BACKGROUND

Last week, the Secretary of Health and Human Services announced that he intended to propose reimbursement regulations for the End Stage Renal Disease program which would pay hospital facilities $133 per treatment and non-hospitals $128 per treatment (See Exhibit "A"). At the present time, hospitals receive $174 per treatment on the average and non-hospital facilities accept a flat rate of $138 per treatment. This is substantially the same proposal that was made by the Carter Administration last September, which was severely criticized at that time and ultimately abandoned. When Secretary Harris made her proposal, the Office of Management and Budget (OMB) intervened and demanded justification for paying hospitals a different rate than non-hospitals. (See Exhibit "B"). The Department then, as now, could produce no such justification. Quite the opposite,they have informed the Secretary that no justification in fact exists. (Exhibit "C"). In essence, HHS is proposing to give hospitals a $5 per treatment subsidy for performing the treatments at a time when private industry will perform them for a lower rate. It is our position that the proposal must be rejected, essentially for the following reasons:

1. Only a single rate approach will result in program savings.

Without competition from private sector, independent dialysis units, hospitals will demand, and receive, higher payments. It is only the threat of losing patients to independent facilities which will force them to accept a lower rate. A dual rate approach destroys competition in the marketplace and rewards the high cost providers. Only the utilization of a single rate approach, as outlined in the attached (Exhibit "D") will produce true program savings through competition. If the low cost providers, whether hospital or non-hospital, increase their market share to 78% then a savings of $104.85 million will be realized immediately and perpetuated from year to year.

2. <u>The proposal will result in increased program costs, not decreased program costs</u>.

The attached memorandum (Exhibit "E") demonstrates that the impact of the annual proposal is very severe on the efficient facilities. Their removal from the program will result in a patient shift to hospital based units. Under the dual rate approach, hospitals will end up dominating the marketplace, and they have historically shown to be the least efficient provider of treatment. With less competition from the private sector, their ability to demand and receive higher payments will increase.

Moreover, every treatment which is shifted from a taxpaying facility to a hospital is a loss of at least $6 of tax revenue to the government, therefore further increasing the true costs of the program. At the present time the government receives approximately $22 million in tax revenue from treatments at dialysis units. This will shrink significantly under the new propoasl (See Exhibit "F").

3. The rates set are unrealistically low.

The Department ignored the analysis prepared by the Office of the Assistant Secretary for Planning and Evaluation, which had recommended a unitary payment with $141 base rate (including payments for bad debt), a realistic rate in light of the fact that the rate has been set at $138 for nearly nine years, and adopted a totally arbitrary and indefensible number. Neither $128 nor $133 is acceptable to the industry, which in 1978/79 had costs in excess of $126 per treatment. The figures selected were from unreliable costs data which is now four years old.

4. A dual payment approach is not required by law.

The Budget Reconciliation Act does not require different rates of payment for different treatment modalities. (Exhibit "G").

Rather, it requires separate analysis of each modality and justification if a higher rate of payment is to be made. It has already been noted (Exhibit "C") that the Department is on record to the effect that it cannot justify any payment differential.

5. A dual rate approach is inconsistent with the philosophy of the Administration.

As the attached article by the President indicates, (Exhibit H) he has been a severe critic of this type of approach in the past. In fact, a dual rate approach rewards inefficiency and destroys the most effective cost containment mechanism any Medicare program currently enjoys--the fact that private industry has an incentive to compete with hospitals and make a profit by offering better service at lower costs to the government. Moreover, as previously indicated, private industry returns revenue to the government in the form of taxes, approximately $6 for each treatment. It seems much sounder to encourage more treatments at these facilities rather than to pay a $5 per treatment subsidy to have them performed at non-taxpaying facilities. Each time this happens, the government loses $11.

LIST OF EXHIBITS

"A" THROUGH "H"

EXHIBIT "A"

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Wednesday, November 25, 1981

Laura Genero (202) 245-6343
(703) 750-0953

Secretary of Health and Human Services Richard S. Schweiker announced today that he would propose regulations establishing new rates of payments to facilities providing kidney dialysis services under Medicare. Secretary Schweiker stated that "The new rates will significantly reduce Federal expenditures and encourage the increased use of less expensive home dialysis methods."

Under the proposal, hospital-based facilities would generally receive $133 for each dialysis service provided and independent facilities would receive $128 for each service. The same payment would be made whether the dialysis is provided in a facility or at the patient's home, thereby creating an incentive for increased use of less costly home dialysis.

The new regulations will implement provisions in the Omnibus Budget Reconciliation Act of 1981. As specified in that Act, the methodology used under the proposal results in composite weighted rates that take into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing services in each setting. The proposal also contemplates an exceptions process that would permit the payment of higher rates in unusual circumstances, and includes changes in methods of physician reimbursement designed to increase the use of home dialysis.

(more)

Dialysis [illegible] are provided under Medicare to individuals of all ages who have end stage renal disease. In 1980, the program served approximately 57,000 patients at a cost to Medicare of about $1.2 billion.

The Department anticipates that the proposed regulations will be published in December for public comment.

# # #

EXHIBIT "B"

LETTER FROM OMB

12 NOV 1980

Honorable Alair Townsend
Deputy Assistant Secretary, Budget
Department of Health and Human Services
Washington, D.C. 20201

Dear Ms. Townsend:

We have reviewed with interest the proposed new method of reimbursing dialysis facilities under Medicare which was published in the Federal Register of September [illegible], 1980. Although we welcome the initiation of prospective reimbursement for these facilities, the methodology for establishing the rate raises some questions. Specifically, the establishment of different rates for free standing facilities and hospital-based facilities, without evidence clearly establishing that such rates are justified by different case mixes, may tend to undermine one of the purposes of prospective reimbursement—to ensure that care is rendered in the most cost-effective manner possible. Fred Kahn's office has expressed similar concerns.

Accordingly, I would appreciate the Department considering issuing a prospective rate that does not distinguish between hospital-based and non-hospital based facilities and that is based on the costs actually experienced in efficient non-hospital facilities. Exceptions could be granted in areas where facilities could demonstrate that a higher rate was justified on the basis of case mix and other variables. In addition, because of the potential budget impact of these regulations, I request that the Department submit the revised proposed regulations prior to issuance, for review along with an estimate of the budget impact.

Sincerely,

GILBERT S. OMENN

Gilbert S. Omenn
Associate Director for Human
Resources, Veterans and Labor

Official File - Health Branch-OMB
Director's Chron
Mr. [illegible] Mr. [illegible]
Mr. [illegible] Mr. [illegible]
Mr. [illegible] Mr. [illegible]

[illegible] 10/[illegible]/80

MEMORANDUM

EXHIBIT "C"

TO : The Secretary

Through: US
ES
AGC

HCFA

MTP-115-PN

FROM : Carolyne K. Davis, Ph.D.
Administrator

SUBJECT: Regulation Action Memorandum - Proposed Notice - Medicare - Proposed Methodology and Payment Rates for Effective Reimbursement of Outpatient Dialysis - ACTION

I. Program Description

The End-Stage Renal Disease (ESRD) program provides Medicare coverage to virtually all persons with chronic renal failure. The Social Security Amendments of 1972 (P.L. 93-603) authorized Medicare reimbursement for ESRD services furnished to eligible patients by approved hospitals and independent dialysis facilities. In general, in order to be eligible for ESRD program benefits, a person must be undergoing a regular course of renal dialysis or have had a kidney transplant, and must be either: (1) insured under social security at the onset of the disease; (2) a monthly social security beneficiary; or (3) the spouse or dependent child of an eligible person.

Since the inception of Medicare coverage, a number of studies and public hearings have been conducted to assess the operation and effectiveness of the ESRD program. The results indicate that the program has been generally successful in protecting renal disease patients against the catastrophic costs of needed care. However, there have been a number of serious problems which threaten to undermine the stability and effectiveness of the ESRD program. The major problem is the high and steadily rising cost of the program and the burden it could place on the Medicare trust funds unless steps are taken to make it more cost effective.

On July 1, 1973, the ESRD program began operation with about 11,000 beneficiaries. In calendar year 1974, the program paid out benefit payments of about $239 million. By calendar year 1979, there were about 42,100 patients on dialysis. They received a total of over 6 million

→

methodology. We have analyzed these [illegible] and responded to them in this notice. With the publication of this revised methodology, we will allow another 60 day comment period for public review of the methodology and the proposed rates.

The ESRD industry is well organized and will comment timely. Some associations, representing either facilities or intermediaries, may request to meet with us to discuss this notice, in which case we would be glad to comply with their request to discuss these issues.

5. Non-Selected Options

A variety of options are presented in detail in the regulatory analysis, which is Part VIII of the notice. The main options discussed there are summarized here.

A. The major alternative which we expect will be advocated by critics of this proposal will be a dual rate system, paying hospitals and independents separate rates, each based on its own group cost experience. The justification for such a system is that hospitals generally have much higher costs than independent facilities, and that a dual rate structure is appropriate recognition of these differences. However, in our view it is not clear that these higher costs are justified, or that they should be reimbursed.

Hospitals justify their costs on two main bases. They claim that:

- They treat patients that are sicker, have more secondary diagnoses or other complications, or who otherwise require greater attention by more skilled personnel, resulting in increased labor costs;

- They are required, by Medicare reimbursement rules, to allocate a portion of the hospital's overhead and administrative expense to the dialysis facility.

We do not have data to support either of these as a general proposition. It is clear, from analysis of costs reported to us, that about half the difference in cost per treatment is related to labor costs. Hospitals have higher staff-to-patient ratios and more highly qualified staff. However, we do not have

documentation that hospital dialysis patients are sicker, or that their labor costs are justified generally. As for the effect of overhead allocation, based on analysis of the case reported costs, it does not appear that this accounts for a substantial share of the difference in cost per treatment (perhaps about $4 per treatment). There does not seem to be any basis for a difference between hospital and independent facilities in the costs of equipment and supplies, the remaining major components of cost per treatment.

This option would not meet the Administration's announced objective of a single rate, based on the cost experience of independent facilities.

B. A second major alternative would be to set a single rate based on the median cost of both hospital-based and independent facilities, instead of just independents as we have proposed. This would result in a basic rate around $131 per treatment. This single rate methodology was supported by a number of commenters on the NPRM.

This method would produce initial savings similar to those projected for the proposed system. However, we do not believe this is a preferable system, despite probable support from some facilities, because it would lock us into a system that would not be as flexible in subsequent years. By setting the rate at the median, rather than a percentage of the median, we would be vulnerable to arguments that we have placed greater reliance on our audit sample data than is justified and have made no allowance for inflation. Using the hospital cost data seems to guarantee a continuing windfall in later years to those facilities that have already shown that they can furnish dialysis services at a cost below this rate.

C. A third set of alternatives is to use a methodology similar to that we proposed based on the median costs of independent facilities, but to set the basic rate at some level other than the 120 percent of the median that we are proposing. We analyzed the possibility of setting the rate at the median itself, around $108 per treatment. This would be the most economical of the alternatives considered, realizing FY 82 savings of nearly $156.8 million. Using 105 percent of the median, would realize $150.9 million, and 110 percent of the median would yield $137.2 million. (Because

EXHIBIT "D"

Sept. 15, 1981

RE: The effect upon ESRD costs of changing the ration of patients dialyzed in higher cost non-taxpaying institutions to lower cost taxpaying freestanding units.

1. The overall cost will be a simple functon of the fraction of treatments performed in each class of facility and the net price of treatment in each, so that:

Annual Cost = $Rx ((F_h \times P_h) + (F_n \times P_n) + F_p \times (P_p - T_p))$

Where: Rx = Treatments per year delivered to ESRD patients
P = Price of each treatment
F = Fraction of treatments
T = Tax paid per treatment

Subscripts: h = hospital
n = non profit free standing
p = for profit free standing

2. Assume:

a. - Rx = Patients x 156 treatments per year
- 47,000 center dialysis patients
- Rx = 47,000 x 156 = 7,332,000 center treatments per year

b. P_h = $174/treatment originally but may or may not decrease

c. $P_n = P_p$ = $138 originally but increases to $148/treatment

d. $T_p = 1/2 (P_p - C_p)$ where C = Cost = $130/treatment

e. F_h = .5 initially and changes by: $F_h = 1 - (F_p + F_n)$

f. $F_n = .24 \times .50 = .12$ and is constant (24% of free standing units are non-profit)

g. $F_p = .76 \times .50 = .38$ originally and fluctuates in this model

3. The current dialysis costs are estimated to be:

Cost = 7,332,000 (0.50 x $174 + 0.12 x $138 + 0.38 ($138 - $4)
= $1132.65 million

and the cost table which results from patient movement between hospitals and for profit free standing units is:

F_h %	F_p %	Total Cost (millions) Hospital Rate $174	Hospital Rate $160	Savings (millions)	
85	3	1235.3		(87.99)	
80	8	1220.63		(73.32)	
75	13	1205.99		(58.66)	Screen
70	18	1191.30		(43.99)	
65	23	1176.64		(29.33)	remain
60	28	1161.98		(14.67)	$138
55	33	1147.31		(16.15)	
50	38	1132.65			
45	43	1142.55	1096.35	50.96	
40	48	1129.7	1088.65	58.66	
35	53	1116.88	1080.96	66.35	
30	58	1104.05	1073.26	74.05	Screen
25	63	1091.22	1065.55	81.76	increase
20	68	1078.39	1057.86	89.45	
15	73	1065.56	1050.16	97.15	to
10	78	1052.73	1042.46	104.85	$148
5	83	1039.90	1034.70	112.61	
0	88	1027.06	1027.67	120.24	

Box in F_h and F_p columns shows existing ratios and current cost estimates

4. If only 25% (down from 50%) remain in high cost hospitals with a rate of $174/treatment, $41.4 million would be saved. If the effective hospital rate falls to $160, $81.76 million would be saved. Eighty percent of this value is $65.4 million.

If the screen remains $138 per treatment, there will be a 2.5% increase in ESRD dialysis costs for each 10% movement of patients to hospitals. If the screen is increased to $148 per treatment while hospital costs remain unchanged, the break even point will occur after approximately a 7% shift and a savings of approximately 2.3% will be realized for each 10% patient shift thereafter. If hospital cost falls to $150

there is an immediate savings of $28.6 million when the screen is set at $148.

If all treatments are provided at $148 there is an immediate savings of $72.6 million.

nmc

EXHIBIT "E"

National Medical Care, Inc.
50th Floor Hancock Tower
200 Clarendon Street
Boston, Massachusetts 02116
617-262-1200

To: Dr. C. L. Hampers

From: Murray Mathews

Date: December 1, 1981

Re: Implications of $128 Base Rate Structure

As you have requested, we have reviewed the implications to our continued operations of the implementation of a $128 base rate reimbursement structure. We have expanded analyses previously furnished to you to include the effect of the 1980 area wage index, earnings derived from acute and ancillary revenues, and the profits earned by our Lifechem laboratory subsidiary and Erika supply subsidiary. The results of that analysis are as follows:

1. Attached is a listing of 51 facilities servicing approximately 2,200 patients whose continued operation would be seriously threatened by the implementation of such a rate structure as the listed facilities would fail to return to us the cost, including a financing charge at 15%, of owning them.

2. The 2,200 patients treated at these facilities would in all probability be transferred in an orderly fashion, coordinated with HCFA, to a hospital setting. We believe that the estimated incremental cost to the program of providing these 311,000 treatments in a hospital setting would be approximately $12M at the commonly accepted $174 cost per treatment in hospital.

3. We should delete approximately $19.6M of new projects from our 1982 budgeted capital expansion of $24.7M.

MM:jf

Attachment

	INTERIM RATE	OTHER REVENUE	FACILITY NET REVENUE	COST OF SERVICE	BAD DEBT ADD-BACK	RESTATED NPC	OVERHEAD ALLOCATION	NPC INVESTMENT	15% COST OF FINANCING	LIFECHEM PROFIT	ERIKA PROFIT	FACILITY PRE-TAX (LOSS)	1982 BUDGETED TREATMENTS	1982 TOTAL LOSS
[illegible] N.J.	133.74	4.02	137.76	127.22	2.23	13.77	7.70	2263563	339535	0.57	2.86	(11.02)	15780	(163658)
[illegible] N.J.	133.21	7.92	140.13	131.20	5.54	20.47	7.70	1454576	218186	1.40	2.77	(1.45)	11864	(17216)
[illegible] N.J.	138.21	3.90	142.11	120.23	3.20	15.08	7.70	1147606	172141	0.24	2.50	(6.33)	9836	(62769)
[illegible] N.J.	[illegible]	3.06	141.15	121.36	3.18	19.11	7.70	1710039	256506	0.35	2.89	(1.20)	16174	(19403)
[illegible] Pa.	136.00	11.66	148.68	151.91	6.67	3.24	7.70	261211	39182	0.00	2.66	(9.18)	5307	(46714)
[illegible] Pa.	134.20	31.16	165.34	150.37	2.37	16.84	7.70	509552	80433	2.47	1.84	(10.42)	3579	(37290)
North Chicago Ill.	131.60	8.60	140.26	138.32	1.96	3.90	7.70	424437	63666	0.74	1.62	(12.49)	3571	(49293)
[illegible] Ill.	136.66	7.53	144.19	132.02	6.50	18.77	7.70	2053820	308073	0.95	1.72	(26.16)	7722	(201935)
[illegible] Wisc.	138.60	30.85	169.45	135.68	2.27	22.04	7.70	851197	129180	0.34	1.57	(2.65)	6652	(17647)
S.E. Wash. D.C.	135.09	7.38	142.47	117.89	9.72	34.30	7.70	1809599	271439	0.30	1.84	(8.77)	7237	(63470)
Takoma Park Md.	135.09	8.40	143.49	133.93	5.60	15.16	7.70	457254	68588	0.44	1.71	(15.57)	2724	(42419)
Annapolis Md.	135.09	16.63	151.72	158.03	8.01	1.65	7.70	997505	149641	0.82	1.76	(38.92)	4222	(164304)
Fredericksburg Va.	126.99	15.21	142.20	144.09	6.99	5.10	7.70	58376	8756	0.92	2.92	(1.77)	2914	(5145)
Roanoke Va.	126.12	6.00	132.12	133.83	1.80	0.09	7.70	461339	69201	1.04	2.84	(12.85)	7586	(97485)
Martinsburg W.Va.	125.54	13.86	142.40	126.43	5.42	11.39	7.70	612486	91873	0.92	2.03	(29.14)	2568	(74822)
Smyth County Va.	126.99	9.54	136.53	139.84	6.64	3.23	7.70	721230	108185	0.00	2.16	(44.24)	2574	(113877)
Sanford Fla.	123.56	7.48	131.04	128.24	8.57	11.17	7.70	675198	101280	0.00	1.61	(23.12)	3592	(83035)
Sarasota Fla	120.57	4.61	125.58	115.31	8.32	18.59	7.70	932447	139867	0.00	1.68	(4.39)	6248	(30217)
Camden S.C.	124.01	5.60	129.61	137.53	9.56	2.04	7.70	307360	46104	0.96	2.09	(12.21)	4353	(53149)
S. St. Petersburg Fla.	127.50	11.44	138.94	139.58	8.05	7.01	7.70	163042	24456	0.00	1.68	(6.59)	3225	(21251)

	[illegible]	OTHER REVENUE	FACILITY NET REVENUE	COST OF SERVICE	BAD DEBT ADD-BACK	RESTATED NPC	OVERHEAD ALLOCATION	NMC INVESTMENT	15% COST OF FINANCING	LIFECHEM PROFIT	ERIKA PROFIT	FACILITY PRE-TAX LOSS	1982 BUDGETED TREATMENTS	1982 TOTAL LOSS
[illegible] Fla.	133.11	7.44	140.55	141.69	12.98	11.84	7.70	1295986	194548	0.00	1.69	(5.50)	16330	(92909)
[illegible] Fla.	[illegible]	13.02	146.14	161.58	15.00	(2.44)	7.70	2107808	316171	0.00	1.76	(59.40)	5268	(350372)
[illegible] Fla.	127.60	6.35	133.95	157.31	12.99	(9.37)	7.70	198596	29789	0.00	2.17	(22.43)	1700	(55126)
[illegible] Fla.	130.46	6.79	137.25	179.69	12.50	(29.94)	7.70	154189	23128	0.00	2.26	(50.93)	1445	(72673)
[illegible] Fla.	130.46	4.99	135.45	150.59	11.57	(3.53)	7.70	1026616	153992	0.00	1.92	(87.30)	1973	(172339)
N. [illegible] Beach Fla.	133.11	4.67	137.78	127.97	11.56	21.37	7.70	1208309	181298	0.00	2.07	(2.92)	9228	(36173)
[illegible] Fla.	[illegible]	5.26	130.36	133.33	11.63	14.73	7.70	877063	131559	0.00	2.69	(8.61)	7025	(67510)
[illegible] Ala.	127.84	16.00	135.94	141.43	3.97	1.48	7.70	219206	32886	0.00	2.73	(15.61)	2721	(42473)
[illegible] Ala.	125.16	13.75	138.91	150.07	2.72	(8.44)	7.70	171968	25795	1.05	2.90	(20.77)	3008	(62464)
[illegible] La.	[illegible]	5.01	131.28	122.40	6.93	9.61	7.70	1692932	253940	0.60	1.78	(9.90)	20302	(192816)
[illegible] La.	126.27	3.67	128.94	131.75	8.77	5.95	7.70	103295	15509	0.00	2.15	(6.98)	2220	(14603)
E. New Orleans La.	126.12	4.42	130.74	151.10	7.56	(12.80)	7.70	368615	55292	0.00	1.75	(44.61)	2137	(95336)
[illegible] Texas	122.03	9.18	122.21	121.34	7.87	16.74	7.70	505309	75796	1.19	1.24	(6.77)	3744	(25350)
[illegible] Arkansas	125.50	6.40	135.40	118.94	3.57	19.97	7.70	1012087	151813	0.00	3.10	(4.10)	7799	(31960)
[illegible] Texas	131.06	6.25	137.31	122.26	10.38	25.43	7.70	509090	76364	0.00	1.49	(0.58)	3866	(2225)
[illegible] Creek Texas	131.06	3.65	134.71	124.75	8.92	18.63	7.70	1113101	166965	1.56	1.43	(30.27)	3757	(113712)
[illegible] Texas	124.76	7.90	132.66	131.21	9.10	10.55	7.70	314226	47134	0.63	2.31	(10.78)	2898	(23499)
[illegible] Texas	121.16	21.17	142.33	130.64	10.02	21.71	7.70	1030235	154535	1.30	1.23	(18.93)	4262	(61157)
[illegible] Texas	132.03	27.70	159.73	103.52	11.96	(26.53)	7.70	455408	68311	0.00	1.63	(61.15)	2000	(122303)
[illegible] Texas	123.03	18.50	141.53	141.56	11.22	11.30	7.70	754454	113168	0.00	1.11	(27.74)	3493	(97029)

	ALLOWED RATE	OTHER REVENUE	FACILITY NET REVENUE	COST OF SERVICE	BAD DEBT ADD-BACK	RESTATED NMC	OVERHEAD ALLOCATION	NMC INVESTMENT	15% COST OF FINANCING	LIFECHEM PROFIT	ERIKA PROFIT	FACILITY PRE-TAX LOSS	1982 ALLOCATED TREATMENTS	1982 TOTAL LOSS
[illegible] Calif.	146.42	5.85	152.28	140.75	6.42	17.94	7.70	1375037	191256	1.25	1.02	(18.85)	5927	(112339)
[illegible] Falls Calif.	141.10	14.50	155.60	150.23	4.05	10.42	7.70	688294	137244	1.22	1.85	(9.65)	6614	(83263)
Santa [illegible] Calif	130.65	17.40	148.05	144.98	2.20	5.40	7.70	620586	102068	1.79	1.91	(14.39)	6462	(93005)
[illegible] Calif.	131.95	10.28	141.23	137.67	2.80	9.16	7.70	303358	140004	0.00	1.96	(7.48)	13659	(102003)
Santa [illegible] Calif.	142.10	12.30	154.40	152.03	1.47	3.84	7.70	1017908	151650	0.63	1.71	(29.98)	5291	(158612)
[illegible] Calif.	133.75	26.10	160.85	146.75	4.33	18.09	7.70	325750	49013	0.00	1.90	(7.27)	2498	(16171)
[illegible] Calif.	143.34	7.36	150.70	146.89	6.95	12.56	7.70	1257470	188620	1.00	1.56	(2.00)	18060	(40555)
Fort Collins Colo.	119.99	9.05	128.64	163.17	4.91	(28.62)	7.70	805378	135802	0.00	2.53	(51.04)	2374	(230916)
[illegible] Calif.	139.76	11.94	151.70	164.95	3.31	(9.97)	7.70	340232	45036	0.00	1.75	(41.54)	1758	(73029)
Albuquerque N.M.	133.04	11.94	120.98	110.78	1.20	11.00	7.70	250098	37515	0.00	2.12	(0.53)	6237	(3212)
[illegible] City Fla.	127.60	7.66	135.26	129.64	10.14	16.76	7.70	520846	78127	0.00	1.42	(17.22)	3442	(42063)

Explanation of the Column Headings and Computations Follow:

INDEXED RATE - The indexed rate is derived from a base rate of $120 (labor component of $40.64 and non-labor component of $79.36). The labor component only has been adjusted by the area hospital wage index for each facility as published in the Federal Register September 30, 1981.

OTHER REVENUE - Budgeted 1982 revenues to be derived from providing acute treatment services to hospitals, ancillary services, etc., divided by 1982 budgeted treatments.

FACILITY NET REVENUE - Indexed rate plus other revenue.

COST OF SERVICE - Budgeted 1982 cost for all facility services.

BAD DEBT ADD-BACK - The amount of expense included in column (2) which would not be incurred under the proposed reimbursement structure. It is based upon the specific experience of each individual facility.

RESTATED NFC - Facility net revenue less cost of service plus bad debt add-back.

OVERHEAD ALLOCATION - The expected charge per treatment to each facility for the cost of common services provided by National Medical Care, Inc and Bio-Medical Applications Management Company, Inc.

NMC INVESTMENT - The amount of net investment in each specific facility of National Medical Care, Inc, as it appears on its books as of September 30, 1981.

15% COST OF FINANCING - 15% of NMC investment.

LIFEGUM PROFIT - Actual profit level, per facility, of NMC subsidiaries providing laboratory services.

ERIKA PROFIT - Representative profit of supply subsidiary (profit margin times 1982 budgeted facility supply usage).

FACILITY PRE-TAX PROFIT - Facility contribution less overhead allocation less cost of financing plus subsidiary profits.

1982 BUDGETED TX - 1982 budgeted treatments.

1982 TOTAL PROFIT LOSS - Per treatment amount exploded to full dollar impact.

EXHIBIT "F"

The Effect of Corporate Tax Payments on the ESRD Program

Efforts to achieve a $100 million annual savings from the budget of the ESRD program have thus far not been successful. No proposal currently before the Secretary of HHS can achieve this result.

The proposal closest to achieving this goal is one which proposes to pay both hospitals and non-hospitals the same rate per treatment, thus maximizing efficiency and promoting savings through competition. This approach has worked successfully in this program previously. The projected savings from this proposal would be $90 million annually.

If this approach were adopted, however, the net savings to the government would actually be greater. Essentially, the savings are calculated from the number of patients who currently receive their treatments at a high cost ($174 per treatment hospital) facility who will shift to a lower cost facility. It is anticipated that a rate of approximately $141 per treatment will be set for all treatments.

The point which has been heretofore disregarded, but which is a real budgetary consideration in this program is the effect of taxes paid by proprietary institutions. Most (75%)

of the low cost facilities are tax paying institutions. The transfer of patients will either be to those facilities or to non-profit facilities who chose to accept the lower rate. The budgetary projections are based upon a transfer of approximately 25% of patients from high cost to low cost facilities.

Proprietary institutions currently pay approximately $6*/ per treatment in federal income taxes. This means that approximately $22,000,000 in revenue is returned to the federal government from treatment payments made to proprietary facilities. If the budget projections for the single payment proposal are correct and there is a 25% shift in patients, and that shift occurs in the same 75/25 ratio as presently exists between proprietary and non-proprietary institutions there will be an additional $8,250,000 returned in taxes. If all shifted treatments were done at taxpaying facilities, the returned revenue would be $11,000,000.

While it is recognized that this approach of including tax revenue as budget savings has not been adopted in the past, certainly the converse has. If the proprietary facilities were removed from the program, this would unquestionably increase program costs in real dollars from the tax dollars

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*NOTE: At a rate of $141 per treatment, proprietary institutions would likely pay approximately $7 per treatment in income taxes, thus returning between $10,000,000 and $12,000,000 in revenue, as opposed to between $8.25 and $11 million.

lost. This fact has been recognized in other areas. In the ESRD program, since the revenue comes almost exclusively from the federal government, it seems prudent to include the tax revenue returned as an acceptable budget saving item.

Indeed, this is consistent with the philosophy of the Administration to generate increased revenue for the budget without increasing taxes. In this program, that goal can be achieved and will be achieved by encouraging treatments at tax paying facilities, which is accomplished by paying all types of facilities the same rate. There is no reason not to recognize that fact when calculating budget savings.

EXHIBIT "G"

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November 13, 1981

Constantine L. Hampers, M.D.
Chairman, Board of Directors
National Medical Care, Inc.
50th Floor Hancock Tower
200 Clarendon Street
Boston, Massachusett 02116

Re: Proposed Regulations to Implement Section 2145 of the Omnibus Reconciliation Act of 1981.

Dear Dr. Hampers:

You have asked that we advise you whether, and under what circumstances, the Medicare statute, as amended by Section 2415 of the Omnibus Reconciliation Act of 1981, contemplates a differential in the rates of prospective reimbursement for hospital and independent outpatient dialysis.

As you know, Section 2145 of the Omnibus Reconciliation Act of 1981 adds Section 1881(b)(7)[1] to the Social Security Act. P.L. 97-35, §2145 (1981) That new section requires the Department of Health and Human Services to issue regulations establishing a method (or methods) for the prospective determination of provider reimbursement under the Medicare Part B ESRD program. We understand that the Department is in the process of preparing proposed regulations to implement Section 1881(b)(7).

We believe that, under the Medicare statute as amended:

1. Although prospective reimbursement rates for both hospital-based and independent outpatient ESRD facilities are to be separately determined, both rates must reflect the efficient delivery of dialysis services to patients.

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[1] 42 U.S.C. §1395rr(b)(7)

2. The basic hemodialysis service provided by hospital-based and independent outpatient facilities is identical.

3. Accordingly, to the extent the proposed regulations provide for any difference in the rate of reimbursement for the provision of the same service by the two types of facilities, that difference can only be justified to the extent persuasive evidence demonstrates that factors necessarily inhere in the operation of the facility by a hospital which directly increase the cost of efficiently providing outpatient dialysis services over the cost of providing the same services in an independent facility.

4. Evidence that hospital based outpatient dialysis treatment presently incur higher costs is not sufficient to meet this burden. Rather there must be persuasive evidence that the higher costs incurred by hospital based facilities could not be eliminated by efficient management because of factors inherent in, and unique to, the hospital setting.

We believe this construction to be compelled by the statute and its policy. Section 1881(b)(7) requires the Secretary of Health and Human Services to "provide by regulation for a method (or methods) for determining prospectively" (sic) payments for dialysis services. The prospective rate is to be established by use of a "single composite weighted formula" for both facility and home-based care, and must take into account "the mix of patients who receive dialysis services in a facility or at home and the relative costs of providing ... services" in facility-based and home-based settings. The Secretary must separately establish composite formulas for hospital-based and for independent dialysis facilities. That the basic purpose of Section 1881(b)(7) is to secure the efficient delivery of hemodialysis services is demonstrated by the grant to the Secretary of the power to establish an alternate method of reimbursement if "detailed analysis" reveals that the alternate method "will more effectively encourage the efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis services." (emphasis supplied)

Section 1881(b)(7)'s provision for separate calculation of prospective reimbursement rates for hospital based and independent facilities, does not require a differential in the

rates of reimbursement reached by these separate calculations. Nowhere does the statute create a presumption that hospitals are entitled to a higher rate of reimbursement than independent facilities providing the same services. Nor does the amendment alter the Medicare statute's commitment to assuring the most efficient and economical delivery of renal dialysis services possible consistent with the provision of quality care. Indeed, it strengthens that commitment.

Section 1881(b)(2)(B) of the Social Security Act, as amended by Section 2145 of the Omnibus Reconciliation Act of 1981, directs the Secretary, with respect to the Medicare Part B ESRD program, to

> "prescribe in regulations any methods and procedures to ... (ii) determine, on a cost-related or other economical and equitable basis (including any basis authorized under Section 1861(v))[2] and consistent with any regulations promulgated under paragraph (7), the amounts of payments to be made for Part B services furnished by providers and facilities to such individuals." 42 U.S.C. §1395rr(b)(2)(b) (emphasis supplied).

Section 1861(v), which is specifically referenced in Section 1881(b)(2) above, directs the Secretary to exclude from reasonable cost "any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. §1395x(v)(1)(A). And as noted above, Section 1881(b)(7) itself encourages the Secretary to adopt an alternate method or methods of determining prospective reimbursement for dialysis services if he finds an approach which will:

> "more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis services than through the single composite weighted formulas." (emphasis supplied)

This confirms the drafters' intent that the Secretary establish a method of prospective reimbursement which will effectively assure the economical delivery of services.

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2 42 U.S.C. §1395x(v).

Thus, the provision of reimbursement based on efficient costs is an overriding concern of the Medicare statute, and of its ESRD provisions. Both hospital-based outpatient dialysis and dialysis services provided by independent facilities must meet this test. Because the basic dialysis services provided by independent facilities and by hospitals on an outpatient basis are identical, any differential in the prospective rate can be justified only by persuasive evidence that differences in cost inhere in the nature of the two types of facilities. Evidence that hospitals typically pay more for personnel or to procure supplies and equipment would not meet this test. Where hospitals and independent facilities have the same opportunity to achieve efficiency, and hospitals have not on average done so, neither the ultimate rates established, nor the calculation used to reach them, should incorporate a windfall benefit to hospital providers based solely on their inefficiency.

We have reviewed the recent article which you published, together with Dr. Edmund G. Lowrie of the Kidney Center, in the August issue of The New England Journal of Medicine and Surgery. The article demonstrates that in inflation-adjusted real terms the average annual cost per patient of dialysis treatment declined nationally from $14,895 in 1974 to $12,212 in 1979, due largely, and perhaps entirely, to the efficiencies achieved by independent dialysis facilities. The article also demonstrates from HCFA data (see Table 2) that there are no clinically important differences between the patients receiving outpatient dialysis services in hospitals and those receiving services in independent facilities. If anything, the patients served by independent facilities appear, because of their age, race and disease characteristics, to be at greater medical risk.

To our knowledge, and in the face of this evidence, there appears to be an absence of the evidence necessary to justify higher costs and a higher reimbursement rate for hospitals based on the characteristics of their patients. Inefficiencies in the use of personnel, in procurement or in similar areas cannot justify a rate differential. Only the identification of specific costs that apply uniquely to efficient provision of outpatient dialysis in a hospital setting can do so.

Very truly yours,

Hale and Dorr

HALE AND DORR

E PIERSON
ID COHEN
AETMORE, JR
OGHEGAN
ANIE
REEN
SCHAEFF
OLEMAN
OX
TZ
AWTON
LARK
RSON
OVEER
AN III
SINGER
ULE
DMAN
OYAL
MARINO III
ONTZ-
F. CARR III
ACKSON
INEMAN
OSS
UTCHINSON III
ARVEY
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MASCO

HARRISON F. SLAUGHTER
DEAN PURCH
ROBERT B. [illegible]
WILLIAM O. BITTMAN
PETER D. O'CONNELL
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RETIRED 1980

October 15, 1981

Carolyne K. Davis, Ph.D.,
Administrator
Health Care Financing Administration
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Davis:

We write on behalf of Community Psychiatric Centers which operates 37 freestanding facilities across the United States that provide hemodialysis services for patients with end stage renal disease (ESRD). We understand that the Department of Health and Human Services (HHS) is currently considering options for implementation of the provisions on reimbursement of dialysis services under the Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35, § 2145 (1981)). We submit the following comments in support of our legal conclusion that, under the amended statute, the Secretary of HHS may establish formulae that limit the differential between hospital and independent facility rates to variations in costs that exist for reasons other than relative efficiency, i.e., variations that cannot be eliminated through more efficient operations. To accomplish this result, the Secretary may afford different weight to comparable kinds of costs incurred by hospitals and independent facilities so as to exclude from reimbursement costs found to be unnecessary in the efficient delivery of dialysis services. In fact, since the Secretary must establish rates that encourage efficiency, we believe this approach is mandated.

BACKGROUND OF THE ESRD PROGRAM

Section 299I of the Social Security Amendments of 1972 (Pub. L. No. 92-603) amended title II of the Social Security Act to provide that fully or currently insured individuals

under Social Security (and their dependents) with chronic renal disease would be considered disabled for purposes of coverage under parts A and B of Medicare. 42 U.S.C. § 426(e) (1972). */ This change in the law has resulted in nearly universal coverage for chronic maintenance dialysis services under the Medicare program.

Since 1974, the Medicare program has used a national "screen" of $138 to limit payment for dialysis services. Hospitals are paid the lower of their costs or the screen. Independent facilities receive the lower of their charges or the screen. Hospitals and independent facilities may also request exceptions to the screen as a result of higher costs. However, while nearly half of the hospitals that provide dialysis services operate under an exception, exceptions for independent facilities are extremely rare. According to data recently compiled by the Health Care Financing Administration (HCFA), the average payment for dialysis services in hospitals is $159, and the average payment in independent facilities is $138.

Following several years of rapid growth in the ESRD program, Congress enacted legislation in 1978 which, among other things, directed the Secretary of HHS to develop incentive reimbursement methods for dialysis services. (Pub. L. No. 95-292, § 2 (1978).) The 1978 legislation added a new section 1881(b)(2)(B)(ii) to the Social Security Act requiring the Secretary to develop regulations for determining payment for dialysis services "on a cost-related basis or other economical and equitable basis...." 42 U.S.C. § 1395rr(b)(2)(B)(ii) (1978). The statute further provided that "[s]uch regulations shall provide for implementation of appropriate incentives for encouraging more efficient and effective delivery of services (consistent with quality of care)...." 42 U.S.C. § 1395rr(b)(2)(B) (1978).

On September 26, 1980, HHS published a notice of proposed rulemaking to implement the incentive reimbursement provisions. 45 Fed. Reg. 64008-14. However, the Secretary of HHS never promulgated final regulations following this proposal.

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*/ The provisions on Medicare coverage for individuals with ESRD were subsequently transferred to 42 U.S.C. § 426A by Pub. L. No. 95-292, § 1 (1978).

DISCUSSION OF SECTION 2145

Section 2145 of Pub. L. No. 97-35 establishes a new paragraph (7) under section 1881(b) of the Medicare statute. 42 U.S.C. § 1395rr(b)(7). This provision governs payment for renal dialysis services. Paragraph (7) requires the establishment of a method (or methods) for prospective determination of a rate (or rates) for dialysis services furnished by hospitals and independent facilities based upon (1) a single composite formula for hospital-based facilities and a single composite formula for other renal dialysis facilities, or (2) such other method (or methods) determined by the Secretary to more effectively encourage the efficient delivery of dialysis services than the composite rate (or rates).

The legislative history of this amendment does not provide specific directions to the Secretary on the implementation of section 1881(b)(7) other than an explanation of how the "composite" feature of the formulae is to be weighted in favor of home dialysis. (The issue of weighting the composite formulae is not addressed in this letter.) However, the language of section 1881(b), read in its entirety, makes it clear that the Secretary of HHS is required to develop rates that encourage effective, economical, and efficient delivery of dialysis services to eligible Medicare beneficiaries.

In developing the new payment requirements, Congress retained section 1881(b)(2)(B)(ii) which requires the Secretary to

> prescribe in regulations any methods and procedures to ... (ii) determine, on a cost related or other economical and equitable basis (including any basis authorized under section 1861(v)) and consistent with any regulations promulgated under paragraph (7), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals.*/

This section directs the Secretary to utilize economical bases for establishing payment rates and specifically incorporates the principles in section 1861(v) as additional authority for setting payment rates. Under section 1861(v)(1)(A), the

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*/ Section 2145 added the language "and consistent with any regulations promulgated under paragraph (7)."

Secretary of HHS has broad discretion to define the parameters of reasonable cost. The Secretary is specifically required to exclude from a provider's actual costs "any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A). In order to implement this mandate, the statute authorizes the Secretary to develop regulations which limit the recognition of costs for classes of providers:

> Such regulations...may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services recognized as reasonable....

42 U.S.C. § 1395x(v)(1)(A). Further, the regulations "may provide for using different methods in different circumstances" to calculate reasonable cost. 42 U.S.C. § 1395x(v)(1)(A).

Thus, under 1861(v), which is incorporated by reference in section 1881(b), the Secretary has broad authority to define cost and to exclude costs that result from inefficiency. For example, under this authority, the Secretary has adopted limits on costs for various classes of providers. The methodologies utilized by the Secretary to define the scope of inefficiency have varied based upon the factors present in each case. Therefore, to the extent not otherwise precluded under section 1881(b), the Secretary would have authority to establish different payment methods for hospitals and independent facilities that take into account their efficiencies in providing dialysis services to Medicare beneficiaries.

The one remaining issue is whether anything in section 1881(b)(7) would preclude this result. We would submit that, to the contrary, this section requires the Secretary to consider efficiency in setting payment rates.

While section 1881(b)(7) requires the Secretary to establish separate formulae for hospitals and independent facilities, there is no requirement that the formulae developed by the Secretary be uniform. Congress could easily have imposed such a requirement upon the Secretary but chose instead to mandate only separate formulae based upon an assessment of the costs of the two types of providers. The statute leaves to the Secretary's discretion the application of the two formulae and the determination of how each type of provider will be reimbursed for dialysis services.

Moreover, section 1881(b)(7) itself imposes the requirement that payments be based upon methodologies that encourage efficiency. First, as noted above, paragraph (7) must be read in conjunction with sections 1881(b)(2)(B)(ii) and 1861(v) which require the Secretary to base the determination of rates for dialysis services on considerations of economy and efficiency. Secondly, the alternative method authorized by paragraph (7) specifies that it is to be applied if the Secretary determines that such method "will more effectively encourage the efficient delivery of dialysis services" (emphasis supplied). Implicit in this language is the requirement that either method must encourage efficiency and that the alternative method is to be applied only if it results in greater efficiency. In both cases, rates that encourage efficiency are mandated.

Thus, in establishing the formulae for hospitals and independent facilities, the Secretary has authority under sections 1881(b) and 1861(v) to exclude those portions of cost for each class of provider that are found to be unnecessary in the efficient delivery of dialysis services. For example, in considering supply costs, the Secretary could properly conclude that there is no reasonable basis for any cost differences between hospitals and independent facilities. If the Secretary concluded that supply costs of independent facilities represented efficient operations, he should not recognize that portion of the hospital supply costs which exceeds independent facility costs.

Similarly, the Secretary should determine the appropriate labor costs for providing dialysis services in hospitals and independent facilities and exclude from recognition those costs that are unreasonable. To the extent that no probative evidence exists showing that the higher labor costs in hospitals are necessary for the efficient delivery of services, it would be inappropriate for the Secretary to construct a hospital rate formula recognizing those costs. */

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*/ Compliance with requirements imposed by the government could justify higher costs. In this regard, HCFA has found that, as a result of the Medicare cost allocation process, hospitals incur higher overhead costs than independent facilities. We understand that this difference in cost is between $1 and $4 per treatment.

(Footnote continued)

CONCLUSION

There is no basis in the amended statute or in its legislative history for the conclusion that one reimbursement formula must be uniformly applied to hospital and independent facility costs. Indeed, uniformity would be prohibited unless uniform application would encourage the efficient delivery of services in both classes of provider. In order to satisfy the statute, we believe the the Secretary must develop methods for payment of dialysis services which exclude those costs that are unnecessary in the efficient delivery of services. While the Secretary is directed to develop separate formulae for hospitals and independent facilities, he retains full discretion to define those costs that will be recognized in applying the formulae. Thus, if all or a portion of the higher costs attributable to hospital dialysis services is the result of inefficiency, the Secretary is authorized to exclude those costs from recognition under the hospital formula. This approach preserves the intent to establish separate formulae while retaining the Secretary's authority to limit any differential in the rates to variations in costs that exist for reasons other than relative efficiency.

(Footnote continued)
It should also be noted that costs in excess of rates established by the Secretary can be recognized in exceptional circumstances. It was clearly the intent of the conferees responsible for the recent amendments to the ESRD program under the Omnibus Budget Reconciliation Act that the exceptions process be retained. Conference Report, H. Rep. No. 97-208, 97th Cong., 1st. Sess. 949 (1981). Through this process, the Secretary can address situations where higher costs, such as those associated with providing dialysis services to pediatric patients, are necessary in the efficient delivery of dialysis services.

We would be pleased to meet with you to elaborate upon the points raised in this letter.

Sincerely yours,

PIERSON, BALL & DOWD

Stephan E. Lawton

Eugene Tillman

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

EXHIBIT "H"