

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

January 19, 1999

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

Chris —
You asked
for a packet
of Provider
BBA-type
letters. Barbara

Dear Ms. DeParle;

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

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

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

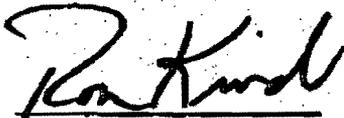
Third, it appears that the new level of reimbursement does not include any provisions for outlier status payment. We believe that accounting for statistical outliers -- such as ventilator dependent patients or other very high cost patients -- is crucial to calculating an appropriate payment for a facility.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

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

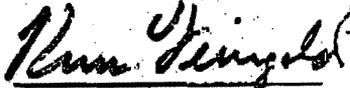
Min DeParle
page 2

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

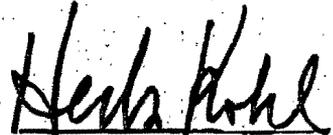
Sincerely,



Rep. Ron Kind



Senator Russ Feingold



Senator Herb Kohl

Enclosure

43 senators calling

for Medicare changes

MS 5/22/99

Michigan Journalist

By JOE MANNING
of the Journal-Sentinel staff

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

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

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

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

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

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

But nursing homes, patients and hospitals are beginning to feel the pinch from the cuts

Nursing homes could close, they warn

that went into effect at the beginning of the year.

"These cuts are causing us (nursing homes) hundreds of dollars a day. Facilities are just now understanding what this means," Saver said.

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

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

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

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

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

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

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

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

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

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

Nursing home administrators say their costs continue to

Please see LETTER page 3

Letter/Senators say new Medicare rules need changing

From page 1

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

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

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

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

"How many of those patients

can we take? How can we afford to do that?" Rau asked.

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

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

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

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

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

But, even with a willing Congress, it could take two years or

longer to straighten out the under-funding problem, Lubarsky said.

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

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

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

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

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

June 17, 1999

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

Dear Mr. President:

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

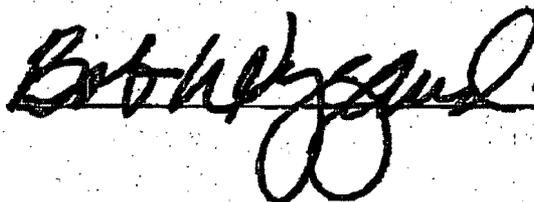
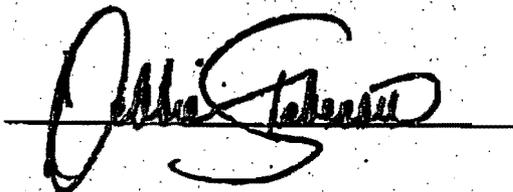
The Balanced Budget Act of 1997 (BBA) made substantial cuts to the Medicare program. While we understand and support the need to address cost savings and issues of fraud and abuse, in some cases we believe the cuts have exceeded their congressionally intended result. Some of these cuts have already led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

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

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

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

Sincerely,



Tom Allen
Bob Sypak

Michael E. Capra
Miss McDermott

Carol E. Kildes

Jan Schabowski

~~Angela White~~

Bob Adams

Cynthia L. Telford

Shelley D. Kelley

Jane White

Hyd. Taylor

Alice L. Hastings

Ron Kist

J. Barcia

~~MAJ. SMO~~

Jim Jones

Ray Jones

Harold E. Smith

Bob Smith

Bobby Beck

Rita M. Lowery

John Conroy

Carol B. White

John (17-04)
Ed Pastor

Charles Romero-Bacelo
Nancy Flores

Jose E. Llanusa
He Keller

Al. Rehall
Tomas

Edward S. Neal

Michael R. McNulty

Jana M.C. Christman

David D. Phelps

Neil Abernethy

Mill look

Michael S. Capron

Sam Tan

Lois Ayers

Paul Brown

Rubin Tinjosa

Grace J. Depalitano

William

John

Flynn E. Cummings

Joseph Crowley

John B. Larson

Conroy H. Davis

John Jensen

Mary Munk

John & Della

Matthew H. Martens

Barney Frank

Ralph M. Hall

Dennis J. Kucinski

Max Frost

Frank Lallone

Frank Mascara

Bob Clener

Pete Altieri

Lynn Woolsey

Barbara Lee

Mark A. Jones

Jed Strickland

John

Earl F. Hilliard

Fai Johnson

Donald Wayne

Gregory B. Coby

David Price

Pete Higgins

Norm Dickis

~~Eric Dickis~~

Al Dunkel

Harold Paul

Bill Powell

John [unclear]

John J. [unclear]

Tom Sawyer

Ed. [unclear]

Wm. [unclear]

Al [unclear]

Ellen [unclear]

Wade [unclear]

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

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

Signers on the 6/17 letter to President Clinton
Page 2

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

Congress of the United States
Washington, DC 20510

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

Dear Mr. President:

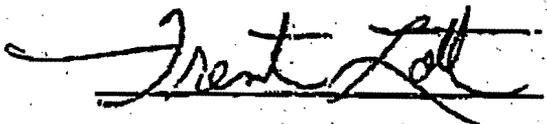
We are writing to express our shared concern regarding the impact of the Balanced Budget Act (BBA), and its proposed implementing regulations, on our nation's nursing homes and the Medicare beneficiaries they serve.

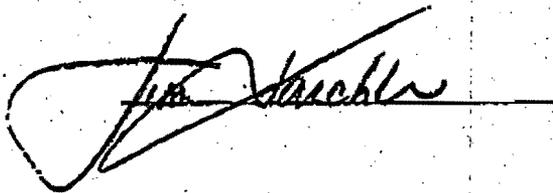
Unfortunately, it was impossible to foresee all the possible unintended effects implementation of the BBA would have on particular categories of care available to Medicare beneficiaries.

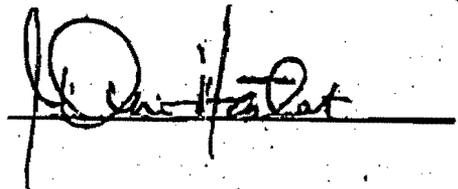
We believe the growing crisis in the nursing home industry stems, in part, from the implementation of the BBA. If steps are not taken to improve reimbursement during the transition to a prospective payment system for skilled nursing facilities, we fear that dedicated care-givers may be laid off, facilities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

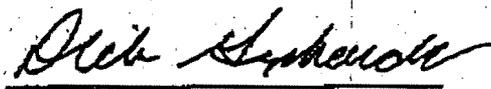
We have been advised the Administration has the ability to address some of these concerns by revising its regulations that are likely contributing to the problem, and by making every effort to ensure that the transition to a prospective payment system does not ultimately harm patients. We would like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

Sincerely,









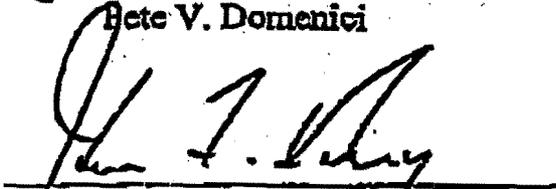
May 19, 1999

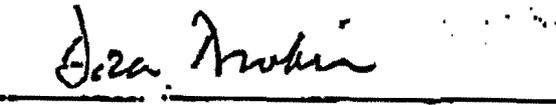
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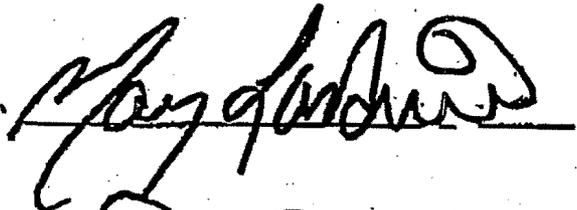
We know you share our commitment to ensuring that elderly and disabled Medicare beneficiaries receive the highest quality care. We would like to work with you in a bipartisan fashion to address this impending crisis in whatever manner is appropriate.

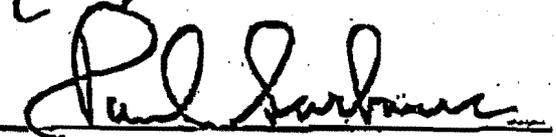
Sincerely,

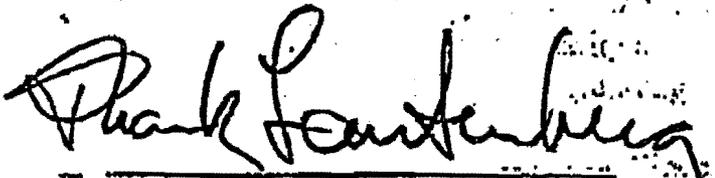

Pete V. Domenici

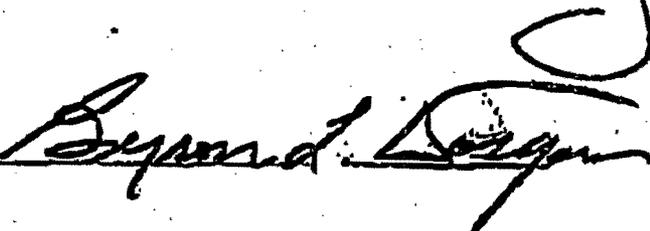

John J. Dingell

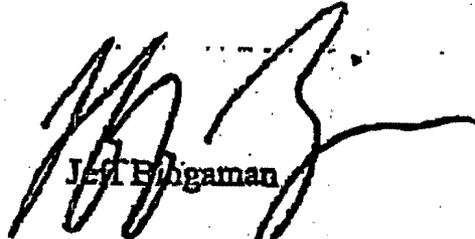

Dora Dymally


Roy Blunt

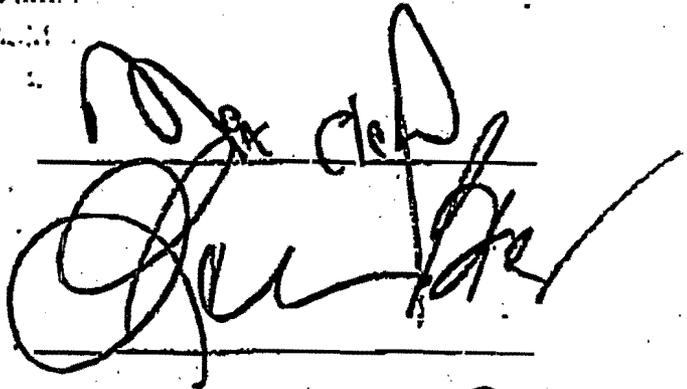

Paul Sarbanes

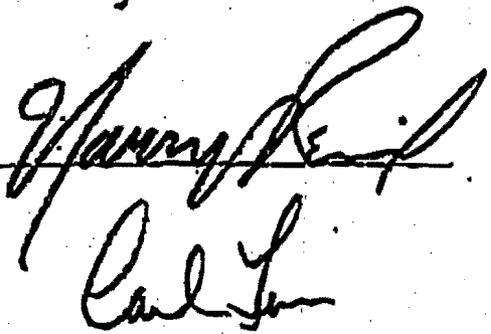

Frank Lautenberg

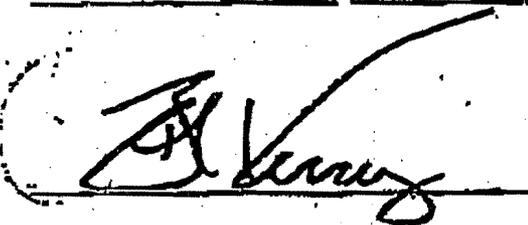

Byron Dorgan


Jeff Bingaman


Tom Wyden


Dan Claitor


Harry Reid
Carl Levin


Bill Kennedy

May 19, 1999

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Tom Varche

Peter Hollings

Robt. Vain

Cluck Robb

Bice Just

DAVID HAGER

Al M. Conell

Rick Sutorum

Blank L. Lincoln

Allen Reed
SNF RS

Mike Tatum

Jim Jefford

Carl

Jeff Bond

Chris Hatch

Spencer Abraham

T. Hutchinson

John Ascroft

Jim Berman

Red Secura

Paul Ryan

Mike Capor

Paul Coburn

Max Baucus

Barry Pomeroy

John Sauer

Robert Bennett

Tom Kupa

Pat Roberts

Lucy Frydell

Robert C. Neuberger

Patty Murray

May 19, 1999

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John McLean

Barbara Pifer

Republican	Democrat
Domenici	Bingaman
Bunning	J. Kerry
Bennett	Wyden
Burns	Durbin
Grams	Cleland
Crapo	Landrien
Campbell	Sarbanes
Cochran	Reid
Warner	Lautenberg
Roberts	Levin
Hutchinson	Dorgan
Santorum	R. Kerry
McConnell	Daschle
Frist	Lincoln
Specter	Hollings
Lott	Robb
Jeffords	Toricelli
G. Smith	Murray
Hatch	Conrad
Hagel	Feingold
Gorton	Mikulski
Abraham	Kennedy
Ashcroft	Baucus
Bond	Wellstone

Kyl	Johnson
Coverdell	Kohl
Craig	Boxer
Voinovich	
DeWine	
Collins	
Sessions	
Brownback	
Shelby	
Chafee	
Lugar	
McCain	

LINDSEY GRAHAM
3rd DISTRICT, SOUTH CAROLINA
EDUCATION AND THE
WORKFORCE COMMITTEE
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Congress of the United States
House of Representatives
Washington, DC 20515-4003

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July 20, 1999

Help Preserve Quality Nursing Home Care for America's Elderly

Dear Colleague:

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

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

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

Sincerely,



Lindsey O. Graham
Member of Congress

ROBERT G. TORRICELLI
NEW JERSEY

COMMITTEES:

GOVERNMENT AFFAIRS

JUDICIARY

RULES AND ADMINISTRATION

FOREIGN RELATIONS

United States Senate

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<http://torricelli.senate.gov/>
Senator_Torricelli@Torricelli.Senate.Gov

June 3, 1999

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

Dear Mr. President:

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

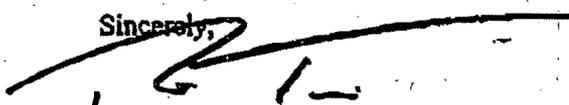
The Balanced Budget Act of 1997 was an important step toward ensuring the long-term strength of the Medicare program; however, the unintended consequences of reimbursement reductions included in the BBA have been economically devastating to skilled nursing facilities (SNFs) in my state. Thus, I want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

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

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

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

Sincerely,



ROBERT G. TORRICELLI
United States Senator

RGT:km

WWW.AHCA.ORG

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

April 29, 1999

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Paul R. Willging, PhD
PRESIDENT

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

Dear Administrator DeParle: *Nancy*

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

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

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

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

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

Administrator DeParle
April 29, 1999

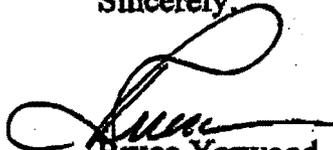
included" in a SNF. HCFA should replace the current market basket index with an index that reflects the average annual change in the prices of SNF outputs. Currently, the Bureau of Labor Statistics has such an index, which, if used, could provide immediate relief to providers and beneficiaries. This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

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

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

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

Sincerely,


Bruce Yarwood
Legislative Counsel

*As you know
we need full
funds!*

SUSAN M. COLLINS
MAINE

172 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-3323
(202) 224-2093 (FAX)

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SPECIAL COMMITTEE
ON AGING

United States Senate

WASHINGTON, DC 20510-1904

July 27, 1999

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

Dear Chairman Roth:

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

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

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

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

The Honorable William V. Roth, Jr.
Page 2

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

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

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

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

The Honorable William V. Roth, Jr.
Page 3

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

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

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

Sincerely,

Susan Collins

Susan M. Collins

Jeff Bond

Christopher S. Bond

Mike Enzi

Carl Levin

Rich Frist

Rich Durbin

Spurr Abraham

Sam Brownback

John Edwards

Alvin Lopez

Frank R. Laufenberg

Wayne Allen

Pat Roberts

J. P. Morgan

United States Senate

WASHINGTON, DC 20510

June 10, 1999

Dear Colleague,

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

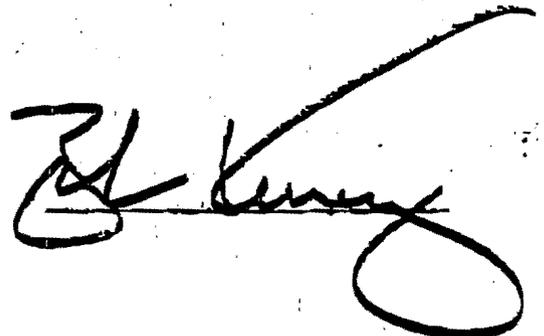
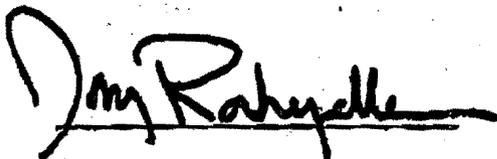
The attached letter opposes the Department's Notice of Proposed Rulemaking for implementation of the outpatient prospective payment system, as required by the 1997 Balanced Budget. Congress must clarify that an unintended minor technical change in the statutory language will impose an additional 5.7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

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

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

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

Sincerely,



United States Senate

WASHINGTON, DC 20510

Draft Letter to HCFA Administrator
The Honorable Nancy Ann Min DeParle

Dear Madame Administrator:

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

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

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

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

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

Sincerely,

United States Senate

WASHINGTON, DC 20510

June 18, 1999

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

Dear Madame Administrator:

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

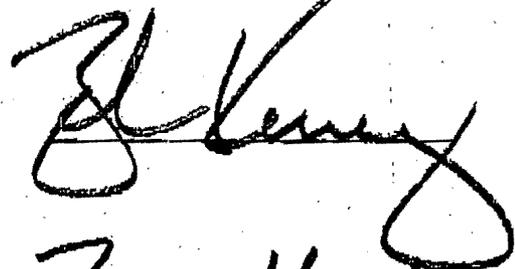
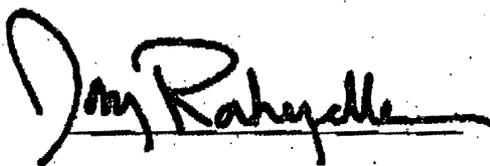
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We urge that HCFA not implement an outpatient PPS rule which is inconsistent with Congressional intent.

Sincerely,



BILL THOMAS, CALIFORNIA, CHAIRMAN
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BILL VAUGHAN, SUBCOMMITTEE MINORITY

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

June 18, 1999

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

Dear Nancy-Ann:

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

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

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

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

Sincerely,



Bill Thomas
Chairman



May 21, 1999

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

Dear Ms. DeParle:

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

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

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

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

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

Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2802
(202) 636-1100

Nancy-Ann DeParle

Page 2

May 21, 1999

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

Sincerely,

A handwritten signature in black ink that reads "Rick Pollack". The signature is written in a cursive, slightly slanted style.

Rick Pollack
Executive Vice President

Attachment

UNITED STATES SENATE
WASHINGTON, DC 20510

WASHINGTON, DC 20510

June 18, 1999

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

Dear Madame Administrator:

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

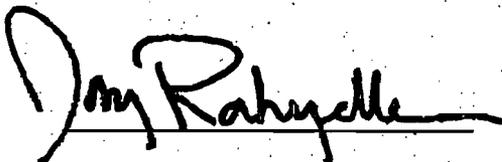
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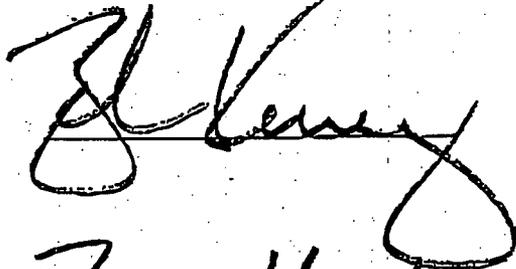
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Congress clearly intended that these changes to outpatient copayments be achieved on a budget-neutral basis - the identical language that originally passed the House and the Senate clearly precluded any payment reduction for this policy. While a minor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

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

Sincerely,









J. L. L...

Byron T. Doyan

Alex Jech ^{9/17/99}

Robert T. Bennett

Jim Jford

Mike DeWitt

Sam Banning

Mark Land

Jay E. King

Sam Hunkeler

Heik Kohl

Jim Johnson

Frank W. Tynall

John Anagnost

Paul D. Webster

Pat Rota

Craig Thomas

George V. Vornoch

Red Arma

T. H. H. H.

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Olympic Snow

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Rick Santorum

Patty Murray

Jeff Bond

Ray Bailey Hutchison

John Warner

Ann Perry

Ben Ray Lujan

Mike Harkin

HCFA Letter
June 18, 1999
Page 4

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Chris Dodd

Carl DeLoach

Jeff Dingman

Walter D. Long

Wayne Allard

Bob Gorton

Laura Collins

Charles Schumer

Chuck Grassley

Max Baucus

Richard Blumenthal

Clude Robb

Paul D. DeLoach

Phil Wyden

Barbara Boxer

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John Edwards

Mike Crapo

Patrick Leahy

Ed Kennedy

Jimmy

Tom Taxtle

Jack Reed

John Breany

Strom Thurmond

Richard Shelby ~~off~~ Senators

Blank R. Lucian

John H. Chayer

Robt. F. Fagel

Em Bayh

Garry Keip



American Health Care Association

1201 L Street, NW • Washington, DC 20005-4014

FAX: 202-842-3860

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BRUCE YARWOOD

Chris
 these seemed
 to a question on
 whether HCFAT could
 assist in "meds train"
 - Will there is David
 again say that there
 is authority to
 do it now

Bruce
 7/25

HOGAN & HARTSON

L.L.P.

DARREL J. GRINSTEAD
 PARTNER
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 DJGRINSTEAD@HHLAW.COM

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 WASHINGTON, DC 20004-1109
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 FAX (202) 637-5910

M E M O R A N D U M

July 21, 1999

TO: David Seckman, President
American Health Care Association

FROM: Darrel J. Grinstead

**Re: Adjustments to the Skilled Nursing Facility Market Basket
 Index to Account for Extraneous Cost Factors**

Your have asked for an analysis of the authority of the Health Care Financing Administration ("HCFA") to revise the annual update of skilled nursing facility ("SNF") rates under the prospective payment system to account for cost factors that are not included in the SNF market basket index. In my previous memorandum to you on a related issue, I discussed the broad discretion provided in the statute for the Secretary to establish a market basket index for SNF annual updates. Similarly, even though HCFA has apparently decided to use the market basket index set forth in the May 12, 1998 interim final rule, I conclude that the statute would permit the agency to adjust the annual update to reflect cost factors that were not specifically included within the market basket index discussed in the preamble to that rule.

Statutory Authority for SNF Annual Updates

In my June 7, 1999 memorandum, I discussed the role of the SNF market basket index in the annual updates of both the facility specific and the federal per diem rates. While other factors, which will be discussed below, may be taken into account in determining the annual adjustment to Medicare SNF rates to account for inflation and other factors, the principal component of the annual update is the market basket index.

HOGAN & HARTSON L.L.P.

Section 1888(e)(5) of the Social Security Act ("SSA"), as added by the Balanced Budget Act of 1997 ("BBA"), provides as follows with respect to the establishment of the SNF market basket index:

(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.--The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

Unlike the market basket index used to update rates for other services under Medicare, the statute makes no reference to an existing market basket index and provides no constraints on what may be included in the index, other than requiring that it reflect changes over time in the "prices of an appropriate mix of goods and services included in covered skilled nursing facility services." As noted in our earlier memorandum, the Secretary has substantial discretion to determine what factors should be included in the market basket index. More importantly for the present question, the broad language in the statute provides the agency substantial discretion to determine how and when the market basket index should be adjusted or revised to accurately reflect the cost of providing covered services.

While the statute is drafted broadly with respect to how the market basket index may be determined, it is quite specific with respect to how the index is to be applied in order to determine initial facility-specific and federal per diem annual updates. The market basket index percentage (minus 1 percentage point for some years) is applied to the facility-specific and the federal base rates to determine the PPS rates for the initial year.¹ Thereafter, the market basket index percentage (again minus 1 percentage point for some years) is applied to the previous year's rates to update the per diem rates for each subsequent year.² Other than the authority to make adjustments for "case mix creep" under section 1888(e)(4)(F), discussed below, there does not appear to be any authority in the statute, other than through the market basket index, to affect the annual update of per diem rates through administrative action by the agency.³

¹ See SSA §§ 1888(e)(3)(B) (facility-specific) and 1888(e)(4)(B) (federal rate).

² See SSA §§ 1888(e)(3)(D) (facility-specific) and 1888(e)(4)(E) (federal rate).

³ Each facility's per diem rates are, of course, adjusted for case mix and for geographic variations in labor costs under SSA § 1888(e)(4)(G).

HOGAN & HARTSON L.L.P.

The Market Basket Index and HCFA's Interim Final Rule

Nevertheless, we believe the Secretary has ample authority under the statutory language relating to the SNF market basket index to make adjustments to the annual updates to take into account cost factors that were not initially included within the market basket index. While the preamble to the May 12, 1998, interim final rule set forth a fairly specific set of factors that would be included in the market basket,⁴ that methodology was not incorporated into the regulation itself. Rather, the regulation, in defining the "market basket index," merely reflects the statutory definition quoted above.⁵ It does not adopt the various market basket factors and methodologies described in the preamble in the form of a rule that would be binding on the Secretary until changed by a subsequent rule.

Thus, the description of the market basket index contained in the preamble to the regulation provides guidance and information to the public on how the index will be calculated. However, it does not constrain the Secretary from adjusting the index when making annual updates to take into account factors that are otherwise not reflected in the straightforward year to year changes in the prices of the goods and services included in the market basket. Such factors could include, for example, productivity changes and changes in the intensity of goods and services required to provide a particular level of SNF service. The statute requires the market basket index to reflect changes in prices over time "of an appropriate mix of goods and services." The market basket index, therefore, is a function not only of the prices of the goods and services the Secretary uses in the index but also of the *volume and mix* of those goods and services. Productivity changes and intensity changes will certainly affect the volume and mix of goods and services required to provide a given level of service and may legitimately be considered by the Secretary in making adjustments to the market basket update for any year even though those factors were not listed in the market basket discussion in the preamble to the interim final rule. Such considerations could be announced by the Secretary in the annual notice updating per diem rates. Because the market basket factors and methodology are not established as formal rules, such adjustments could be made in that notice without going through formal rulemaking.

The preamble to the May 12, 1998, interim final rule confirms the above conclusion that HCFA does not consider itself to be bound by the factors and methodology for determining the SNF market basket index that were published along with the interim final rule. The preamble contains a discussion of the fact

⁴ 63 Fed. Reg. 26252, 26289-94 (May 12, 1998).

⁵ 42 C.F.R. § 413.333.

HOGAN & HARTSON L.L.P.

that HCFA is considering a mechanism to adjust future SNF updates to correct for forecasting errors in the event that fluctuations in prices cause significant differences (greater than .25 percent) between actual increases in prices faced by SNFs and the forecast used in calculating the update factors.⁶ The notice indicates that if HCFA determines such an adjustment to be appropriate, it would be made through the annual update to the SNF PPS rates.⁷ Thus, it is clear that HCFA believes it has the authority to make adjustments to the annual SNF PPS rate updates to account for factors in the market basket index that fail to reflect actual changes in the cost of providing a given mix of goods and services.⁸

The only other authority in the statute to adjust the annual update is in section 1888(e)(4)(F) which authorizes adjustments for "case mix creep." This provision authorizes the Secretary to adjust federal per diem rates for a year if she determines that case mix adjustments have resulted, or are likely to result, in a change in aggregate payments as a result of coding or classification of residents that does not reflect real changes in case mix. Thus, if the coding or classification of residents by facilities fails accurately to reflect the level of services they require, the Secretary may adjust rates either up or down to take into account deficiencies in the coding or classification of residents. This adjustment is separate from the development of the market basket index and would be in addition to (or subtracted from) the market basket update.

Conclusion. We believe the Secretary has the authority, under the broad statutory language requiring her to develop a SNF market basket index, to make adjustments to the update factor resulting from that index to reflect changes in the cost of providing an appropriate mix of goods and services. The Secretary is not bound by the precise methodology set forth in the preamble to the May 12, 1998, interim final rule, but may adjust that methodology from time to time to reflect additional factors that she determines will affect the price of providing a given level of SNF service.

⁶ 63 Fed. Reg. at 26293.

⁷ *Id.*

⁸ The statutory language defining the "SNF market basket percentage," which is the actual factor by which rates are updated, also confirms the Secretary's broad discretion in this regard. Section 1888(e)(5)(B) defines that term to mean "for a fiscal year or other annual period *and as calculated by the Secretary*, the percentage change in the skilled nursing facility market basket index...." (Emphasis added.)

BACKUP: MEDICARE POLICIES

March 10, 1999

MODERNIZING FEE-FOR-SERVICE: (-\$9 billion over 5 years; -\$22 billion over 10 years)

- **Preferred Provider Arrangements:** Permit DHHS to develop preferred provider arrangements, either nationally or by region. DHHS would be able to negotiate global payments or discounted fee-for-service payments with preferred providers, perhaps starting in regions where competition in the private market has brought payment rates down below Medicare's rates.
- **Competitive Bidding and Negotiated Pricing Authority; Selective Contracting:** Authorize use of either competitive bidding or price negotiations to set payment rates. DHHS would have the authority to select both the items and services and the geographic areas to be included in a bidding or negotiation process based on the availability of providers and the potential for achieving savings. Bids would be accepted only if the providers met specified quality standards. DHHS also would have the authority to selectively contract only with providers who accept negotiated or bid prices and other contract terms.
- **Purchasing Through Global Payments.** Authorize DHHS to select providers and suppliers to receive global payments for services directed at a specific condition or needs of an individual (e.g. diabetes, congestive heart failure, frail elderly, cognitively or functionally impaired, need for DME). If suppliers or providers are selected to be paid on a global basis, Medicare would not be required to contract with other entities, even if they otherwise met program standards. Beneficiaries would voluntarily elect to participate in such arrangements for a defined period during which they would be "locked-in" for the covered services.
- **Flexible Purchasing Authority:** Give DHHS the authority to negotiate alternative administrative arrangements with providers, suppliers and physicians who agree to provide price discounts to Medicare. These discounts could be based on current fee schedules or payment rates or could involve alternative payment methods. It could be targeted to those areas where market competition in the area makes other arrangements common. In general, before an alternative arrangement went into place, DHHS would have to certify that the arrangement would achieve program savings.
- **Contracting Reform:** Provide HCFA with more flexibility to require incentive arrangements and performance-based measures in contracts with intermediaries and carriers. For example, such contracts could introduce incentives such as bonus payments for benefits saving that result from better utilization management. It would also expand the pool of available entities with which HCFA could contract for claims processing, customer service, provider outreach, provider appeals, and other program functions.

Issues:

- Providers generally do not like competitive approaches
- Republicans oppose giving HCFA authority without premium support

BBA EXTENDERS: (-\$7 billion over 5 years; -\$57 billion over 10 years)

For 2003-2007:

- Extend PPS capital reduction of 2.1 percent
- Extend the 15 percent PPS-exempt capital reduction
- Reduce hospital market basket update by 1.1 percentage points
- Reduce PPS-exempt hospital update using BBA relationship between hospital's operating costs and hospital's target amount
- Reduce SNF update by 1 percentage point
- Reduce hospice update by 1 percentage point
- Reduce OPD update by 1 percentage point
- Reduce ambulance payment updates to CPI minus 1 percentage point
- Reduce prosthetics and orthotics updates by 1 percentage point
- Freeze lab updates, DME updates, and PEN payments
- Reduce ambulatory surgical centers update to CPI minus 2 percentage points

Issues:

- Hospital hits
- On top of President's FY2000 budget
- SNF update issue

COST SHARING PACKAGE

<u>Cost sharing with home health cap:</u>	-\$1 billion over 5 years; +\$1 billion over 10 years
<u>Cost sharing without home health cap:</u>	-\$9 billion over 5 years; -\$20 billion over 10 years
<u>Medigap:</u>	-\$5 billion over 5 years, -\$11 billion over 10 years

Current Law

Preventive Services Copayments:

- **Deductible** applies to hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer (digital rectal exams only) and diabetes self-management benefits.
- **Coinsurance** applies to screening mammography, pelvic exams, hepatitis B vaccinations, colorectal screening, bone mass measurements, prostate cancer (digital rectal exams only) and diabetes self-management benefits.

Cost of buying this down: **\$770 million for 2001-04.**

Medicare Cost Sharing

Benefit	Current Law (1999)	Proposal
PARTS A AND B	--	\$350 deductible indexed to inflation
PART A		
Inpatient Hospital	\$768 deductible No copay: 0- 60th day \$192/day: 61-90th day \$384/day: 60 lifetime reserve days	None
SNF	None: 0- 20 days \$96/day: 21-100th day	20%
Post-institutional HH	None	10% per visit up to 60 visits
Hospice	Nominal copays	20%
PART B	\$100 / yr deductible	None
Physician services	20%	20%
Outpatient Hospital	About 50%	Current law
Ambulatory surgical service	20%	20%
Clinical lab	None	20%
Outpatient mental health	50% for psychotherapy, 20% for medical mngt.	Current law
Home health	None	10% per visit up to 60 visits
DME	20%	20%
PREVENTIVE SERVICES	VARIES	NONE
Screening mammography	20%	None
Pelvic & clinical breast exams, glucose monitoring, diabetes education, bone mass measurement	20%	None
Screening pap smear	None	None
Colorectal cancer screening	Varies	None
Immunizations	None	None

Issues:

- Home health copay: always controversial
- Medigap reform: Is this feasible; should a similar policy be applied to employer-based insurance

INCOME-RELATED PREMIUM

Income Cutoff	Share of Single Elderly Above Cutoff (16.3 m)	Share of Elderly Couples Above Cutoff (17.1 m)	Total Elderly (33.4 m)
\$15,000	24.9%	61.4%	44% / 15 m
\$25,000	15.3%	43.9%	30% / 10 m
\$40,000	9.3%	31.1%	21% / 7 m
\$50,000	7.1%	26.2%	17% / 6 m
\$60,000	5.0%	21.3%	13% / 5 m
\$75,000	3.2%	14.8%	9% / 3 m
\$100,000	1.8%	8.5%	5% / 2 m
\$150,000	0.9%	3.9%	2% / 1 m

- For premiums imposed at \$25,000+, the total number of beneficiaries affected would be about 7.1% higher if disabled beneficiaries were included. For premiums imposed at \$40,000+, the total number would be about 6.7% higher. For premiums imposed at \$50,000+, the total number would be about 5.5% higher. For premiums imposed at \$75,000+ or higher, the total number would be only slightly higher.
- Income-related premiums imposed between around \$20,000-\$40,000 lead to high marginal tax rates, because they interact with the phase in of taxability of Social Security benefits.
- In general, phase-ins over larger income ranges are less likely to affect the financial actions of the elderly, because they amount to smaller additional “taxes” on income. For a 25% income-related premium (beneficiary payments going from 15% of the combined premium to 40% of the combined premium), phase in over at least a \$20,000-25,000 income range would keep the incremental rate low enough that little distortion would occur. A \$25,000 range for phase in of a 25% premium is equivalent to around a 6% increase in the income tax rate in that range. A \$10,000 phase in range is equivalent to around a 15% higher rate.
- The 1997 analysis of income-related premiums concluded that approximately:
 - 2.5% of affected beneficiaries would drop Part B if required to pay 50%,
 - 7.5% would drop Part B if required to pay 75%, and
 - 15% would drop if required to pay 100%.

Comparable income-related premiums for combined Parts A and B would probably not lead to any substantial opting-out, because beneficiaries would still be receiving 50-60% subsidies for the combined program.

STATEMENTS BY THE PRESIDENT ON PROVIDER REIMBURSEMENT UNDER THE BALANCED BUDGET OF 1997

JUNE 29, 1999 – REMARKS ON STRENGTHENING MEDICARE

“And to make sure that health care quality does not suffer, my plan includes, among other things, a quality assurance fund to be used if cost containment measures threaten to erode quality.”

JULY 21, 1999 – PRESS CONFERENCE

“In the 1997 Balanced Budget agreement – and this is the reason all these teaching hospitals are in trouble today – we agreed to a Medicare savings figure. And we said okay, here is our health information... And the CBO said no, no, no, that won't come close; you need these changes plus these changes. And we said, okay, we're following the CBO, we put it in there. And that's one of the reason the surplus is somewhat bigger than it otherwise would be – the cuts in Medicare were far more severe, our numbers were right, their numbers were wrong and that's why you've got all these hospitals all over America, every place I go, talking about how they're threatened with bankruptcy.”

JULY 22, 1999 – REMARKS ON MEDICARE IN LANSING, MICHIGAN

“And we took some very tough actions in 1993 and again in 1997 to lengthen the life of the trust fund – actions which, I might add, most hospitals with significant Medicare caseloads, and teaching hospitals which deal with a lot of poor folks, believe went too far. And we're going to have to give some money back to those hospitals in Michigan and throughout the country.”

JULY 27, 1999 – REMARKS ON WOMEN AND MEDICARE

“Then the next year we did the Balanced Budget Act and it has worked superbly. The only problem with it is that the Medicare cuts were too burdensome on certain groups, and we are trying to fix that.”

AUGUST 8, 1999 – REMARKS TO THE NATIONAL GOVERNORS ASSOCIATION

“And it doesn't count what I hear at every place I go, in every state, in communities large and small, which is that we had cuts that were too severe in the Medicare budget in 1997, which has imposed enormous burdens on the teaching hospitals in every state in the country, on the hospitals with large numbers of poor people, and on a lot of therapy services, for example, for home health care, which have been cut back... We've got to do something about these teaching hospitals.”

SEPTEMBER 8, 1999 – REMARKS ON HEALTH CARE PRIORITIES

“I have also set aside a fund to deal with the Medicare problems that we now have because of the budget decisions made in the Balanced Budget Act, which have imposed severe problems on a lot of our teaching hospitals, some of our therapy services, and other problems of which many of you in this room are quite familiar.”

OCTOBER 12, 1999 – REMARKS TO THE AMERICAN ACADEMY OF PEDIATRICS

“We passed a balanced budget bill in 1997. It had very tough spending caps. The spending caps were too tough – if you work in a teaching hospital, or at other hospitals that have been handicapped by the Medicare cutbacks, you know they're too tough.”

BACKUP: MEDICARE POLICIES

April 16, 1999

COMMISSION'S BBA EXTENDERS: (\$51 billion over 10 years)

For 2003-2007:

- Reduce hospital market basket update by 1.1 percentage points
- Extend hospital PPS capital reduction of 2.1 percent
- Extend the 15 percent hospital PPS-exempt capital reduction
- Reduce PPS-exempt hospital update using BBA relationship between hospital's operating costs and hospital's target amount
- Reduce skilled nursing facility (SNF) update by 1 percentage point
- Reduce hospice update by 1 percentage point
- Reduce OPD update by 1 percentage point
- Reduce ambulance payment updates to CPI minus 1 percentage point
- Reduce prosthetics and orthotics updates by 1 percentage point
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Potential Changes:

- Extend policies through 2009 to get additional savings
- Home health: put back update factors that were lowered in Fall 1998 home health bill
- Therapy caps: Raise from \$1,500 limit to \$2,000
- Hospital market basket update: From 1.1 to 1.0 for 2003-09
- Rural hospital market basket: From 1.0 to xx

MODERNIZING FEE-FOR-SERVICE: (\$14 billion over 10 years)

- **Preferred Provider Arrangements:** Permit DHHS to develop preferred provider arrangements, either nationally or by region. DHHS would be able to negotiate global payments or discounted fee-for-service payments with preferred providers, perhaps starting in regions where competition in the private market has brought payment rates down below Medicare's rates.
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For Tomorrow's
Meeting

DRAFT May 6, 1999

MODERNIZING FEE-FOR-SERVICE MEDICARE

As various proposals are being considered to either structurally or incrementally reform Medicare, we cannot lose sight of the fact that over 83 percent of the currently 39 million Medicare beneficiaries rely on the traditional FFS Medicare program. Much of the focus of the last several years has been on the phenomenal growth and change that the Medicare managed care or Medicare + Choice program has undergone. However, even with this unprecedented growth due to enhanced benefit packages and lower costs promised through managed care, the vast majority of Medicare beneficiaries have elected to remain in the FFS program. It seems obvious then that one of the choices that Medicare beneficiaries would like to retain is the Traditional FFS Medicare program.

Over time, Medicare spending has grown at about the same rate as that of the private sector, and its administered pricing system generally has been recognized as achieving some of the lowest prices for health care services. The past decade, though, has seen the development among health care purchasers of a variety of techniques that appear to be successful at maximizing value by controlling costs and increasing quality of care. In contrast to other public and private purchasers of health care, Medicare lacks the necessary flexibility to target providers, geographic areas, medical care practices, and beneficiaries with specific strategies directed at maximizing quality of care and appropriate utilization. Along with administered pricing, these newer *tools* include competitive bidding / pricing, negotiation, selective contracting, and utilization management and such *applications* as preferred provider arrangements, Centers of Excellence, targeted budgets for integrated delivery arrangements, case management, targeted prior authorization and various forms of bundled payments. Use of these strategies will vary with market environment, medical condition, service setting, geographic area, and other variables that influence which of these tools and applications would be most efficacious. Flexibility to customize the approach and choice among these tools and applications would maximize Medicare's ability to achieve high value under the traditional program.

External groups, including the National Academy for Social Insurance, have called for HCFA to be given greater flexibility to use these tools and applications in Medicare. Within the Bipartisan Commission on the Future of Medicare various strategies for modernizing Medicare were put forward. In addition, HCFA, through demonstrations and in some legislative proposals, has been exploring for several years the possibility of greater flexibility in how Medicare might pay providers and health plans.

This paper consolidates a variety of these proposals where legislative authority is needed. For some proposals, actual legislative language has previously been prepared, and this language is included. For some of these earlier proposals thinking has evolved, and the paper identifies areas where possible changes may need to be made to previously drafted legislative language.

PROPOSALS INCLUDE

1. Medicare Par-Plus Authority
2. Selected Centers of Excellence
3. Flexible Purchasing
4. Global Payments
5. Implement Target Budgets for Qualified Integrated Delivery Arrangements, If After Demonstration Proven Effective
6. Competitive Bidding and Negotiated Pricing Authority: Selective Contracting
7. Prior Authorization and Utilization Review
8. Primary Care Case Management Authority
9. Contracting Reform

ISSUES:

There are three major issues that arise related to most of these proposals.

1. Most of the modernizing package proposals involve selecting a subset of providers for special treatment. Medicare has historically used an “any willing” provider framework. Even though the “any willing” provider framework will continue to dominate the program, the flexibility to treat targeted providers or geographic areas differently will be viewed by providers as a threat to their business.
2. Medicare FFS in terms of overall policy structure has not varied across geographic areas or within a class of providers. By targeting specific geographic areas for special treatment, the modernizing package may be viewed as changing Medicare from a single national program.
3. Because of Medicare’s size there will be significant concern about giving it the flexibility to use its market power in a targeted fashion.

1. MEDICARE PAR-PLUS AUTHORITY

BACKGROUND and RATIONALE:

The Medicare program currently makes a distinction between participating physicians and non-participating physicians. In exchange for an agreement to abide by certain payment rules that are advantageous to beneficiaries using Medicare-participating physicians, the participating physicians are given payment and administrative advantages (such as faster claims payment) not enjoyed by non-participating physicians. Non-participating physicians who do not submit a claim on an assigned basis are permitted to "balance bill" a beneficiary beyond Medicare-allowed amounts, up to a limit. As part of the participation agreement, a "par" physician agrees to submit all claims on an assigned basis, accepting the Medicare payment (plus any beneficiary allowed cost sharing) as payment in full for covered services. Medicare publicizes the availability of participating physicians, listing them in directories, for example. In the sense that no par physician is permitted to balance bill, Medicare beneficiaries choosing between participating and non-participating physicians can face differential cost sharing if a non-par physician chooses to submit a bill on other than an assigned basis. (The Medicare program generally does not make similar distinctions among other types of providers, such as hospitals, except through demonstration projects such as the Centers of Excellence.)

In the private sector, preferred provider organizations (PPOs), point-of-service (POS) plans, and other organizations such as the Health and Welfare Fund of the United Mine Workers, make distinctions between participating and non-participating providers (physicians as well as other providers). Enrollees of these kinds of plans face differential cost sharing, and may have other advantages in using participating physicians or other providers, such as freedom from prior authorization requirements (e.g., hospital care in the Federal Employees' Blue Cross PPO), or coverage of otherwise non-covered services if preferred providers are used.

Providers that agree to the contract terms for preferred, or network, providers of the sponsoring plan can often expect an increase in volume of patients seen, resulting in greater total revenue even though the provider may also agree to a discounted payment rate.

In addition to payment terms that may involve a discounted fee, the agreements and relationships between preferred, or network, providers and the sponsoring plan often impose other conditions related to quality and cost containment. For example, a preferred or network provider may be expected/required to abide by any prior authorization or other utilization review rules of the plan; they may be required or asked to use only particular providers for referrals, or use only one lab; and they may be expected to participate in quality assurance activities, be available at off-hours, and handle administrative aspects of the plan, such as member appeals. Sponsoring organizations also use certain criteria to pre-screen providers wishing to participate as preferred providers (a process generally referred to as "credentialing"), and/or continually monitor the performance of a provider in relation to its peers or expected levels of quality standards and levels of expenditures and utilization. Providers can be "de-selected" from networks (i.e., the contract is terminated) if the norms are not met.

Better-performing providers in these plans can receive bonus payments in addition to their usual fee-for-service payments if they meet expenditure and utilization targets, or if they meet certain quality standards.

PROPOSAL: Establish what would be called a PAR-PLUS program for Medicare. The PAR-PLUS set of providers could include physicians, and other practitioners, as well as institutional providers. Only physicians already enrolled in the par program would be eligible (i.e., one of the standards for being a PAR-PLUS provider is that you must agree to all the terms required for par status).

In addition to physicians agreeing to participation status, PAR-PLUS providers would be expected to meet quality standards and utilization standards established by the Secretary. The Secretary could pre-screen, or “credential,” providers applying to be PAR-PLUS providers based on their claims history and any quality information to determine whether the providers are cost-conscious, high-quality providers. As PAR-PLUS providers, participants would agree to quality standards and utilization management requirements. The Secretary would “profile” providers on a continual basis to ensure adherence to expected utilization and quality standards, and would provide feedback on performance. Higher performing providers would be eligible for bonus payments in addition to the standard fees. The PAR-PLUS designation could be removed if the provider falls below quality and utilization standards expected of PAR-PLUS providers. Where appropriate, the program would pay PAR-PLUS providers at discounted fees.

PAR-PLUS providers would be

- * Permitted to waive coinsurance and deductible payments under a safe harbor (this is one way for providers to generate higher volume);
- * Given administrative advantages, such as faster claims payment and alternative administrative and related procedures;
- * Eligible for bonus payments for achieving specified performance outcomes, as noted above, and bonus payments for demonstrated results of more health-conscious behavior by patients, or improved accessibility (e.g., more convenient hours).

PAR-PLUS providers may also see a “spillover” benefit in their non-Medicare business by having the quality designation of being a Medicare PAR-PLUS provider.

From the beneficiary point of view, the structure of the PAR-PLUS program would be similar to a PPO or POS plans operated by an indemnity insurer in the commercial marketplace. The lowest level of cost sharing would be available from the PAR-PLUS provider, including the waiver of cost sharing at the option of the provider (which is not available through the basic PAR program). The quality standards of the PAR-PLUS program would provide beneficiaries with a straightforward way of determining that the providers they are using are higher-quality providers.

ISSUES:

- * **Supplemental Coverage.** Because most Medicare beneficiaries have supplemental insurance which covers all or a portion of their out-of-pocket costs, reduced cost sharing for covered services may not induce beneficiaries to use PAR-PLUS providers. It is possible to make the argument that the reduced cost-sharing associated with using PAR-Plus providers may enable beneficiaries to choose the less costly "deductible-only" Medigap plan. Another alternative is to consider developing an alternative Medigap plan type designed to be consistent with the incentives of the PAR-PLUS program.
2. **SELECTED CENTERS OF EXCELLENCE** *(FY 2000 Package modifications shown in redline)*

BACKGROUND AND RATIONALE: From 1991-1998, HCFA conducted a demonstration through which certain facilities, referred to as Centers of Excellence, were paid a single fee to provide all of the facility, diagnostic and physician services associated with coronary artery bypass graft (CABG) surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. Medicare achieved an average of 12% savings for CABG procedures performed through the demonstration.

PROPOSAL: This legislative proposal would create a Centers of Excellence program as a permanent part of Medicare by authorizing the Secretary to competitively pay selected facilities a single bundled rate for all services, potentially including post-acute services, associated with a surgical procedure or hospital admission related to a medical condition. Beginning in Fiscal Year ~~2001~~ 20XX, the Secretary would establish Centers of Excellence for CABG surgery and other heart procedures, knee replacement surgery and hip replacement surgery nationwide. The Secretary would also specify other appropriate procedures and conditions in which Centers of Excellence would be sought. As with the CABG demonstration, selected facilities would have to meet special quality standards and would be required to implement a quality improvement plan. The single rate paid to a Center for a particular procedure or admission can not exceed the aggregate amount that would otherwise be made ~~would result in savings to the program.~~ Medicare would not be required to contract with an entity, even if it otherwise met program standards, if there were already enough Centers of Excellence in that geographic area to meet projected demand. Facilities would retain the Center of Excellence designation for a three-year period as long as they continued to meet quality standards. Beneficiaries would not be required to receive services at Centers, but Centers would be allowed to provide additional services (such as private room) to attract beneficiaries. Alternatively, they could waive a portion of beneficiary cost-sharing. Any beneficiary incentives would have to be approved by the Secretary. The effective date would be in FY ~~2001~~ 20XX.

Five-year budget impact: -\$690 million estimated for FY 2000 package.

ISSUES:

- * The Centers demonstration experienced controversy over limiting the number of winners. While it was never the intent to imply that the providers identified as “Centers” were the only high quality providers in an area, this has been an area of concern from providers. The previous Centers of Excellence proposal received opposition because providers who considered their care of high quality objected to not being included. The term “selected” has been added to the proposal title to try and indicate that providers in the Centers program are selected from a larger supply of high quality providers.

- * Within the centers demonstration, providers have raised the issue that the negotiated payments do not reflect that some providers treat beneficiaries who are sicker, and thus should not be required to have lower payment amounts to be a Center. The previous proposal required that the payment amount be less than what would otherwise be paid. The proposal has been modified to provide flexibility in the negotiated rate.

3. FLEXIBLE PURCHASING

BACKGROUND and RATIONALE: DHHS currently has no authority to modify administrative procedures for selected individual providers or suppliers. This lack of flexibility is in sharp contrast to the ability that other payers have to negotiate various discount arrangements with specific entities or provide administrative incentives / rewards for better performance.

PROPOSAL: Under this proposal, DHHS would be given the authority to negotiate alternative administrative arrangements with providers and suppliers who either: (1) agree to provide price discounts to Medicare, or (2) should be recognized for better performance. The administrative arrangements could include such incentives as alternative claims processing, administrative and related procedures.

Special administrative arrangements could be provided in exchange for discounts. The discounts could be based on current fee schedules or payment rates or could involve alternative payment methods. Special administrative arrangements also could be used as rewards for better performance. Providers and suppliers that have been identified as the result of profiling as demonstrating high quality and appropriate utilization practices could be provided with special administrative arrangements. The use of the special administrative arrangements could be targeted to those areas where market competition in the area makes other arrangements common. Beneficiaries could be informed of the providers and suppliers eligible for the special administrative arrangements.

In general, before an alternative arrangement went into place, DHHS would have to certify that the arrangement would achieve program savings either as a result of the discounts, or as a result of encouraging beneficiaries to utilize provider and suppliers that have been identified as meriting special administrative treatment because of their demonstrated appropriate utilization practices.

ISSUES:

- * Generic issue of special treatment for selected providers.

4. GLOBAL (BUNDLED) PAYMENTS

BACKGROUND and RATIONALE: DHHS currently has no authority to modify FFS payment arrangements to reflect the combinations of services that are provided to beneficiaries in certain care settings or for certain conditions. This lack of flexibility is in sharp contrast to the ability that other payers have to negotiate various arrangements with specific entities, and the recent developments in the private sector to target certain high cost health conditions for special coordinated care delivery and structure payment accordingly.

PROPOSAL: This proposal would authorize DHHS to provide global payments to combinations of selected practitioners, providers and suppliers for all care delivered either:

(1) in a specific site of service (e.g., all physician and hospital services delivered in the hospital setting, or all professional and facility services delivered in psychiatric partial hospitalization programs); or

(2) for services directed at a specific condition, or needs of an individual (e.g., diabetes, congestive heart failure, frail elderly, cognitively or functionally impaired, need for DME).

Practitioners, providers, suppliers would be selected based on their ability to provide services more efficiently, to improve coordination of care (e.g., disease management, case management), or to offer additional benefits to beneficiaries (e.g., respite care, nutritional counseling, adaptive and assistive equipment, transportation). If suppliers or providers are selected to be paid on a global basis, Medicare would not be required to contract with other entities, even if they otherwise met program standards. Within the global payment, providers would have flexibility both in how services are provided and in financing additional, non-covered benefits through the global payment.

In the case of global payments made for services delivered in a specific site, the payment would cover the episode of care at the site of service. For global payments made on the basis of beneficiary conditions, beneficiaries would voluntarily elect to participate in such arrangements for a defined period.

ISSUES:

- * Generic issue of special treatment for selected providers.
- * Need to determine whether the time period the beneficiary is expected to participate is a consistent "lock-in" period, or varies by condition and contract.

5. IMPLEMENT TARGET BUDGETS FOR QUALIFIED INTEGRATED DELIVERY ARRANGEMENTS, IF DEMONSTRATION PROVES EFFECTIVE

BACKGROUND RATIONALE: The physician community is largely responsible for directing health care -- providing services and making referrals. Beneficiaries and the Medicare program could benefit if the physician community through integrated delivery arrangements better coordinated care across sites of service, and invested in administrative structures and processes to assure efficient service delivery. Currently, the Standard Growth Rate (SGR) is the incentive under which physicians operate in FFS, which is designed to control annual growth in expenditures, and pertains only to physician services covered under the Medicare Fee Schedule. Under SGR, individual physicians are subject to blanket penalties or rewards regardless of their relative efficiency, and SGR has no effect on the behavior of physicians as it concerns referrals for non-physician services.

While the majority of physicians are not organized in large groups, the majority of Medicare's physician services are provided by doctors who are organized in large groups. These large groups are often associated with integrated delivery arrangements. Extrapolating this finding to the other types of Medicare services that these doctors direct (e.g., hospitalizations, SNF admissions, durable medical equipment), a target budget derived for existing qualified organizations in local markets that volunteer to participate could effectuate desirable change in a large segment of the FFS program.

PROPOSAL: This authority would permit the Secretary to implement nationally target budgets for qualified integrated delivery arrangements that volunteer to participate, if a demonstration of this concept proves that coordination and quality of care improves, and also proves that the total volume and intensity of all types (Part A and Part B) of Medicare covered services provided to beneficiaries seen in a year by the physicians in a participating arrangement can be reduced.

The Secretary would also have the authority to set qualifying criteria such as size, what constitutes an integrated delivery arrangement, as well as quality, monitoring and reporting standards. The Secretary would have the authority to determine the terms of the selective contract, such as its duration, the financing arrangement, and conditions for renewal.

Beneficiary lock-in would not be allowed; beneficiaries could go to the Medicare provider of their choice. The Secretary would determine what constitutes adequate notification that a beneficiary's physician is participating in such an arrangement.

Currently the demonstration is designed as follows:

Qualifying organizations could be given an annual per capita target, based on the organization's own historic experience -- average total Part A and Part B expenditures for the Medicare FFS beneficiaries seen by the organization in a base year. After each performance year, the target would be adjusted for actual age, reason for entitlement and other relevant factors. The target would need to be updated annually and possibly rebased every 3 to 5 years. A bonus could be

paid to the organization when actual total per capita expenditures in the performance year are lower than the target. The bonus amount could be limited to a portion of the Medicare savings generated, and also adjusted for the portion of total Part A and Part B services that were actually provided by the qualified organization's physicians and other providers.

Beneficiaries would not enroll; they would be notified of their physician's participation, and could obtain care from any provider as they currently do. Participating organizations would have to monitor patient satisfaction, and because there is no enrollment, would have to maintain satisfaction to prevent erosion of their patient base.

To qualify, organizations would have to meet or exceed certain size and scope criteria, submit acceptable clinical and administrative management plans, participate in acceptable quality improvement plans, distribute at least a portion of the bonus payments based on quality performance, and submit required performance data. HCFA would provide performance profiles to support the organization's strategic planning for successful clinical management.

To further incentivize quality improvement, a portion of Medicare savings -- separate from the bonus payment -- could be set aside each year and paid to qualifying organizations based on process and outcome improvements.

ISSUES:

- * The authority to implement target budgets for qualified integrated delivery arrangements is being sought to follow a successful demonstration because this model has not been tested in either the public or private sector. A demonstration would provide a controlled opportunity to refine the technical parameters of the model, assure administrative feasibility and prove that the target budget concept can achieve its intended purpose. If HCFA successfully demonstrates this, then the Secretary would have the necessary authority for immediate national implementation.

**6. COMPETITIVE BIDDING AND NEGOTIATED PRICING AUTHORITY:
SELECTIVE CONTRACTING**

BACKGROUND AND RATIONALE: Under current law, payment for items and services is based on statutorily prescribed payment amounts or fee schedules and any provider or practitioner that meets Medicare's conditions of participation is eligible to receive payment for items and services provided to Medicare beneficiaries. Other purchasers of health care have successfully used competitive processes and negotiation to establish payment rates. HCFA under provisions of the Balanced Budget Act is currently in the process of testing competitive bidding processes for durable medical equipment and is planning to also test a competitive process for procuring laboratory services.

PROPOSAL: This proposal would authorize use of either competitive bidding or price negotiations to set payment rates for all the Part B items and services (except for physician services. DHHS would have the authority to select both the items and services and the geographic areas to be included in a bidding or negotiation process based on the availability of providers and the potential for achieving savings. Bids would be accepted only if the providers met specified quality standards. DHHS also would have the authority to selectively contract only with providers who accept negotiated or bid prices and other contract terms.

ISSUES:

- * Generic issue of special treatment for selected providers.

7. PRIOR AUTHORIZATION AND UTILIZATION REVIEW

BACKGROUND AND RATIONALE: Prior-authorization that targets specific practitioners, types of service, or geographic areas with evidence of outlier patterns or utilization problems is now a common strategy that is used by private sector purchasers. Current law gives the Secretary of the Department of Health and Human Services authority to contract with Peer Review Organizations to perform various functions, including reviewing some or all of the professional activities in the area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made under title XVIII (including where payment is made for such services to eligible organizations pursuant to contracts under section 1876). The purpose of this function is, in part, to determine whether services and items are reasonable and medically necessary and whether services and items **proposed to be provided** (i.e., prior-authorization) on an inpatient basis can be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type.

PROPOSAL: This proposal would give the Secretary clear authority to: (1) use prior-authorization review for specific targeted services and procedures of any participating practitioner, provider, or supplier, in any setting of care; and (2) also contract with other Medicare contractors (e.g., carriers, fiscal intermediaries) to make prior-authorization determinations for specific targeted services and procedures.

Specific high cost, high volume services and procedures would be targeted for prior-authorization. Outlier practice patterns of providers and practitioners would be identified using profiles that measure performance against clinical benchmarks established from evidenced-based guidelines. Outlier providers and practitioners would be required to seek prior authorization for the targeted services and procedures (e.g., certain admissions, invasive procedures and radiology services).

This proposal broadens the existing prior-authorization authority to include a wider range of Medicare covered services and it gives DHHS increased flexibility to use a variety of contractors to assure that Medicare pays for services that are reasonable and necessary. Given the role of the carriers and fiscal intermediaries in making payment decisions and preventing program abuse, it is appropriate to also have the flexibility to use these contractors for utilization management activities, including prior-authorization. This flexibility allows for Medicare to operate an efficient prior-authorization program through a number of organizations. The Medicare contractors have experience with utilization management activities with their private lines of business.

NOTE: We have requested an OGC opinion on whether the existing statute is broad enough to allow us to target, for prior-authorization, any practitioner (e.g., physician) service or procedure and any setting of care. OGC hopes to respond by mid-May.

ISSUES:

- * The issue may be raised as to why not use the existing authority before asking for more. The proposal is designed to clarify the targeting aspect of a prior authorization strategy and provide flexibility in which contractors may be used to perform this function.

- * Prior authorization attempts under the old PSRO program were found not to be effective. The proposal is intended to clarify that prior authorization needs to use a targeted approach, rather than the previous experience which did not use sufficient targeting. There also is now considerable more experience in using targeted prior authorization strategies than existed when the early attempts at prior authorization were made under the old PSRO program.

8. PRIMARY CARE CASE MANAGEMENT AUTHORITY

BACKGROUND & RATIONALE: Currently, there are Medicare beneficiaries who might benefit from assistance with coordinating their health care. Medicaid and private health plans have achieved savings and improved health care outcomes by assuring coordinated service delivery to certain high cost / high risk enrollees through primary care case management (PCCM) programs. Care for certain beneficiaries could be improved if Medicare fee-for-service were given the flexibility to provide and target explicit mechanisms to coordinate care. Primary care physicians and beneficiaries could voluntarily participate in coordinated care programs designed to maximize the health outcomes for selected high cost/high risk populations.

PROPOSAL: This proposal would allow HCFA to provide incentives to both beneficiaries and providers to voluntarily participate in care coordination arrangements for high cost/ high risk beneficiaries. To encourage the targeted beneficiaries to voluntarily enroll in PCCM programs, they would be educated about the option and could be offered additional benefits or lower cost-sharing. Additional benefits that would facilitate beneficiaries receiving optimal, cost-effective care in the best setting regardless of restrictions that otherwise apply under the traditional program could be used. The average additional costs of lower cost sharing or extra benefits would be offset by an average reduction in costly services such as avoidable hospitalizations. Beneficiaries who meet the criteria for the PCCM programs would have to voluntarily agree to be locked into the program for a period of time, and would receive all their needed health care either directly or from referral through a primary care physician of their choice who participates in the PCCM network.

The Secretary would have authority to selectively contract with physicians for PCCM services. Primary care physicians would have an incentive to join the PCCM networks, as the networks would be exclusively for physicians who meet certain performance standards and other criteria. Further, the programs would be marketed so that beneficiary enrollment would guarantee patient volume. Physicians would be paid fee-for-service, possibly under alternative fee schedules. They could receive case management fees that could incorporate physician education and training.

ISSUE:

- * Generic issue of special treatment for selected providers.

9. CONTRACTING REFORM (From FY 2000 Leg Package)

BACKGROUND AND RATIONALE: This proposal is a necessary first step in updating the tools HCFA needs to engage in effective oversight of the Medicare contractors. This proposal gives the Secretary of Health and Human Services increased flexibility in contracting for claims processing, payment, and other Medicare intermediary and carrier functions. The provision brings the Medicare contracting authority into closer alignment with the general government contracting rules contained in the Federal Acquisition Regulation (FAR), while preserving certain essential flexibility in the awarding and renewal of contracts currently available to the Secretary under Medicare law. These changes will improve the cost effectiveness of Medicare contractor operations. Further, it may be a necessary pre-condition for HCFA being able to successfully pursue other proposals to modernize Medicare.

PROPOSAL: This provision would permit the Secretary to enter into a contract with any entity qualified to perform Medicare functions notwithstanding the fiscal intermediary and carrier provisions in the Social Security Act. The Secretary could contract for the performance of Medicare fiscal intermediary functions without regard to the provider nomination provisions in Section 1816. The Secretary could award Medicare contracts on a competitive basis under the FAR, but would also retain her current flexibility to retain current contractors who are performing well and supplement the existing pool of contractors with new entrants as she deems in the best interests of the Medicare program. Further, the Secretary could award any type of contract permitted by the FAR. The Secretary could execute combined Medicare Part A and Part B contracts. The Secretary could terminate a contract without regard to procedural requirements that are unique to the Medicare program, and the conditions under which a fiscal intermediary or carrier contract could be terminated would be subject to the FAR. Finally, the Secretary could consult with providers, health plans, and contractors regarding performance evaluation standards.

ISSUES:

- * As noted in a recent article by Bruce Vladeck, "Perhaps the most effective interest in the interest-group politics of Medicare is one that is rarely discussed or noticed--the *sine qua non* of effective interest-group politics--Medicare contractors." The contractors will view the proposal as a threat to their current special contractual arrangement with the government.
- * Having the authority to recompetete contracts -- while it would be a long jump in the right direction -- will not, alone, solve all of the performance and other issues associated with the Medicare contractors. Ensuring that a sufficient pool of high quality, cost-effective, contractors is available to compete is a larger issue.