessive per treatment costs attributable to one of the specified conditions.

Incentives for Home Treatment

The final regulation includes a number of provisions that will encourage home treatment and the newly developed technology of continuous ambulatory peritoneal dialysis (CAPD). CAPD offers advantages to many patients and is less expensive to the Medicare program than traditional hemodialysis treatments performed in facilities. The final regulation will encourage home dialysis by:

- Paying the same rate to facilities for home and in-facility dialysis. This promotes home dialysis because home dialysis costs less than in-facility dialysis. Facilities will earn a higher rate of return on home dialysis.

- Paying the same rate to physicians for home and in-facility dialysis. This will promote home dialysis because home dialysis patients require less physician care. Most home dialysis patients receive assistance over the phone and have received extra training which makes them more self-sufficient.

- CAPD. The regulation promotes CAPD as any other home dialysis therapy because it is paid at the same rate as in-facility dialysis. CAPD is not as inexpensive as home hemodialysis but can be performed by many more patients. CAPD is cheaper than in-facility dialysis and thus facilities will earn a higher rate of return on these patients than in-facility patients.

- Reimbursement for Home Dialysis Training. Training sessions for patients are reimbursed at a higher rate than in-facility maintenance dialysis. The final regulation also provides an exception process for facilities that have high training costs.

The Department believes that for all these reasons the final regulation will provide sufficient market incentives to encourage home dialysis.

Conclusion

The proposed rates have produced controversy because many firms desire a higher level of reimbursement. Even though in-facility rates are being reduced, facilities nevertheless have ample opportunity to offset the reductions through transfer of patients to low-cost home dialysis, which will now be reimbursed at the same rate as the higher cost in-facility dialysis. Sixty-nine new facilities have entered the program since the Department first announced the proposed rates in November 1981 providing some evidence that new rates are reasonable. Also, the Department has recently been notified that both major suppliers of CAPD equipment have lowered their list prices in anticipation of the new reimbursement system in order to increase their competitive position.

The proposed reimbursement system can benefit all parties--

- o facilities, by rewarding more efficient operations and increased use of home dialysis;
- o patients, by having more opportunities for dialysis at home when deemed medically appropriate.
- o the Federal government, by lowering expenditures.

Vouchers/Competitive Bidding Proposals for the ESRD Program

Under current statutory constraints, the Department believes that the new ESRD prospective reimbursement system will go far toward producing budgetary savings without reducing the quantity or quality of services to patients. However, the Department will continue to look into alternative reimbursement systems that might further improve on efficiencies. HCFA is reviewing a research proposal to test the feasibility of developing a demonstration plan to introduce competitive bidding, or vouchers, into the ESRD program. This should provide sufficient information to set up a demonstration project.

Dick Schweiker

THE WHITE HOUSE
WASHINGTON

f Kidney Dialysis Regulations : HHS

THE WHITE HOUSE
WASHINGTON

Charlie Snyder [redacted]

347-3411

would put priv. dialysis sector out of business

Nat'l Medical Care =

fear is priv. would go out of business

takes money from priv to hospitals

- several HHS doctors in meeting have told priv sector they are upset

Nofziger involved. "Sympathetic"

CHECK

Left message 1-23-91

— Cicconi —

THE WHITE HOUSE
WASHINGTON

get into it — issues — etc. —

Charlie Snyder # - 5 min. Need not to see him —

Nat'l Medical Care —

Deciding — Fuller has — had all action on it — said RR not going to decide —

Tort ref. in Feb. —

Friday — Dr. Ted Hagger *

talk w/ CF for Stated — Dr. Gus Hampsen —

205 - 279 - 0300

MARGARET D. TUTWILER
Office of James A. Baker III
456-6797

no need for meeting

→ Cicconi

Document No. 044253CS

WHITE HOUSE STAFFING MEMORANDUM

DATE: 2/1/82 ACTION/CONCURRENCE/COMMENT DUE BY: 2/3/82

SUBJECT: KIDNEY DIALYSIS TREATMENTS

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☐	☐	GERGEN	☑	☐
MEESE	☐	☐	HARPER	☑	☐
BAKER	☐	☑	JAMES	☐	☐
DEAVER	☐	☑	JENKINS	☐	☐
STOCKMAN	☐	☐	MURPHY	☑	☐
ANDERSON	☑	☐	ROLLINS	☐	☐
CANZERI	☐	☐	WILLIAMSON	☑	☐
CLARK	☐	☐	WEIDENBAUM	☐	☐
DARMAN	☐P	☑SS	BRADY/SPEAKES	☐	☐
DOLE	☑	☐	ROGERS	☐	☐
DUBERSTEIN	☑	☐	_____	☐	☐
FIELDING	☑	☐	_____	☐	☐
FULLER	☐	☐	_____	☐	☐

Remarks:

This is a very controversial matter. It has been reviewed in a working session of CCHR; however, participation was limited. A dual rate, and a rate below $140/treatment reportedly threatens closure of many private facilities.

Please provide any comments by c.o.b. February 3.

Thank you.

Richard G. Darman
Assistant to the President
and
Deputy to the Chief of Staff
(x-2702)

THE WHITE HOUSE
WASHINGTON

CABINET AFFAIRS STAFFING MEMORANDUM

DATE: February 1, 1982 NUMBER: 044253CA DUE BY: close of busines Wednesday, Feb.

SUBJECT: Kidney Dialysis Treatments

	ACTION	FYI
ALL CABINET MEMBERS	☐	☐
Vice President	☐	☐
State	☐	☐
Treasury	☐	☐
Defense	☐	☐
Attorney General	☐	☐
Interior	☐	☐
Agriculture	☐	☐
Commerce	☐	☐
Labor	☐	☐
HHS	☐	☐
HUD	☐	☐
Transportation	☐	☐
Energy	☐	☐
Education	☑	☐
Counsellor	☑	☐
OMB	☐	☐
CIA	☐	☐
UN	☐	☐
USTR	☐	☐
CEA	☐	☐
CEQ	☐	☐
OSTP	☐	☐
_____	☐	☐
_____	☐	☐

	ACTION	FYI
Baker	☐	☐
Deaver	☐	☐
Anderson	☐	☑
Clark	☐	☑
Darman *(For WH Staffing)*	☑	☐
Jenkins	☐	☐
Gray	☐	☐
Beal	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
CCNRE/Boggs	☐	☐
CCHR/Carleson	☑	☐
CCCT/Kass	☐	☐
CCFA/McClaughry	☐	☐
CCEA/Porter	☐	☐

REMARKS: This is a very controversial matter. It has been reviewed in a working session of CCHR; however, participation was limited. A dual rate, and a rate below $140/treatment reportedly threatens closure of many private facilities.

Please provide any comments by COB, February 3, 1982.

RETURN TO:

Craig L. Fuller
Assistant to the President
for Cabinet Affairs
456-2823

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

January 29, 1982

MEMORANDUM FOR THE PRESIDENT

The Department of Health and Human Services has drafted a proposed rule to set new payment rates for kidney dialysis treatments under the Medicare program. This rule is designed to help control spiraling program costs by changing the payment method to encourage efficient delivery of services.

The Medicare program covers most Americans who have end-stage renal disease, without regard to their age. The program provides life sustaining dialysis treatments or kidney transplants as well as other medical care to 56,000 persons. The costs of the program have escalated dramatically from $229 million in 1974 to $1.5 billion last year. The industry providing dialysis treatments consists of about 650 hospitals, most of which are non-profit, and 450 independent dialysis facilities, most of which are for-profit entities.

The current Medicare payment rules have contributed to the enormous growth in cost of the kidney program. Reasonable costs incurred by hospitals are fully covered and hospitals are not permitted to retain any surpluses resulting from efficient operations; thus, hospitals have little incentive to economize. By contrast, independent dialysis facilities are paid at their reasonable charge and they may retain the differences between their costs and the charges paid by Medicare. Audits reveal that the median costs of hospital-based dialysis facilities were $135 per treatment compared to $108 for independent facilities. Indeed, these low costs of independent facilities have raised concern that the current $138 allowable charge may also be resulting in unnecessary Federal expenditures.

The Omnibus Budget Reconciliation Act of 1981 requires rates that differentiate between hospital-based and independent facilities, as well as encourage the increased use of dialysis treatments performed in a patient's own home rather than in dialysis facilities. Treatments performed at home are most economical and there is much potential for expanding this form of treatment since only about 17 percent of dialysis patients are currently treated at home, although home dialysis is believed to be suitable for 30-40 percent.

HHS has prepared a proposal for public comment that would pay hospital-based facilities an average of $132 per treatment; the average rate for independent facilities would be $128. The same rate would be paid for both home and in-facility dialysis.

We expect that providers will object to the proposed rule during the public comment period because this is the first real effort to manage program costs and encourage the most cost effective care. The proposed rates are lower than the ones now paid to many facilities for treatment conducted in the facility. However, facilities have ample opportunity to offset the reductions through transfer of patients to low-cost home dialysis, which will now be reimbursed at the same rate as the higher cost in-facility dialysis. Also, a limited exceptions process would be available to allow higher rates for facilities with justifiably higher costs (e.g., pediatric facilities or essential providers in isolated communities).

The proposed payment rates are projected to save $121 million in the Medicare program in FY 1983 and $164 million in FY 1984.

Richard S. Schweiker
Secretary

THE WHITE HOUSE
WASHINGTON

CABINET AFFAIRS STAFFING MEMORANDUM

DATE: 1/20/82 NUMBER: 050139CA DUE BY: ------

SUBJECT: CABINET COUNCIL ON HUMAN RESOURCES -- January 21 Meeting

	ACTION	FYI
ALL CABINET MEMBERS	☐	☐
Vice President	☑	☐
State	☐	☑
Treasury	☐	☑
Defense	☐	☑
Attorney General	☑	☐
Interior	☐	☑
Agriculture	☑	☐
Commerce	☐	☑
Labor	☑	☐
HHS	☑	☐
HUD	☑	☐
Transportation	☐	☑
Energy	☐	☑
Education	☑	☐
Counsellor	☑	☐
OMB	☐	☑
CIA	☐	☑
UN	☐	☑
USTR	☐	☑
CEA	☐	☑
CEQ	☐	☐
OSTP	☐	☐
_____	☐	☐
_____	☐	☐

	ACTION	FYI
Baker	☑	☐
Deaver	☐	☐
Anderson	☑	☐
Clark	☑	☐
Darman *(For WH Staffing)*	☑	☐
Jenkins	☐	☑
Gray	☐	☑
Beal	☐	☑
Allen Lenz	☑	☐
Don Moran	☑	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
CCNRE/Boggs	☐	☐
CCHR/Carleson	☑	☐
CCCT/Kass	☐	☐
CCFA/McClaughry	☐	☐
CCEA/Porter	☐	☐

REMARKS: Attached are the agenda and briefing paper for the Thursday, January 21 (tomorrow's), meeting of the Cabinet Council on Human Resources, scheduled for 4:00 PM in the Roosevelt Room.

RETURN TO: Craig L. Fuller
Assistant to the President
for Cabinet Affairs
456-2823

CONTACT: Kenneth Cribb, Jr.
Assistant Director
Office of Cabinet Affairs
456-2800

THE WHITE HOUSE

WASHINGTON

CABINET COUNCIL ON HUMAN RESOURCES

January 21, 1982

4:00 AM

Roosevelt Room

AGENDA

1. Kidney Diaylsis Rate Regulations/CM181

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

CABINET COUNCIL DISCUSSION MEMORANDUM

Proposed Rule to Set Rates of Reimbursement Under the Medicare End-Stage Renal Disease Program

Background:

In 1972 Congress extended Medicare benefits to individuals of all ages suffering from end-stage renal disease (ESRD). The treatment for this serious disease is regular kidney dialysis, typically three times a week for the duration of the patient's life, or kidney transplantation. The program was relatively small at the outset--11,000 patients and total 1974 payments of about $229 million. Currently, however, the program serves 56,000 patients at an annual cost to Medicare of over $1.5 billion.

The industry providing dialysis services consists of two basic segments: (1) 654 facilities that are part of hospitals and (2) 466 independent, free-standing facilities that provide only dialysis services. Over three-fourths of all independent facilities are private, for-profit entities, while only 5 percent of hospital units fall into this category.

The current Medicare reimbursement rules have contributed to the enormous growth in ESRD program expenditures. Hospitals are reimbursed for their reasonable costs and have little incentive to make their operations more efficient, since they are not allowed to retain any surpluses that result from cost reductions. This leads to high cost operations and unnecessarily large Federal expenditures. By contrast, independent facilities are reimbursed on the basis of reasonable charges (up to a current cap of $138 per treatment) and may retain any difference between those charges and actual costs. Department of Health and Human Services audits revealed that the median costs of hospital-based dialysis facilities were $135 per treatment compared to $108 for independent facilities. Indeed, these low costs of independent facilities have raised concern that the current $138 allowable charge may also be resulting in unnecessary Federal expenditures.

HHS audit data also showed that the most economical type of dialysis is dialysis in the patient's own home, where the median cost is $97 per treatment. Only about 17% of dialysis patients are currently treated at home, although home dialysis is believed to be suitable for 30-40%.

In March 1981, the Administration's budget for FY 1982 included development of a prospective, single rate system designed to maximize the benefits of marketplace competition

by paying the same rate to all types of facilities. The Omnibus Budget Reconciliation Act of 1981, however, forced HHS to abandon the single rate concept. Instead, the Act requires rates that differentiate between hospital-based and independent facilities, as well as encourage the increased use of home dialysis. The Act specifies a preference for dual composite rates, which would be determined by considering the respective costs of in-facility and at-home dialysis and the respective proportions of patients dialyzing in each location. The same rate would be paid for both in-facility and home dialysis. Composite rates are expected to yield a substantial return to a facility for each patient who is dialyzed at home and a lesser margin for those served in the facility, thus inducing the facility to shift patients to home dialysis where medically appropriate.

HHS Recommendation

The Department has decided to propose a dual composite rate methodology for public comment. Although the rates to be paid to individual facilities would vary with local labor costs, the average rate for hospital based facilities would be $132 per treatment and the average rate for independent facilities would be $128. The same rate would be paid for both home and in-facility dialysis. An exceptions process would be available to allow higher rates for facilities with justifiably higher costs (e.g., pediatric facilities or sole providers in isolated communities). Projected budget savings in FY 1982 depend on how quickly the new rates are implemented, but estimated savings for FY 1983 are $121 million.

The Department determined that the Reconciliation Act requirement for differentiation of hospital from nonhospital facilities should be carried out by adjusting the hospital rate to account only for legitimate higher costs incurred by hospitals as a class. The hospital rate was therefore raised to reflect excess hospital overhead costs resulting from Medicare cost accounting principles that apply only to hospitals. No adjustment was made to recognize the hospitals' generally higher labor and supplies costs, since these have not been shown to be justifiable.

Nonselected Option

An alternative considered but not adopted would be to base the rate for hospitals on all costs incurred by hospitals, whether or not justifiable, and to base the rate for independent facilities on the costs incurred by independents alone. Under this methodology, there would be a wide spread between the two rates, e.g., $141 for hospitals and $116 for independents. This option was rejected because the large differential rewards hospital inefficiencies instead of maximizing the potential for the marketplace to reward efficient operation.

Conclusion

The proposed rates have produced controversy because many firms desire a higher level of reimbursement. Even though in-facility rates are being reduced, facilities nevertheless have ample opportunity to offset the reductions through transfer of patients to low-cost home dialysis, which will now be reimbursed at the same rate as the higher cost in-facility dialysis. The proposed reimbursement system can benefit all parties --

- facilities, by rewarding more efficient operations and increased use of home dialysis;
- patients, by having more opportunities for dialysis at home;
- the Federal government, by lowering expenditures.

(6) by inserting "(including methods established under paragraph (7))" in the fifth sentence of paragraph (6) after "any other procedure";

(7) by redesignating paragraphs (7) through (9) as paragraphs (8) through (10), respectively; and

(8) by inserting after paragraph (6) the following new paragraph:

"(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas). The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6)."

Effective date.
42 USC 1395rr note.

(b) The amendments made by subsection (a) apply to services furnished on or after October 1, 1981, and the Secretary of Health and Human Services shall first promulgate regulations to carry out section 1881(b)(7) of the Social Security Act not later than October 1, 1981.

Supra.

MEDICARE PAYMENTS SECONDARY IN CASES OF END STAGE RENAL DISEASE SERVICES COVERED UNDER CERTAIN GROUP HEALTH POLICIES

42 USC 1395y.

SEC. 2146. (a) Section 1862(b) of the Social Security Act is amended by inserting "(1)" after "(b)" and by adding at the end thereof the following new paragraph:

"(2)(A) In the case of an individual who is entitled to benefits under part A or is eligible to enroll under part B solely by reason of section 226A, payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service furnished during the period described in subparagraph (C) to the extent that payment with respect to expenses for such item or service (i) has been made under any group health plan (as defined in section 162(h)(2) of the Internal Revenue Code of 1954) or (ii) the Secretary determines will be made under such a plan as promptly as would otherwise be the case if payment were made by the Secretary under this title.

26 USC 162.

"(B) Any payment under this title with respect to any item or service to an individual described in subparagraph (A) during the period described in subparagraph (C) shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under a plan described in subparagraph (A). The Secretary may waive the provisions of this subpara-

nmc

National Medical Care, Inc.

50th Floor Hancock Tower
200 Clarendon Street
Boston, Massachusetts 02116
617-262-1200

January 26, 1982

The Hon. James Ciccone
Special Assistant to the President
First Floor West Wing
The White House
Washington, D.C. 20500

Dear Mr. Ciccone:

At the request of Charles Snider, I am forwarding to you some materials regarding the announced intention of the Department of Health and Human Services (HHS) to promulgate a dual rate of payment for treatments furnished under the End Stage Renal Disease Program (ESRD) of Medicare. As you know, we strongly object to this decision of the department on the grounds that it is anticompetitive and would cost Medicare an enormous amount of money.

The materials enclosed clearly document that this decision, if enacted, would destroy the free market which currently is the only force working to control ESRD program costs. The approach announced by Secretary Schweiker would have one of two results: it would either drive total program costs completely out of control, or it would curb the entitlement of patients to care. The latter approach would violate both the law and morality, since each patient under this program is legally entitled to care and the government will not simply let patients die. The former approach is contrary to common sense, since the express purpose of the proposal is to save money. Yet by subsidizing the inefficient hospital sector $4.00 per treatment ($16 million at 1981 levles) and by setting the payment level ridiculously low, that is excatly what this proposal will accomplish.

We favor a system such as is currently in effect, with a single rate of payment set at market levels, which will encourage efficiency. The department should have an exceptions

policy to handle special circumstances of need, but otherwise should force hospitals that currently receive an average of $174 per treatment to either accept the market rate (probably between $145 and $150 per treatment) or let the more efficient facilities treat the patients for those rates. For every treatment which is performed at the lower rate,the government will be saving approximately $25.00. Moreover, for every treatment performed at a taxpaying facility, approximately $7.00 will be refunded to the government in the form of corporate income taxes paid. This could amount to between $40 and $45 million annually.

This method of reimbursement guarantees that facilities operate efficiently, and we believe it is exactly the type of competition in the health care sector which the Administration has been advocating. We believe that the proposal announced by HHS is the antithesis of a competitive system and we know it would destroy the competitive forces which are currently working effectively in the ESRD program.

Thank you for taking the time to review this. We have also discussed this with Robert Carleson at the Office of Policy Development. I would certainly look forward to talking to you myself at any time that is convenient for you.

Very truly yours,

Constantine L. Hampers

Constantine L. Hampers, M.D.
Chairman of the Board

CLH:jf

Health care and politics don't mix

By RONALD REAGAN

Like a fly in amber, the idea that more government is the cure, not the cause, of inflation seems never to change with the passage of time. The same seems true of the notion that government — by way of socialized medicine ("national health insurance") — can bring down the cost of health care.

Despite the evidence here and in other countries that government control of health care encourages overuse, brings out the larceny in some practitioners and discourages efficiency, socialized medicine's adherents stick to it like bees to honey.

This may be due partly to the fact that in most sectors of the federal establishment the idea of making a profit — thus encouraging competition and efficiency — is looked on with distaste, even horror. This belief is most fanatic in the bureaucracy of the Department of Health, Education and Welfare and on Capitol Hill when the issue is health care.

Much is made of the average income of doctors and the profits of drug companies. The idea that anybody in health care might make money from the sickness of others is considered by many in the precincts of government as immoral.

Yet, a scale model for a national health program already in existence for five years shows that the providers can make a profit and save the government money at the same time.

This program involves people with kidney problems (specifically, those suffering from kidney failure or "end-stage renal disease" — ESRD). There are two ways to treat the disease; transplant the kidney or go through dialysis, using an artificial kidney machine three times a week. Most patients are unable to undergo transplantation, so they must rely on dialysis.

In 1973, Congress decided to cover ESRD patients under Medicare, regardless of age. Thus they created the first comprehensive national health care program. It is an expensive one. In the last fiscal year some 34,000 patients were treated at a cost of $640 million and the cost will soon go over $1 billion a year.

It is at this point that a few lessons can be learned for future consideration in the health care debate. Someone, either on Capitol Hill or in the press, discovered that there were a few private firms involved in providing dialysis treatment under this program and doing it for profit. Stories appeared concerning doctors making millions on kidney treatment and a bill, ironically labeled "cost containment" legislation, was passed. It was aimed at withdrawing kidney patients from private facilities and paying facilities on a "cost-related" basis.

Consider some facts: the largest private facility, National Medical Care Inc., treats 17% of the kidney patients, yet receives only eight percent of the program's revenues. While the average cost of providing dialysis treatment at an out-patient facility is $150, the average charge by National Medical Care is only $134.

Non-profit facilities providing the same service as the for-profit ones charge the government as much as $300. In general, the record shows, the for-profit facilities have been performing dialysis for 25-to-35% less than either non-profit outfits or the government.

Despite the fact health care costs have gone up an average of 15% a year, the private costs in this program have gone up at a per capita rate of only 2% since it began. It is probably the only example of cost-containment in government-financed health care.

H.E.W. bureaucrats are now in the process of rewriting the regulations for the kidney program. Experience would lead one to predict that instead of doing the obvious and encouraging more involvement by private companies, H.E.W. will concentrate on how to reduce the profit outfits such as National Medical Care make.

What else can you expect from an agency that can lose — by its own admission — $7 billion a year to fraud and waste?

CLEVELAND PRESS, June 30, 1978

On November 25, 1981, the Secretary of Health and Human Services announced that his department would soon seek to implement a dual rate of payment for dialysis services furnished under the End Stage Renal Disease (ESRD) Program.

This proposal creates two significant problems. The first is that any system mandating a separate payment for hospitals and independent non-hospital dialysis facilities is inherently unworkable. The Health Care Financing Administration (HCFA) itself concedes that there is no justification for the cost disparity between hospital and independent non-hospital facilities. No evidence exists to support the contention that hospitals treat a different or sicker class of patients. Moreover, after studying the three cost components of dialysis services--labor, overhead and supplies--HCFA could not justify making any payment differential. (See Option Memorandum, pp. 2, 3). Their recommendation to pay a differential based upon excess medicare overhead allocation has been severely criticized on the basis that if such a payment were ever to be made, it should be made on a case by case basis. Independent, non-hospital facilities have similar overhead items which are not reimbursed. The result of a dual payment structure such as the one proposed is that all facilities will seek the higher rate through affiliation with a hospital. This is wasteful and unnecessary.

Equally important is the fact that the rates set by the Secretary are far too low ($133 for a hospital; $128 for an independent non-hospital. Today, the average payment to a hospital is $174. The fixed payment to an independent non-hospital is $138). By their own admission (see Option Memorandum, p. 12) HCFA estimates that 48% of all hospital facilities and 30% of all independent non-hospital facilities have costs above these rates, and thus cannot continue to provide service. This raises the issue of how these patients will receive the care to which they are entitled. Either hospitals will receive an exception, at very high rates, or patients will not receive treatment. Neither scenario is tolerable from the standpoint of public policy.

The hope proffered by some that home dialysis will either lower costs or afford a generally acceptable treatment modality to supplant those facilities which would have to close is totally unrealistic. Most studies indicate that dialysis at home costs approximately the same as facility dialysis. If the cost of a paid aide is included, then home dialysis is far more expensive than facility dialysis. In addition, not all patients are suitable candidates for home dialysis. Worldwide, the data indicates that at the most, one patient in five is a suitable candidate for home care.

The solution for the Department is to stress competition through a single payment methodology. Hospitals which can justify hardship will receive exceptions but all others will have to compete at the rate set. This was the proposal which the Department was prepared to make prior to enactment of the Budget Reconciliation Act. The proposal most favored by industry is the one which called for a base rate of $141 per treatment, multiplied by an area wage adjustment, with reimbursement for bad debt accounts. If this proposal were adopted, it would assure that all patients would receive care. Moreover, it would provide substantial program savings ($50 - $100 million, depending upon the level of exceptions granted), by shifting patients from high cost ($174) treatment centers to low cost ($141) centers. (See Memo attached).

A single rate of payment which is clearly permissible under the provisions of the Omnibus Budget Reconciliation Act (see opinion letter, attached) at an acceptable market rate will attract the private capital that is required to provide low-cost treatment. If this capital is not invested, then the government is in effect replacing it through higher per treatment rates to hospital facilities. Conversely, if the payment rate offers appropriate incentives, private

industry will invest; new, low-cost facilities will open, and older facilities will be renovated and program costs will be reduced. There will be competition to offer the service and costs will be contained.

Failure to devise a competitive reimbursement system will result in either a loss of entitlement to care by the patients, which would be illegal, or an enormously greater program expense as all facilities will ultimately be reimbursed on the basis of their costs. This is completely unnecessary, as the environment for a successful, cost containing reimbursement system already exists.