

Medicare Provider File

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:

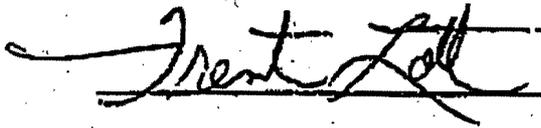
We are writing to express our shared concern regarding the impact of the Balanced Budget Act (BBA), and its proposed implementing regulations, on our nation's nursing homes and the Medicare beneficiaries they serve.

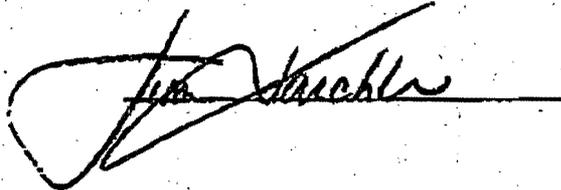
Unfortunately, it was impossible to foresee all the possible unintended effects implementation of the BBA would have on particular categories of care available to Medicare beneficiaries.

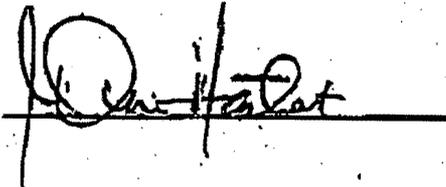
We believe the growing crisis in the nursing home industry stems, in part, from the implementation of the BBA. If steps are not taken to improve reimbursement during the transition to a prospective payment system for skilled nursing facilities, we fear that dedicated care-givers may be laid off, facilities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

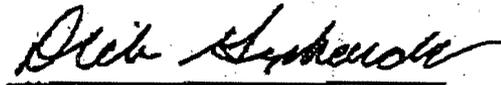
We have been advised the Administration has the ability to address some of these concerns by revising its regulations that are likely contributing to the problem, and by making every effort to ensure that the transition to a prospective payment system does not ultimately harm patients. We would like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

Sincerely,









United States Senate

WASHINGTON, DC 20510

May 19, 1999

The Honorable Donna Shalala
Secretary

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madame Secretary:

We are writing to express our deep concerns about the growing crisis in the nursing home industry. We are concerned that payment rates for Skilled Nursing Facilities (SNFs) are well below the levels envisioned by Congress, and this reduction in payments could seriously erode the quality of care available to our seniors.

The Balanced Budget Act of 1997 (BBA) has produced a number of positive results. We have a balanced budget, and Medicare's solvency has been extended by many years.

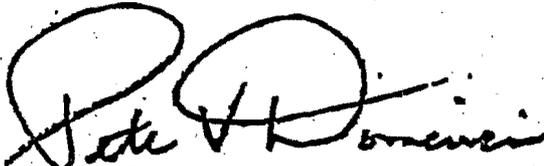
However, it should not come as a surprise that implementing complex legislation such as the Medicare provisions in the BBA is producing some unexpected and undesirable consequences in certain sectors.

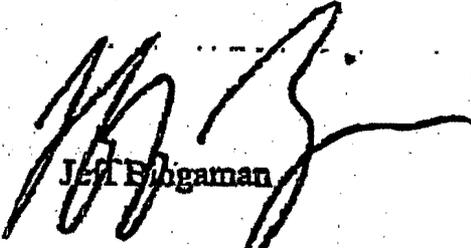
In particular, we believe that the regulations implementing the SNF payment changes may reduce rates substantially more than was intended and projected at the time of enactment. If HCFA does not revise the regulations, we fear we will soon see closings of facilities, layoffs of dedicated care-givers, reductions in access to SNF services, and erosion in the quality of care.

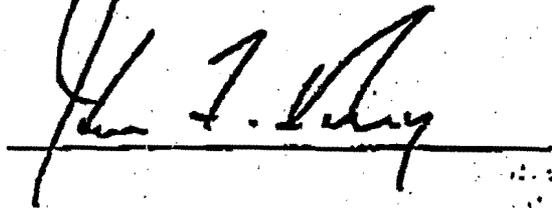
We urge you to use your authority to revisit the regulations to ensure the transition to the new prospective payment system (PPS) does not harm beneficiaries with unnecessary reductions in payment rates that go beyond what any of us anticipated. In particular, we would urge you to revise the regulations to reflect the needs of medically complex patients, particularly their need for non-therapy ancillary services.

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.

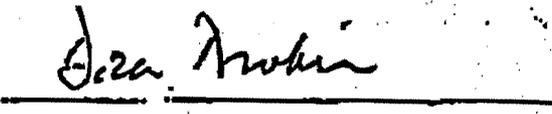
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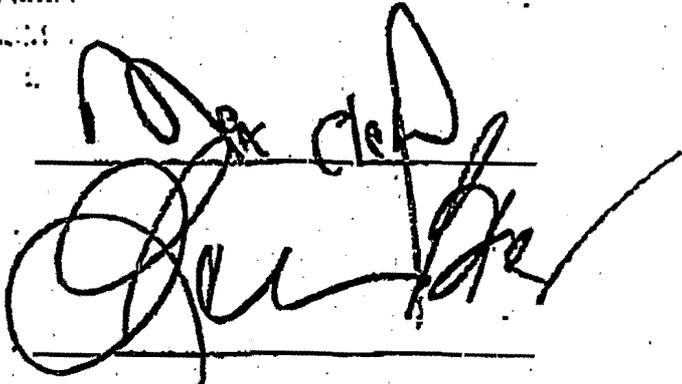

Pete V. Domenici

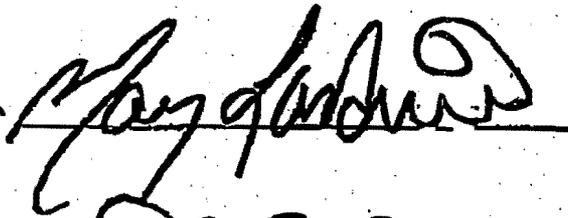

Jeff Bigman

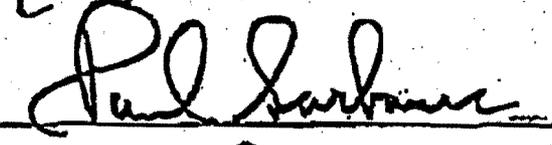

Jim J. Walsh

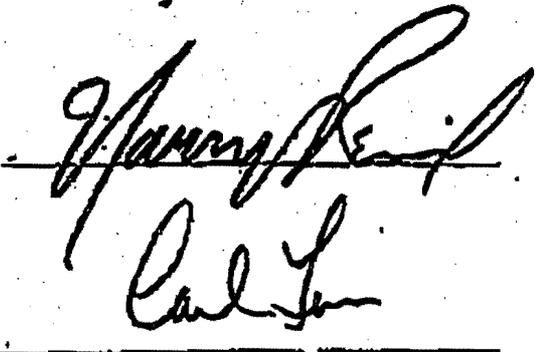

Ron Wyden

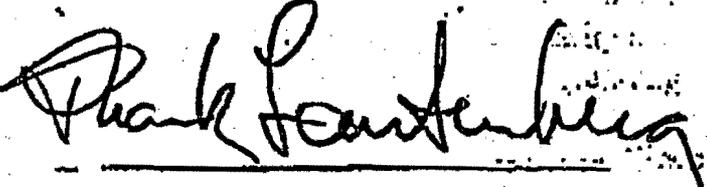

Dana Rohrabacher

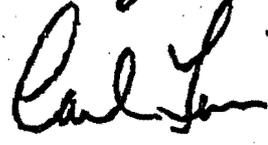

Dan Claitor

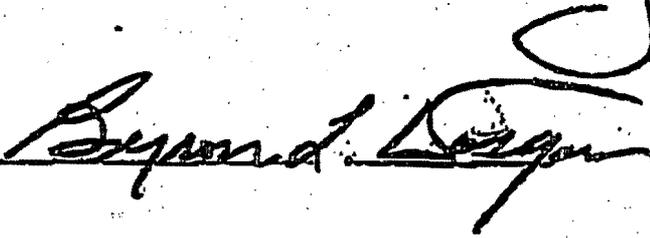

Ray Lujan

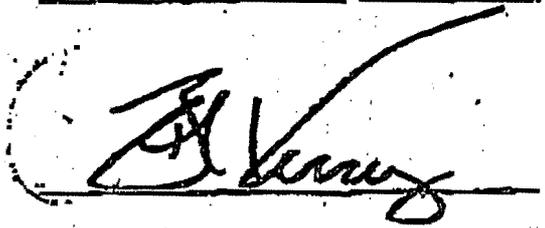

Paul Sarbanes


Harry Reid


Frank Lautenberg


Carl Levin


Byron Dorgan


Ed Kennedy

Tom Vachon

Peter Hollings

Robb Linn

Chuck Robb

Bill Just

ANDR HAGEZ

Al McConell

Rick Sutorius

Blank L. Lincoln

Allen Reed

SNF IRS

Mike Tator

Jim Jeffers

Carl

Art Bond

Chris Hatch

Spencer Abraham

T. Hutchinson

John Asmeroyt

Jim Bennett

Paul Secor

Paul Bunn

Mike Crapo

Paul Cohen

Max Bensusan

Benjamin C. Appel

John D. Ames

Robert F. Bennett

Tom Kelly

Pat Roberts

Russ Feingold

Robert A. Taft

Patty Murray

May 19, 1999
Page 6

John McLane

Belva R. Pifer

Republican	Democrat
Domenici	Bingaman
Bunning	J. Kerrey
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	Torricelli
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
NATIONAL SECURITY COMMITTEE
JUDICIARY 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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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.

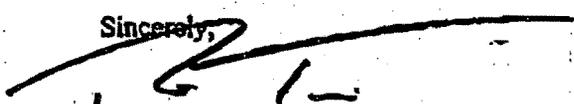
The Balanced Budget Act of 1997 was an important step toward ensuring the long-term strength of the Medicare program; however, the unintended consequences of reimbursement reductions included in the BBA have been economically devastating to skilled nursing facilities (SNFs) in my state. Thus, I want 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

April 29, 1999

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Shelly Peterson
PRESIDENT OF ASHCIAE

Paul R. Wilging, PhD
PRESIDENT

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

Dear Administrator DeParle :

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

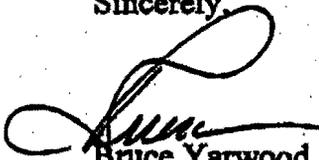
included" in a SNF. HCFA should replace the current market basket index with an index that reflects the average annual change in the prices of SNF outputs. Currently, the Bureau of Labor Statistics has such an index, which, if used, could provide immediate relief to providers and beneficiaries. This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

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WASHINGTON, DC 20510
(202) 224-3822
(202) 224-3993 (FAX)

COMMITTEES:
GOVERNMENTAL AFFAIRS
HEALTH, EDUCATION, LABOR,
AND PENSIONS
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

Chris Bond

Christopher S. Bond

Mike Enzi

Carl Levin

Bill Frist

Rick Santorum

Spencer Abraham

Sam Brownback

John Edwards

Frank R. Laufenberg

Pat Roberts

Alicia Legar

Wayne Allard

Jeff Peregian

FAX

Date 5/27/99

Number of pages including cover sheet 10

TO: CHRIS JENNING

FROM: John Schaeffler, Dir
of Congressional Affairs
American Health Care
Association
1201 L Street NW
Washington DC 20004

Phone
Fax Phone 456-5557

Phone (202)-898-2808
Fax Phone (202)-842-3860

CC:

REMARKS: Urgent For your review Reply ASAP Please Cor

456-0257
Jan

05/21/98 12:08 FAX

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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 (PSS) 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.

The Administration has the ability to address some of these concerns by revising its regulations that currently may be 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,

*Double/
Geppert
will sign*

150-5257

United States Senate

WASHINGTON, DC 20510

May 19, 1999

The Honorable Donna Shalala
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madam Secretary:

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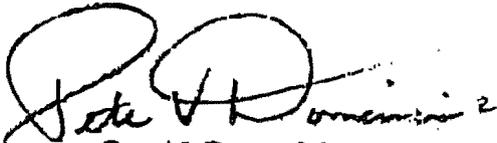
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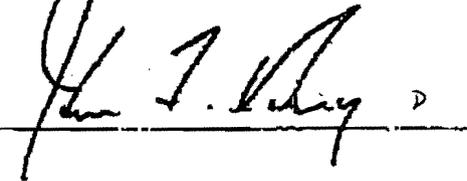
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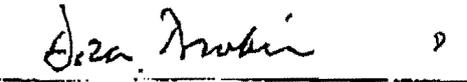
May 19, 1999
Page 2

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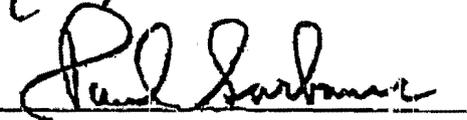
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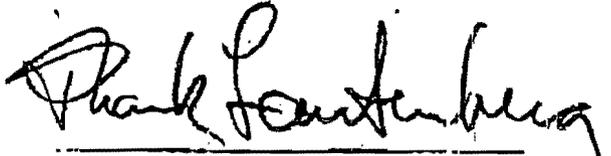

Pete V. Domenici

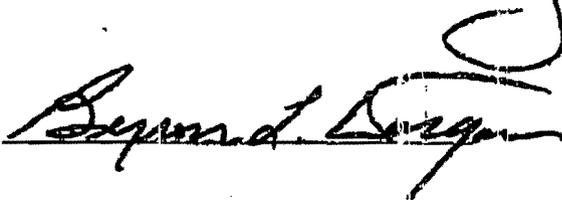

Jim I. Walsh

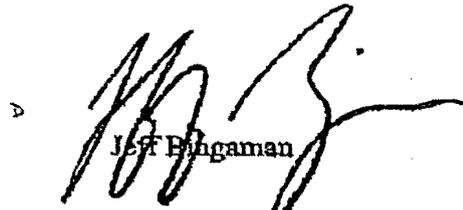

Don Nickles


Clayton D. Williams

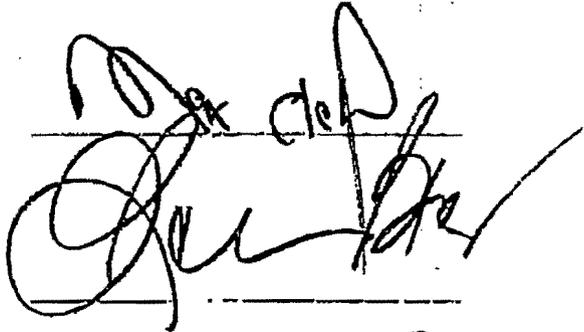

Paul Sarbanes

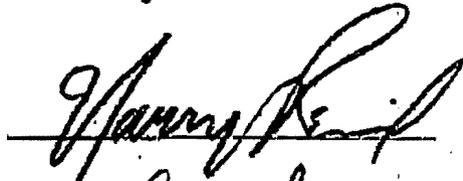

Frank Lautenberg

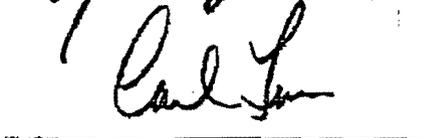

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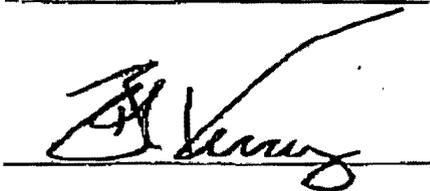

Jeff Bingaman


Ron Wyden


Max Baucus


Harry Reid


Carl Levin


Bill Vitter

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Jim Warbler

Peter Hollings

Rita Linn

Chuck Robb

Bill Frost

DAVID HAGEC

Al McConnell

Rick Souton

Blanche L. Lincoln

Allen Peck

SNF PFS

Bill Tatum

Jim Jeffers

Carl

Art Bond

Chris Hatch

Ernest Abraham

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T. Hutchinson

Barbara [unclear]

Jan [unclear]

John [unclear]

Jim [unclear]

Bob F. [unclear]

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Tom [unclear]

Paul [unclear]

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Mike [unclear]

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Patty [unclear]

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Text Lat

Ed Kennedy

George V. Voinovich

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Larry E. Craig

Paul Doudley

Mike DeWine

Jim Jones

~~Sam~~ Rumbaugh

Richard Shelby

Paul W. Walsh

John H. Choe

Susan Collins

Jeff Leach

Herb Kohl

Alicia Logan

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John McLean

Barbara F. Felt

Kyl	Johnson
Coverdell	Kohl
Craig	Boxer
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DeWine	
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Brownback	
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Chafetz	
Lugar	
McCain	

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



FAX COVER SHEET

OFFICE OF LEGISLATION

Number of Pages: _____

Date: _____

To: <i>Chris Jennings</i>	From: <i>Bonnie Washington</i>
Fax: _____	Fax: <u>202-690-8168 or 205-5157</u>
Phone: _____	Phone: _____

REMARKS: *Here are the drafts of the physician, HH + SNF papers. As you can see - most of the language is the same for each. Hospitals, mgd care + drugs will follow, but this should give you a sense if you want something different. Also, there's some controversy about the nursing home workgroup, so we showed discuss*

Bonnie

HEALTH CARE FINANCING ADMINISTRATION

200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

Provider Group: Physicians

- ▶ The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.
- ▶ The plan achieves these goals without imposing new provider cuts during the time where the BBA cuts are currently in effect. The plan does not include savings from provider payment updates until 2003.
- ▶ In addition to the drug benefit and other important program reforms, the President's plan includes a number of time-limited administrative actions we will take to smooth the implementation of some of the more severe provisions of the BBA.
- ▶ These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future.
- ▶ The President's plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling \$x billion over ten years, is funded in the context of the entire reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would best address specific problems in a fiscally responsible way.
- ▶ The plan does build on the BBA, by including moderated provider payment reduction policies beginning in 2003 through 2009. These policies will help preserve and protect Medicare for the future and extend the life of the trust fund. There are no provider payment reductions for physicians in the plan.
- ▶ The President's FY 2000 budget/legislative program, which was submitted in February 1999, contains a legislative proposal for a budget-neutral technical amendment do fix a number of problems with the physician sustainable growth rate (SGR). The SGR is a target rate of growth for Medicare physicians' services which was legislated in BBA.
- ▶ The problems and solution are highly technical. As a result of some design flaws, Medicare updates for physicians' services are expected to oscillate between large increases and large decreases. In addition, there is a problem since the SGR cannot be revised to correct for estimation errors.

- ▶ The physician community has argued strongly that they believe we have the existing authority to correct for estimation errors in the SGR. They believe that the 1999 and 2000 updates were lower than what they would have been by at least 1 percent in each year if we corrected for projection error. The HHS General Counsel has indicated that we cannot fix this problem under current law. Thus, we have submitted a legislative proposal to fix all the SGR problems in a budget-neutral manner.
- ▶ In addition to payment reforms, the President's plan includes a strategy for modernizing management of the Medicare program by bringing private sector expertise to the Health Care Financing Administration.
- ▶ The plan includes a strategy to assess HCFA's personnel needs and plans to submit legislation to waive some Federal personnel rules to ensure the proper expertise, if warranted.
- ▶ The plan also includes a number of public/private advisory bodies to make the decision-making process more open and to allow HCFA to benefit from private sector expertise in the important areas of overall management, Medicare coverage policy, and the Medicare beneficiary education campaign.
- ▶ Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

Provider Group: Home Health Agencies

- ▶ The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.
- ▶ The plan achieves these goals without imposing new provider cuts during the time where the BBA cuts are currently in effect. The plan does not include savings from provider payment updates until 2003.
- ▶ In addition to the drug benefit and other important program reforms, the President's plan includes a number of time-limited administrative actions we will take to smooth the implementation of some of the more severe provisions of the BBA.
- ▶ These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future.
- ▶ Specifically, the President's plan increases the time for repayment of overpayments related to the interim payment system from one year to three years, with interest. Currently, home health agencies are provided with one year of interest-free extended repayment schedules. This will alleviate cash flow problems some home health agencies are facing as a result of the interim payment system.
- ▶ In addition, the plan postpones the requirement for surety bonds until October 1, 2000, when the new home health prospective payment system will be implemented. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds. Also, agencies will be required to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.
- ▶ The President's plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling \$x billion over ten years, is funded in the context of the entire reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would best address specific problems in a fiscally responsible way.
- ▶ In addition to payment reforms, the President's plan includes a strategy for modernizing management of the Medicare program by bringing private sector expertise to the Health Care Financing Administration.

- ▶ The plan includes a strategy to assess HCFA's personnel needs and plans to submit legislation to waive some Federal personnel rules to ensure the proper expertise, if warranted.
- ▶ The plan also includes a number of public/private advisory bodies to make the decision-making process more open and to allow HCFA to benefit from private sector expertise in the important areas of overall management, Medicare coverage policy, and the Medicare beneficiary education campaign.
- ▶ Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

Provider Group: Skilled Nursing Facilities

- ▶ The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.
- ▶ The plan achieves these goals without imposing new provider cuts during the time where the BBA cuts are currently in effect. The plan does not include savings from provider payment updates until 2003.
- ▶ In addition to the drug benefit and other important program reforms, the President's plan includes a number of time-limited administrative actions we will take to smooth the implementation of some of the more severe provisions of the BBA.
- ▶ These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future.
- ▶ Specifically, for SNF PPS,
 - we know that there are concerns that the PPS does not fully reflect the costs of non-therapy ancillaries such as drugs for high acuity patients. We share these concerns and are conducting research that will serve as the basis for refinements to the RUGs that we expect to implement next year.
 - We know, too, that we will need to periodically evaluate the system to ensure that it appropriately reflects changes in care practices and in the Medicare population.
 - HCFA has also asked the HHS Inspector General's office to interview hospital discharge planners about whether they are having difficulty placing beneficiaries in nursing facilities or home health.
- ▶ The President's plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling \$x billion over ten years, is funded in the context of the entire reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would best address specific problems in a fiscally responsible way.
- ▶ In addition to payment reforms, the President's plan includes a strategy for modernizing management of the Medicare program by bringing private sector expertise to the Health

Care Financing Administration.

- ▶ The plan includes a strategy to assess HCFA's personnel needs and plans to submit legislation to waive some Federal personnel rules to ensure the proper expertise, if warranted.
- ▶ The plan also includes a number of public/private advisory bodies to make the decision-making process more open and to allow HCFA to benefit from private sector expertise in the important areas of overall management, Medicare coverage policy, and the Medicare beneficiary education campaign.
- ▶ Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

At the same time, MedPAC recognized several factors pointing to the need for caution in specifying future updates, including emerging evidence that the decade-long trend in rising case mix complexity, which automatically increases PPS payments, may be subsiding. We also questioned whether the unusually low rate of hospital cost inflation observed in recent years can be sustained without adverse effects on quality of care. With these factors in mind, we concluded that the operating update for FY 2000 enacted in BBA—1.8 percentage points less than the increase in HCFA's operating market basket index—will provide reasonable rates. (Under current forecasts, that would be an update of 0.9 percent.) MedPAC's recommendation took into account part, but not all, of the cumulative reduction in costs per case due to shifts in the site of care.

*MedPAC Testimony, Senate Finance Committee,
June 10*

A Since MedPAC made its recommendation in March, the hospital industry has issued several reports projecting the impact of the BBA on hospital revenues and margins. These reports contain new projections but no new data. In response to congressional requests, MedPAC staff have analyzed these studies and found that all of them project a more adverse impact of the BBA than we believe to be the case. Some present a particularly inaccurate picture of the impact in FY 1998 by assuming a rate of increase in costs that substantially exceeds what we already know has occurred. Data from the American Hospital Association's National Hospital Panel Survey suggest that when complete Medicare cost report data become available, we will again see a decline in Medicare cost per discharge for FY 1998, the fifth year in succession.

Although we believe that these reports overstate to some degree the impact the BBA will have on hospital margins, the overall direction of that impact is correct. The law has thus reversed a six-year trend of Medicare payments rising more rapidly than the costs of treating Medicare payments. But changes in total margins also reflect developments in the private sector, where HMOs and other payers have continued to exert strong downward pressure on hospital revenue flows. As Medicare tightened its payment policies in 1998, the combined pressure on revenues has caused the financial distress that hospitals are currently experiencing.

Projections of margins also need to be interpreted with caution. Because hospitals will respond to financial pressures, MedPAC views projected margins only as a gauge of the pressure that Medicare payment policies will impose on hospitals but not as a prediction of what will occur. Evaluating whether those responses affect quality and access to care will be just as important as measuring financial performance. MedPAC has seen no evidence that the changes to date have affected either quality or access in the inpatient sector, but we will continue to monitor developments.

Outpatient hospital services

In addition to changes in payments for inpatient services, the BBA also enacted major changes in Medicare's payments for services provided in hospital outpatient departments. It eliminated the so-called formula-driven overpayment under which Medicare's payments did not correctly take into account the effect of beneficiaries' cost sharing and extended the reduction in payments for

- Q. Both Lewin and Ernst & Young came out with reports on the impact of the BBA on hospitals. What is HCFA's position on these studies?**
- A. HCFA is still in the process of analyzing both the Lewin and Ernst & Young studies. However, after a preliminary review, HCFA believes that there are many methodological problems with the studies. As you may know, MedPAC released an analysis of the Ernst & Young report that also questioned the methodology used. We will continue to evaluate these studies and keep you abreast of our progress.

WHAT THE PRESIDENT'S MEDICARE REFORM PROPOSAL DOES FOR HOSPITALS

1. NO NEW TRADITIONAL FEE FOR SERVICE SAVINGS UNTIL AFTER THE BALANCED BUDGET ACT EXPIRES IN 2003
2. INCREASES PAYMENTS THROUGH 2002

A. TAKES ADMINISTRATIVE ACTION TO RELIEVE SOME BURDENS OF BALANCED BUDGET ACT 1997

- **Delay of hospital transfer policy.** The BBA requires the Secretary to reduce payments to hospitals when they transfer patients to another provider that is supposed to be included in acute care payment rates for 10 diagnoses and authorizes her to extend this provision to other diagnoses after October 1, 2000. To minimize the impact on hospitals, this extension is being postponed for two years.
- **Delay of volume control mechanism.** Because the new prospective payment system provides hospitals with a fixed payment per unit of service (visit) it gives providers an incentive to increase the number of visits they provide. BBA requires Medicare to develop a mechanism to protect against this. However, to help hospitals with the transition to the new payment system, we are considering delaying the implementation of any volume control mechanism for the first few years.
- **Slow transition to the prospective payment system for outpatient services.** We are considering implementing a three year transition to this new system by making budget-neutral adjustments to increase payments to hospitals that would otherwise receive large payment reductions, such as low-volume rural and urban hospitals, teaching hospitals, and cancer hospitals.

B. PROPOSED LEGISLATIVE ENHANCEMENTS

- **Direct payments to disproportionate share hospitals.** Academic health centers and public hospitals have long called for this provision because they believe that HMOs are not passing disproportionate share payments back to hospitals. Given the important role that these hospitals play in serving the 43 million uninsured Americans, the President proposed a policy that would pay disproportionate share payments directly to these facilities.

- **Included \$7.5 billion quality assurance fund.** To ameliorate unanticipated negative impact on the ability for providers to provide access to quality services, the President included this \$7.5 billion fund to help finance reforms jointly agreed to in consultation with the Congress. The Administration will work with Congress, Congressional advisory commissions, provider and beneficiary groups to identify which BBA policies have produced major access and quality problems for beneficiaries and will develop with Congress specific policies that address problems in a fiscally prudent way.

3. MODERATES BALANCED BUDGET ACT 1997 SAVINGS PROVISIONS AFTER 2003

- **The President's proposal provides for more reasonable growth rates.** Under the President's proposal, the growth rates exceed those that would have been provided if BBA had been extended as suggested by the Medicare Commission – 4.3 percent as opposed to 3.8 percent.
 - **No new cuts for hospital outpatient departments**
 - **No new cuts for disproportionate share hospitals**
 - **No new cuts for nursing homes**
 - **No new cuts for home health providers**

2. FULL GEOGRAPHIC ADJUSTMENTS FOR MANAGED CARE PLANS

The current risk adjustment methodology increases private plan payments in low-cost rural areas, but reduces them in high-cost urban areas. These increased costs would be passed on to beneficiaries, raising premiums and discouraging enrollment in high cost areas. The President's plan would adjust payments for plans in high cost areas to reflect the full local costs, which is more than under the BBA formula, to smooth out the difference between the premiums for managed care and the traditional program.

IMPACT OF THE PRESIDENT'S MEDICARE REFORM PROPOSAL ON HOSPITAL SYSTEMS

- 1. NO NEW TRADITIONAL FEE FOR SERVICE SAVINGS UNTIL AFTER
THE BALANCED BUDGET ACT EXPIRES IN 2003**
- 2. INCREASES PAYMENT FOR 2000 THROUGH 2002**
 - A. TAKES ADMINISTRATIVE ACTION TO RELIEVE SOME BURDENS OF
BALANCED BUDGET ACT 1997**
 - Delay of hospital transfer policy
 - Delay of volume control mechanism
 - Slow transition to the prospective payment system for outpatient services
 - B. PROPOSED LEGISLATIVE ENHANCEMENTS**
 - Direct payments to disproportionate share hospitals beginning in 2001
 - Included \$7.5 billion quality assurance fund
- 3. MODERATES BALANCED BUDGET ACT 1997 SAVINGS PROVISIONS
AFTER 2003 FOR HEALTH SYSTEMS**
 - No new cuts for hospital outpatient departments
 - No new cuts for disproportionate share hospitals
 - No new cuts for nursing homes
 - No new cuts for home health providers
- 4. FULL GEOGRAPHIC ADJUSTMENT FOR MANAGED CARE
PAYMENTS**

MEMORANDUM

TO: John Podesta

FROM: Chris Jennings

CC: Steve Richetti
Jack Lew
Bruce Reed
Gene Sperling
Larry Stein
Joel Johnson
Mary Beth Cahill
Dan Mendelson
Barbara Woolley

RE: Meeting with Hospital Groups on Medicare Reform

Tomorrow, you are scheduled to meet with representatives of the American Hospital Association, the Catholic Health Association, the National Association of Public Hospitals, the New York and Presbyterian Hospitals Care Network, Partners Health Care System, and the American Association of Medical Colleges.

The purpose of this meeting is to attempt to refocus the hospitals' advocacy efforts to assure that a significant portion of the surplus is dedicated to Medicare. In this regard, we also would like to point out that the absence of success in this endeavor will undermine our ability to provide immediate provider give-backs and / or to avert future excessive cuts when the baby boom retires. We need to redirect the attention of these hospitals away from their fixation on their relatively modest concerns about the President's plan towards the structural calamity that will result if we do not dedicate significant new resources to Medicare and / or enact the Breaux-Thomas Medicare reforms.

BACKGROUND

The Catholic Health Association and the National Association of Public Hospitals represent the constituency of providers that have been consistently supportive of the Administration's health care agenda and are likely to be less aggressive in complaining about provider cuts. They will be most open to the argument that the dedication of the surplus is an extraordinary contribution by the President and will be more trusting of our commitment to work with them on short term BBA reforms. The public hospitals are particularly appreciative of the carve-out out of managed care payments that reallocate disproportionate share payments directly to hospitals.

The American Hospital Association and the American Association of Medical Colleges continue to strongly advocate for us to explicitly identify administrative and or legislative initiatives that will directly benefit them. While they acknowledge that the dedication of the surplus is helpful, they feel that their membership requires more specific initiatives for them to be more supportive – or at least less critical – of the President's Medicare reform proposal. Clearly, their first priority continues to be relief from HCFA's preliminary interpretation of the reductions in reimbursement for outpatient departments.

There is no question that the hospitals want to use their leverage to extract as many commitments from us as possible before even contemplating sending a message of support on our Medicare proposal. Moreover, they fear alienating Republican chairmen, who they hope will produce a freestanding provider give-back bill later this fall. Since they are unsure about how much they can expect from either the Republicans or the President on this issue, they are reluctant to send an open ended message of support, regardless of the concerns we commit to addressing.

Last week, we held an informal meeting with Chuck Ruff to discuss alternative interpretations of the outpatient department payment reduction language included in BBA. He and his staff are working aggressively to determine options in this regard, and have hinted that it may be possible for us to develop an alternative interpretation (contrary to the preliminary HCFA reading) by citing the statute's ambiguous language as well as the burdens the government will face through litigation if our regulation goes against the hospitals' interests. We are not likely to know how this issue will be resolved until later this week at the earliest.

On a related matter, the hospitals have yet to succeed in extracting a letter of Congressional intent from either Congressman Thomas or Senator Roth. However, the hospital community has indicated that they have yet to give up hope of obtaining such a letter. Although no one suggests that a letter from Congressman Thomas or Senator Roth would necessarily be dispositive, all agree that it would significantly enhance the likelihood that an alternative interpretation could be developed.

Lastly, it is important to note that the President has been extremely vocal in publicly expressing his concern about the impact of the BBA on hospitals. These comments, in addition to our \$7.5 billion quality assurance fund, should be used by you as an example of his commitment to the hospital community and his already significant contribution to beginning to address their issues. We should also contrast our position against what Republicans are now saying is their position on Medicare – the Breaux-Thomas Medicare reform initiative. (Parenthetically, I should note that the career policy experts at both OMB, HCFA, GAO, and MedPAC continue to believe that there is very little evidence to suggest that the reduction in Medicare payments can reasonably be linked to any financial difficulties that the hospitals are currently facing.)

Attached for your information are talking points for tomorrow's meeting and specific cites from the President's remarks that document his concerns about hospitals.

TALKING POINTS

- We all recognize that the irresponsible tax cut produced by the Republicans will be vetoed. However, it is important to point out that even a much smaller tax cut would seriously crowd out surplus dollars directed to Medicare.
- In fact, the \$295 billion tax cut designed by Senate Finance Committee Democrats significantly reduced the Medicare commitment. In the absence of a very strong push-back from all interested parties, the amount dedicated to Medicare will almost inevitably decline. Tax cuts or discretionary priorities will almost inevitably reduce the level of this commitment.
- I raise this because we have three Medicare funding priorities that are at risk, two of which are likely to be priorities of your own. If we don't secure a significant surplus contribution to Medicare, not only will the drug benefit be at risk, but a significant contribution of revenue to BBA provider give-backs will be as well. In addition, as the surplus dedication declines, so too will those dollars dedicated for solvency, effectively increasing the likelihood that we will see Medicare cuts that meet or exceed those in the BBA as the baby boomers retire.
- We recognize that you are seeking specific commitments to administrative or legislative provider give-backs. As you have noted, the President has been very public in his recent remarks about his concern for hospitals. This, combined with the President's \$7.5 billion quality assurance fund and the redirected disproportionate share payments to hospitals, lay the foundation for the type of assistance you seek. Moreover, we continue to work hard on the issue of reimbursement to outpatient departments, but still need a letter from Senator Roth and especially from Congressman Thomas to clarify Congressional intent on this matter.
- Lastly, we should not take for granted that every Republican in the Congress consistently cites the Breaux-Thomas plan as the most meaningful and appropriate reform for Medicare. It's bipartisan name provides camouflage for provisions that I believe we share a mutual concern over. In particular, as reported out of the Commission, it does not dedicate one dime of the surplus to Medicare, provides no provider relief from BBA 1997, assumes a straight extension of BBA reductions in provider reimbursement, and its premium support proposal coerces beneficiaries in managed care into low paying managed care plans that receive no full geographical adjustment in urban areas.
- We wanted to have this meeting to discuss our common interests and to make certain that we do not take positions that inadvertently harm our visions for reform. I believe that our visions are not too dissimilar from one another and want to work closely with you in the weeks and months to come.

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

JUNE 29, 1999

REMARKS BY THE PRESIDENT 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

PRESIDENT CLINTON'S 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

PRESIDENT CLINTON'S 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

PRESIDENT CLINTON'S 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.”

LEWIN/AHA TALKING POINTS

- The Lewin/AHA analysis uses total hospital cost data from the AHA survey. This data includes costs Medicare does not allow such as private rooms, telephones, cafeterias, parking lots, etc. The difference is about 6.6%. So even accepting everything else about the Lewin analysis, the 4.4% loss would be a 2.2% profit if Medicare audited data were used for all hospital cost centers. This difference in interpreting costs directly raises the issue of whether Medicare should be paying only the costs of its patients or sharing in all hospital costs to help support hospital profit margins.
- Lewin/AHA project hospital costs at Market basket minus 1 percent. Since the Lewin report was published MEDPAC has presented data that Medicare costs per case have declined for an unprecedented fifth year in a row. If Medicare costs per case are declining so should Medicare payments.
- The Medicare actuaries are going to project hospital margins using Medicare cost assumptions and alternative cost growth scenarios. This work is not yet complete.
- Stu Gutterman, formerly at MEDPAC, now at the Urban Institute, has projected hospital margins to 2002 using the AHA cost assumptions but substituting alternative scenarios of cost growth. His projected range of margins for 2002 is 1.5% to 4.5%. If the 4.5% margin is in fact achieved it would be the highest hospital total margin historically except for one or two years.
- Hospital Outpatient losses are driving the overall losses in the Lewin/AHA analysis. By law we pay only 95% of hospital operating costs and other provisions place reasonable cost limits on surgical and radiology procedures. Moreover hospitals have shifted overhead over time from a fixed inpatient PPS percentage to a cost reimbursed outpatient cost center. Although, this shift will not affect a total Medicare margin analysis, it does make Outpatient services large net losers and inpatient services larger net winners, distorting the discussion of how to pay individual services.
- SNF and Home Health services are also projected as net losers in the Lewin/AHA analysis. But hospital based SNF's and home health agencies allow hospitals to both control the healthier short term patients under the new prospective payment systems and generate downstream income for their profitable inpatient cost centers. If this were not true in the mind of the hospital CEO, these lines of business which were created in the last decade when they were cost-reimbursed and hospital inpatient DRG payment were fixed, can be dropped by the hospital. The GAO has told us there has been no loss of access to services by Medicare beneficiaries because of the recent decline in home health agencies. If hospitals drop unprofitable services, we would need to know if this affects beneficiary access.
- The Lewin/AHA analysis is a static projection. It does not account for any additional cost cutting activities hospitals can engage in to remain profitable.

OPTIONAL FORM 99 (7-80)

FAX TRANSMITTAL

of pages ▶ 1

To <u>Dan M. / Chris J.</u> Dept./Agency _____ Fax # <u>410-21</u>	From <u>Barry Clayton</u> Phone # <u>690-6670</u> Fax # <u>410-7321</u>
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Office of Legislation



Number of Pages: Ct6

Date: 6-24-99

To: Chris Jennings - 456-5557 Mark Miller - 395-7840	From: Bonnie Washington
Fax: _____	Fax: _____
Phone: _____	Phone: <u>690-5960</u>

REMARKS: _____

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

American Hospital Association Center for Public Affairs



*Copies for
Peter H
Nancy - Ann
Bob Beaman
Chris P.
pls fax to
Chris Jennings
Mark Miller
OHIS: BW*

TO: Bonnie Washington

FROM: Mary Beth Savary-Taylor

DATE: 6-24-99

NUMBER OF PAGES TO FOLLOW: 5

COMMENTS: _____

Washington, DC Center for Public Affairs
Chicago, Illinois Center for Health Care Leadership
Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2902
(202) 638-1100

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).

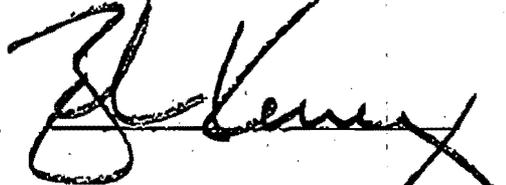
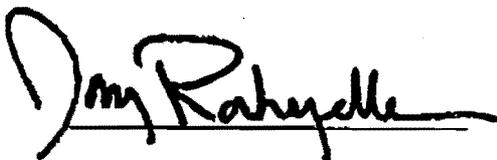
With the encouragement of Congress, HCFA, seniors' representatives and providers cooperatively developed the outpatient PPS policy. The new policy was designed to address a longstanding flaw in outpatient payment policy and to gradually rationalize Medicare's outpatient copayments, without imposing unmanageable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

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

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

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

Sincerely,



--more--

J. L. ...

Byron T. ...

Allen ...

Robert T. ...

Jim ...

Mike ...

Jim ...

... ..

... ..

... ..

Herb Kohl

Jim ...

Frank H. ...

John ...

Paul D. ...

... ..

Craig ...

George V. ...

... ..

T. ...

HCFA Letter
June 18, 1999
Page 3

Jesse Helms

Max Cleland

Mike Cray

Art Hollings

Olympic Snow

Robert H. Byrd

Michael B. Eni

Thomson

John F. Kerry

Bill McClell

John Hutchinson

Sam Brown

Rick Santorum

Patty Murray

Jeff Bond

Ray Bailey Hutchinson

John Warner

Ann Perry

Barbara Mikulski

Mark Hatch

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June 18, 1999
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Joe Chaboy

Chris Dodd

Carl DeLoach

Jeff Dingus

Walter D. Long

Wayne Allard

Bob Costello

Jessie Collins

Charles Schumer

Chuck Grassley

Max Baucus

Richard Lugar

Chuck Robb

Paul D. Douglas

Phil Wyden

Barbara Boxer

Mike Strotz

John Edwards

Mike Crapo

Patrick Leahy

HCFA Letter
June 18, 1999
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Ed Kennedy

Jimmy

Tom Taxler

Jack Reed

John Breacy

Strom Thurmond

Richard Shelby

Blank R. Levin

John H. Chayer

Pete Fitzgerald

Em Boyl

Garry

Medicare Legislative Ideas Suggested By Provider Groups

Inpatient Hospitals

- (a) Change indirect medical education (IME) add-in payments to 6.5 percent for the last 6 months of FY 2000 (instead of 6.0 percent) and for all of FY 2001 (instead of 5.5 percent). Current law IME add-on payments of 5.5 percent would begin with FY 2002.

5-year (FY 00-04): \$1.5 bil

10-year (FY 00-09): \$1.5 bil

- (b) Effective for portions of cost reporting periods occurring on or after April 1, 2000, pay hospitals 100 percent (instead of 60 percent in FY 2000 and 80 percent in 2001) of the direct graduate medical education when a Medicare+Choice enrollee has a discharge from a teaching hospital.

5-year (FY 00-04): \$0.8 bil

10-year (FY 00-09): \$0.8 bil

- (c) Maintain the DSH reduction at 3 percent in FY 2001 and FY 2002 (instead of increasing the reduction to 4 percent in FY 2001 and 5 percent in FY 2002). The current law provision for no reduction in DSH payments beginning in FY 2003 would remain in place.

5-year (FY 00-2004): \$0.4 bil

10-year (FY 00-09): \$0.4 bil

Hospital Outpatient Departments (OPDs)

- (a) Implement a transition to the OPD prospective payment system (PPS) by establishing a floor on OPD payments for the first three and a half years of the new system (7/1/00 to 12/31/03). A comparison would be made between a hospital's payment to cost ratio in 1996 (after removing amounts associated with any formula-driven overpayment a hospital may have received) with the actual payment to cost ratio for the adjustment year. If, in any of the first three and a half years, a hospital's payment to cost ratio fell below a specified percentage of the 1996 payment to cost ratio, the hospital would receive additional payments to bring the payment to cost ratio up to that specified percentage amount. Between July 1, 2000 and December 31, 2001, hospitals would receive additional payments to assure that their payment to cost ratio does not fall below 90 percent of their 1996 ratio of payments to costs. In 2002 and 2003, the percentages would be 85 percent and 80 percent respectively. An interim payment policy would be established so that hospitals would not have to wait until settlement of their cost report to receive a benefit from this transitional policy. After each year, adjustments would be made based on the actual payment to cost ratio calculated on the basis of cost reports.

5-year (FY 00-04): \$1 to 1.5 bil

10-year (FY 00-09): \$1 to 1.5 bil

- (b) Eliminate the 5.7 percent impact of the OPD PPS on hospitals, effective when PPS is implemented. The copayment amounts that beneficiaries would pay would remain unchanged and be based on 20 percent of median charges. Medicare program payments would increase to account for the entire 5.7 percent increase in payments to hospitals.

5-year (FY 00-04): \$6 bil (\$4.5 bil net) 10-year (FY 00-09): \$16 bil (\$12 bil net)

Home Health:

- (a) Eliminate the reductions, established by section 5105(d) of OCESA, in the home health market basket increase of 1.1 percentage points for each of fiscal years 2001, 2002 and 2003. (Note: The reduction for FY 2000 would remain.)

5-year (FY 00-04): \$1.5 bil 10-year (FY 00-09): \$5.0 bil

- (b) Eliminate all of the scheduled 15 percent reduction in the home health per visit cost limits and per beneficiary limits in effect on 9/30/00.

5-year (FY 00-04): \$8.5 bil 10-year (FY 00-09): \$25 bil

- (c) Eliminate half (i.e., 7.5 percentage points) of the scheduled 15 percent reduction in the home health per visit cost limits and per beneficiary limits in effect on 9/30/00.

5-year (FY 00-04): \$4.2 bil 10-year (FY 00-09): \$12.5 bil

Skilled Nursing Facilities:

- (a) Allow SNFs to elect to receive the full Federal rate (i.e., go to the full SNF PPS), effective beginning 60 days after enactment.

5-year (FY 00-04): \$0.5 bil 10-year (FY 00-09): \$0.5 bil

*a (c)
allow
SNF
to stay
at
250%
only during
transition*

- (b) Effective 30 days after enactment legislation, exclude certain specified items and services from consolidated billing (chemotherapy, chemotherapy administration, radioisotopes, and specified customized prosthetic device, ambulance trips and, when furnished in any setting, surgical procedures previously excluded only when furnished in a hospital OPD). The SNF would submit a bill to the carrier for such items and services.

5-year (FY 00-04): \$0.1 bil 10-year (FY 00-09): \$0.2 bil

Effective for services furnished beginning 4/1/00, increase the Federal portion of per diem payments by 1 percent for 6 specified RUGs III groups (for extensive and special care). The RUGs covered are: SE3, SE2, SE1, SSC, SSB, and SSA. This policy would be effective until the Secretary refined RUGs to deal with non-therapy ancillary costs/medically complex cases (expected to be 10/1/00) at which time this temporary add-on policy would end and the additional costs of it would be included in the SNF expenditure base for the refined RUGs.

5-year (FY 00-04): \$0.3 bil 10-year (FY 00-09): \$0.9 bil

- (d) Effective for services furnished beginning 4/1/00, increase the Federal portion of per diem payments by 1 percent for all RUGs.

5-year (FY 00-04): \$0.8 bil 10-year (FY 00-09): \$2.0 bil

- (e) Increase SNF payments for 15 RUGs by specified dollar amounts add-ons. The add-on payments would be permanent and increased annually by the SNF market basket.

5-year (FY 00-04): \$9 bil 10-year (FY 00-09): \$21 bil

- (f) Effective for services furnished on or after April 1, 2000, increase SNF payments for all RUGs by 3 percent (which is equal to elimination of the 1 percentage point per year reduction in SNF market basket used to update FY 1995 base data for the SNF PPS to the FY 1998 starting point of the PPS).

5-year (FY 00-04): \$2.5 bil 10-year (FY 00-09): \$6 bil

(5) Therapy Caps

- (a) Increase each of the two therapy caps (physical/speech therapy and occupational therapy) from \$1,500 to \$2,000 per year, effective 1/1/00 for all services furnished by providers but not those services furnished by independent practitioners where the cap would remain at \$1,500 during 2000 and be increased to \$2,000, effective 1/1/01.

5-year (FY 00-04): \$1.6 bil (\$1.2 bil net) 10-year (FY 00-09): \$4.2 bil (\$3.2 bil net)

- (b) Create a third therapy cap, separating speech and physical therapy with each having a limit of \$1,500 per year, effective 1/1/00.

5-year (FY 00-04): \$0.7 bil (\$0.5 bil net) 10-year (FY 00-09): \$1.9 bil (\$1.4 bil net)

- (c) Repeal BBA provision, effective 1/1/00.

5-year (FY 00-04): \$4 bil (\$3 bil net) 10-year (FY 00-04): \$10 bil (\$7.5 bil net)

- (d) Create exceptions from the cap.

5-year (FY 00-04): \$4 bil (\$3 bil net) 10-year (FY 00-04): \$10 bil (\$7.5 bil net)

b. Administrative actions to smooth implementation of the BBA

Policy: The Administration will take a number of actions that are within its administrative authority under the statute to smooth the implementation of some of the provisions of the BBA. These changes will help ensure beneficiary access to care while maintaining the fiscal discipline of the BBA that is essential for protecting Medicare's future.

Inpatient hospital transfers. The BBA requires the Secretary to reduce payments to hospitals when they transfer patients to another hospital or unit, skilled nursing facility or home health agency for care that is supposed to be included in acute care payment rates for ten diagnoses. It also authorizes HCFA to extend this "transfer policy" to additional diagnoses after October 1, 2000. To minimize the impact on hospitals, extension of the transfer policy to additional diagnoses is being postponed for two years.

Hospital outpatient payments. The BBA requires Medicare to begin paying for hospital outpatient care under a prospective payment system (PPS), similar to what is used to pay for hospital inpatient care. To help all hospitals with the transition to outpatient prospective payment, we are considering delaying a "volume control mechanism" for the first few years of the new payment system. The law requires Medicare to develop such a mechanism because prospective payment includes incentives that can lead to unnecessary increases in the volume of covered services. The proposed prospective payment rule presented a variety of options for controlling volume and solicited comments on these options. Delaying their implementation would provide an adjustment period for providers as they become accustomed to the new system.

Also to help hospitals under the outpatient prospective payment system, we included a proposal in the proposed rule to use the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

We are considering implementing a three-year transition to this new PPS by making budget-neutral adjustments to increase payments to hospitals that would otherwise receive large payment reductions such as low-volume rural and urban hospitals, teaching hospitals, and cancer hospitals. Without these budget-neutral adjustments, these hospitals could experience large reductions in payment under the outpatient prospective payment system. For all of these outpatient department reform options, the rulemaking process precludes any definitive statement on administrative actions until after the implementing rule is published.

Rural hospital reclassification. Hospital payments are based in part on average wages where the hospital is located. We are making it easier for hospitals whose payments now are based on lower, rural area average wages to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are changing those average wage threshold percentages so more hospitals can be reclassified.

Home health. The BBA significantly reformed payment and other rules for home health agencies. We are taking several new steps to help agencies adapt to these changes including: (1) increasing the time for repayment of overpayments related to the interim payment system from one year to three years, with interest. Currently, home health agencies are provided with one year of interest free extended repayment schedules; (2) postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds; (3) following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier; (4) eliminating the sequential billing rule as of July 1, 1999. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree; (5) phasing-in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provisions. By allowing this degree of flexibility for a temporary period we will prevent any agency cash flow problems or returned claims.

Background/rationale: The BBA required implementation of many changes on a rapid schedule, without fully taking into account the need to make Y2K computer changes and other implementation issues. Because of the magnitude of some of the changes, certain providers may need additional time to prepare or adjust to them. The plan includes these administrative actions to ensure that the implementation of the BBA changes is done in a way that simultaneously assures appropriate payment and access to high-quality health care.

BASIC INFORMATION ON THE SUSTAINABLE GROWTH RATE SYSTEM

Q: What is the Sustainable Growth Rate (SGR)?

A: Medicare payments for physicians' services are updated annually by HCFA. Payment rates are based on a relative value scale system that reflects the physician work, practice expense and professional liability insurance costs involved in each service. The relative value for each service is multiplied by a dollar conversion factor to establish actual payment amounts. The conversion factor is required to be updated each calendar year, which involves establishing an update factor that is adjusted annually by the SGR.

The SGR was enacted as part of BBA 1997. Under the SGR, a target rate of spending growth is calculated each year. Physician payment updates depend on whether actual spending growth exceeds or falls short of the target. If actual spending exceeds target spending, then payment updates will be less than inflation, and may be negative. If actual spending is below target spending, then above-inflation payment updates are indicated.

Limits are set on annual changes to the Medicare conversion factor under the SGR. The annual conversion factor update can be no greater than inflation plus 3 percent; the update can be no lower than inflation minus 7 percent.

Q: How is the SGR calculated?

A: The SGR target rate of spending growth is determined by four factors:

- Percent increase in payments for physician services before legislative adjustments (market basket);
- Percent increase in Medicare fee-for-service enrollment;
- Percent increase in real per capita gross domestic product (GDP); and
- Percent increase in physician expenditures due to legislative and regulatory factors.

The calculation of the SGR for any given year is based on projected values, so updates may be higher or lower than they would be if later data were used.

Q: What was the target growth rate for FY 1999?

A: The target growth rate for FY 1999 was a negative 0.3 percent. Since expenditures did not decrease by that amount nationwide, it led to a cut in the physician payment update for this year.

Q: What is the problem with how the SGR is calculated?

A: The SGR is based on the HCFA estimate of the four factors that determine allowable spending growth. If HCFA estimates inaccurately, the payment updates will be either too high or too low. However, HCFA believes that it does not have the legislative authority to correct projection errors once actual data becomes available. In addition, because the SGR system is cumulative, any projection errors that are left uncorrected will carry over from year to year. In addition, because physician payment updates are established on a

calendar year basis, SGR targets are established on a federal fiscal year basis, and cumulative spending (used to calculate the SGR) is established on an April 1 through March 31 basis, there is a time lag between identifying the need for an adjustment and HCFA's ability to make that adjustment. AMA believes these errors cost physicians \$645 million in 1999.

Q: What changes would AMA like to see to the SGR?

A: The AMA would like to see four changes to the way the SGR is calculated:

HCFA should begin to correct the errors in the SGR estimates when actual data are available, and provide a retrospective adjustment to the payment rates back to 1998. The AMA believes that HCFA has the administrative authority to do this now. HCFA does not believe that it currently has the legislative authority to make such corrections, but recognizes that this is a problem. In order to address this issue, HCFA has submitted a legislative proposal that would provide it with the authority to prospectively adjust the payment rates based on the actual data. The HCFA legislative proposal does not include the retrospective payment adjustment the AMA wants.

Congress should take action to stabilize the payment updates under SGR by calculating the SGR and the update adjustment factor on a calendar year basis. Projections show the SGR formula producing alternating periods of maximum and minimum payment updates. for several years, only to shift back again. The primary reason for this instability is the fact that there is a time lag in measurement periods for the SGR. Specifically, while physician payment updates are established calendar year basis, SGR targets are established on a federal fiscal year basis and cumulative spending (used to calculate the SGR) is established on an April 1 through March 31 basis. These time periods must all be consistent and calculated on a calendar year basis to attempt to restore some modicum of stability to the SGR system. HCFA and OMB agree and have developed a legislative proposal to address this problem. (what is?) Timed? 2

Congress should revise the SGR to include a factor of growth in the GDP for technological advancement. AMA argues that the invention of a new medical device cannot, in and of itself, improve health care. physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. To address this problem, the SGR should be set at GDP + 2 percentage points to take into account technological innovation. I do not know the HCFA/OMB positions on this proposal.

Congress should consider an approach to setting a growth target that takes into account site-of-service changes, as well as health status and other differences between Medicare's fee-for-service and managed care populations. AMA would like AHCPR to do a study on the best way to estimate the economic impact on Medicare expenditures for physician services resulting from improvements in advancements in scientific technology, changes in the composition of enrollment of beneficiaries under the fee-for-service Medicare program and shifts in usage of sites-of-service. I do not know the HCFA/OMB positions on this proposal.

WILLIAM V. ROTH, JR., DELAWARE, CHAIRMAN

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United States

COMMITTEE
WASHINGTON, D.C.

Medical Reforms

~~SSA~~

Provider Give-Back

File

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

Septer

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

Dear Trent:

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

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

1. Tax Extenders - \$2.2 billion. Extension of tax provisions that expired in 1999 must be addressed. My preference is to pass the identical provisions that were included in the conference report to accompany H.R.2488, which included a five year extension of many of the provisions.

2. Alternative Minimum Tax (AMT) - \$1 billion. The AMT for individuals should be corrected in order for millions of Americans to take advantage of numerous tax credits such as the \$500 per child tax credit, HOPE scholarship credit, and the dependent care tax credit. We promised these benefits to middle income families and we should not let the AMT interfere with these credits. We provided AMT relief for one year in last year's omnibus appropriations bill. We need to extend this relief this year as well.

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

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

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

Sincerely,



William V. Roth, Jr.
Chairman

WVR/jkw

Medicare:

ie issues:

- BBA give body / Admin & Leg
Reform →
At Drugs → care & low income

- Budget favorable outcomes
FEB 08 -- ↑ 10% at 1st 3 yrs

- Taxes & Trade

- Finance must be workable

- Staff support.

- Recommendation. Mand. Income added Provision

- Committee outline:
Kathy Mann.

• Competition aspects -- good

• For Drugs -- cost concern
no consensus in it

• No transition or relaxation contained

• Needing time to digest ideas

• Members might want to take a vote

• Co. BBA for first for best off bipartisan relationship

- I'm a conservative & I understand the politicians

- Create a letter to POTUS or down staff

- Can't be left to be about politicians

- LACK OF TRUST

- Take no ~~more~~ Bush

- Not interested in pushing beyond what market will bear

09/23/99 17:57

SEP. 22 '99 (WED) 16:10

SENATE FINANCE COMM

TEL: 202 228 0554

003/004
P. 002

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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

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

September 22, 1999

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

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

Dear Trent:

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

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99/23/99 17:57

004/004

SEP. -22' 99 (WED) 16:11

SENATE FINACE COMM

TEL: 202 228 0554

P. 003

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

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

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

Sincerely,



William V. Roth, Jr.
Chairman

WVR/jkw



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

Dear Mr. Chairman:

I am writing to respond to your request regarding how the Administration would score the attached language clarifying Congressional intent on the outpatient prospective payment system (PPS) enacted in the Balanced Budget Act (BBA).

As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of \$7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

Jacob L. Lew
Director

SEC. ____. INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.

THE WHITE HOUSE

WASHINGTON

October 19, 1999

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

Dear Mr. Chairman:

It was a pleasure to meet with you and Senator Moynihan earlier this month to discuss our mutual commitment to strengthening and modernizing Medicare. It continues to be my hope that the Congress will take action this year to, at minimum, make a down-payment on needed reforms of the program. I look forward to working with you toward that end.

In 1997, the Medicare trustees projected that Medicare would become insolvent in 2001. Working together across party lines, the Congress passed and I enacted important reforms that contributed towards extending the life of the Medicare trust fund to 2015. As with any major legislation, the Balanced Budget Act (BBA) included some policies that are flawed or have had unintended consequences that are posing immediate problems to some providers and beneficiaries. In addition, the program faces the long-term demographic and health care challenges that will inevitably result as the baby-boom generation ages into Medicare. As we worked together in 1997 to address the immediate threat to Medicare, we must work together now to address its short-term and long-term challenges.

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

You have requested a summary of the administrative actions that I plan to take to moderate the impact of the BBA. In the letter that you sent to me last Thursday, you also asked about four specific issues related to payment for hospital outpatient departments, managed care, skilled nursing facilities, and disproportionate share hospitals.

Attached is a summary of the over 25 administrative actions that my Administration is currently implementing or will take to address Medicare provider payment issues. The Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will accrue to the benefit of hospitals, nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was to not impose an additional reduction in aggregate payments for hospitals and I favor a policy that achieves this goal. The enactment of clarifying language on this subject would be useful in making clear Congressional intent with regard to this issue. I have attached a letter from Office of Management and Budget Director Jack Lew, which was sent at the request of Congressman Bill Thomas, detailing how such language would be scored by OMB.

With regards to managed care, we share your commitment to expanding choice and achieving stability in the Medicare+Choice marketplace. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support my Administration's risk adjustment plan. Consistent with this position, most policy experts believe that a further slowdown of its implementation is unwarranted. However, we remain committed to making any and all changes that improve its methodology. Moreover, as you know, any administrative and legislative changes that increase payment rates to providers in the fee-for-service program will also increase payments to managed care plans.

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. While we believe that these adjustments must be budget neutral, we are continuing to review whether we have additional administrative authority in this area.

Finally, it appears that there has been confusion about the current policy for disproportionate share hospital (DSH) payments. Hospitals across a considerable number of states have misconstrued how to calculate DSH payments. The Department of Health and Human Services (HHS) has since concluded that this resulted from unclear guidance. Thus, as reported last Friday, HHS will not recoup past overpayments and will issue new, clearer guidance as soon as possible.

We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care.

I hope and expect that our work together will lay the foundation for much broader and needed reforms to address the demographic and health care challenges confronting the program. We look forward to working with you, as well as the House Ways and Means and Commerce Committees, as we jointly strive to moderate the impact of BBA on the nation's health care provider community.

Sincerely,

Ben Clinton

**ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

ISSUE	STATUS
HOSPITALS: GENERAL	
✓ Capping hospital transfer policy at 10 DRGs for 2 years, through '02	Now being implemented
✓ Stop administrative recoupment of DSH payments based on unclear guidance	Now being implemented
HOSPITALS: OUTPATIENT	
** Eliminate the 5.7 percent payment reduction resulting from drafting problem in the Balanced Budget Act	Under review
✓ Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions	Planned for regulation early next year*
✓ Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS)	Planned for regulation early next year*
✓ Delay implementation of prospective payment system for cancer hospitals until additional data are collected	Planned for regulation early next year*
✓ Make technical refinements to the Ambulatory Payment Classification (APC) system	Planned for regulation early next year*
✓ Allow for temporary cost-based APCs for certain new technologies	Planned for regulation early next year*
✓ Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs)	Planned for regulation early next year*
✓ Create separate APCs to pay for blood and blood products	Planned for regulation early next year*
✓ Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery	Planned for regulation early next year*
✓ Eliminate use of diagnostic codes in payments for medical visits and reassess in the future	Planned for regulation early next year*
SKILLED NURSING FACILITIES	
✓ Increase payment for high acuity patients	Will be implemented
✓ Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy	Now being implemented
HOME HEALTH	
✓ Delay tracking patients and pro-rating payments	Now being implemented
✓ Provide for extended interim payment system repayment schedules for agencies	Now being implemented
✓ Postpone the requirement for surety bonds until October 1, 2000	Now being implemented
✓ Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues	Now being implemented

ISSUE	STATUS	
✓	Eliminate the sequential billing rule	Will be implemented
✓	Phase in reporting of services in 15-minute increments	Will be implemented
PHYSICIANS		
**	Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions	Under review
RURAL PROVIDERS		
✓	Change the average wage threshold percentages so more rural hospitals can reclassify	Will be implemented
✓	Use same wage index for inpatient and outpatient PPS	Planned for regulation early next year*
✓	Provide stop-loss protection in the transition to the outpatient PPS	Planned for regulation early next year*
**	Modify Health Professional Shortage Area designations	Under review
AMBULATORY SURGICAL CENTERS		
X	Postpone implementation based on 1999 survey	
MANAGED CARE		
✓	Phase-in risk adjustment over a 5-year period	Now being implemented
✓	Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension	Now being implemented
X	Phase-in risk adjustment over a 7-year period	
✓	Improve beneficiary protections and access to information	Now being implemented
✓	Ease provider participation rules	Now being implemented

"X" indicates that this policy is not advisable, as described in the attachment.

*Federal law requires that the Administration cannot commit to changes in a proposed rule before the final publication.

**Under review.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

Dear Mr. Chairman:

I am writing to respond to your request regarding how the Administration would score the attached language clarifying Congressional intent on the outpatient prospective payment system (PPS) enacted in the Balanced Budget Act (BBA).

As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of \$7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

Jacob J. Lew
Director

SEC. __. INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.

**DESCRIPTION OF ADMINISTRATIVE ACTIONS BY THE
CLINTON ADMINISTRATION TO MODERATE THE IMPACT OF THE
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

HOSPITALS: GENERAL

Capping hospital transfer policy at 10 DRGs for 2 years, through 2002. We will postpone for two years the extension of the hospital transfer policy to additional diagnoses beyond the current set of 10 Diagnosis Related Group (DRG) categories. We also will consider whether further postponement of extension to additional diagnoses is warranted.

Stop administrative recoupment of DSH payments based on unclear guidance. We have recently determined that certain hospitals received additional disproportionate share hospital (DSH) payments because guidance on how to claim these funds was insufficiently clear. We will therefore hold harmless hospitals that have received these additional payments. We also will soon clarify guidance to hospitals and our claims processing contractors on how to claim these funds. And we will provide further clarification to State Medicaid agencies because they are the primary source of data critical to the DSH calculations. We will apply the clarified policy and hold hospitals responsible for being in compliance as of January 1, 2000.

HOSPITAL OUTPATIENT PAYMENTS

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was for this policy to be implemented in a way that is budget neutral for hospitals and the Administration favors a policy that achieves this goal. Unfortunately, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. In addition, there are a number of changes that we believe are necessary to address specific policy concerns and moderate the payment reductions in the Medicare prospective payment system (PPS) for outpatient departments. Although we are prohibited by law from committing to changes before the final rule is published, we can outline the approaches we believe are consistent with Administration policy and expect to take in the outpatient department rule. These include:

Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions. We expect to delay implementing the proposed "volume control mechanism." The statute requires the agency to develop a volume control mechanism. In the proposed rule, we suggested use of a mechanism that might lead to a downward adjustment in the payment rates as early as 2002 (to reflect volume increases in 2000). Delaying this mechanism would provide time for providers to adjust to the new system.

Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS). We expect to include a 3-year transition to the new PPS by making budget-neutral adjustments that will increase payments to hospitals that would otherwise incur large payment reductions. These hospitals would include certain rural, inner city, cancer, and teaching hospitals. Some hospitals, like cancer hospitals, are projected to experience a reduction in excess of 30 percent. This transition policy would ensure that payments do not drop below a specified threshold to protect against such reductions.

Delay implementation of prospective payment system for cancer hospitals until additional data are collected. The lack of reliable data from cancer centers makes developing a prospective payment system for them difficult. Consequently, we now expect to delay full implementation of the PPS system for the cancer hospitals and to use an interim payment system for at least 18 months from the initiation date of PPS for other hospitals. We would not end this interim system until we are ready to implement a prospective system for cancer hospitals based on full information.

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

Allow for temporary cost-based APCs for certain new technologies. Concerns have been raised about the adequacy of payments in APCs for medical technologies that are new (and hence are not reflected in the data bases on which we do our estimates) and where the cost of the item is very large relative to the payment for the APC. In some instances it may be possible to accommodate new, high-cost technology items within the APCs. In others, we expect to specify in advance and use a set of cost-related APCs for some period of time while better data about actual costs are collected.

Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs). Packaging payments for certain covered drugs with the procedure or visit with which they are furnished could underpay hospitals and slow the introduction of new drugs into the system. Thus, we anticipate creating additional APCs to pay for certain drugs, particularly high-cost drugs. Where appropriate, we would permit billing for multiple APCs depending on dosages actually used. With respect to chemotherapy, we expect to substantially increase the number of APCs for chemotherapy agents to minimize the variability within groups and assure beneficiary access is not compromised. We would also create APCs for supportive and adjunctive therapies.

Create separate APCs to pay for blood and blood products. Under the proposed rule, we would pay for blood and blood products as part of the payment for a surgical procedure or blood transfusion service. As a result of concerns raised in comments, we have reconsidered our proposal and now expect to implement separate APCs to pay for blood, other blood products and anti-hemophilic factors.

Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery. Under the proposed rule, we would pay for corneal tissue acquisition costs as part of the payment for corneal transplant surgery. Given the variable rates at which hospitals acquire the tissue from eye banks, we are likely to accept the recommendation to decouple payment for tissue acquisition from that for the surgical procedure and to pay for it, at least until further experience is gained, based on acquisition cost.

Eliminate use of diagnostic codes in payments for medical visits and reassess use in future. The proposed rule based payments for medical visits to clinics and emergency departments on codes for both medical procedures and diagnosis. Because diagnostic codes are not used in payment for all other services, we now expect to revise our medical groups by eliminating the use of diagnostic codes in computing payment amounts for the present.

SKILLED NURSING FACILITIES (SNF) PAYMENTS

Increase payment for high acuity patients. We will use administrative flexibility to increase relative weights for the Resource Utilization Groups for high acuity patients under the Skilled Nursing Facility Prospective Payment System (SNF PPS). We expect to have research findings on advisable refinements completed by the end of this year and to include them in a proposed rule next Spring, for implementation in October 2000. We believe these changes should be budget neutral. However, we are continuing to review whether we have additional administrative authority.

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

HOME HEALTH PAYMENTS

Delay tracking patients and pro-rating payments. Although fiscal intermediaries are responsible for tracking and pro-rating payments, we were unable to make the necessary systems changes to accomplish this due to our efforts related to Year 2000 computer systems requirements. Therefore, we are delaying implementation of the requirement until the implementation of the prospective payment system. We have developed a way to implement this proposal under the prospective payment system that will allow fiscal intermediaries and HCFA to more directly track beneficiaries. We also want to clarify that the law does not make home health agencies responsible for tracking utilization for purposes of pro-rating payments.

Provide for extended interim payment system repayment schedules for agencies. As part of our Medicare reform plan, we are allowing agencies an automatic 36 months to repay excess interim payment system (IPS) overpayments. The first year is interest-free.

Postponing the requirement for surety bonds until October 1, 2000. We are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds.

Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues. We are also following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

Eliminate the sequential billing rule. As of July 1, 1999, we eliminated the sequential billing rule. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree.

Phase in reporting of services in 15-minute increments. We are phasing in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provision. By allowing this degree of flexibility for a temporary period, we will prevent any agency cash flow problems or returned claims.

PHYSICIAN PAYMENTS

Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions. As we indicated in the *Federal Register* on October 1, 1999, at this time, we do not believe we have the ability under current law to make adjustments to revise the Sustainable Growth Rate (SGR) based on later data. We agree that there is a problem and thus have submitted, as part of the FY 2000 budget, a budget-neutral legislative proposal to require that revisions be made to correct estimation errors in calculation of the SGR and to fix other technical aspects of the SGR. However, we are continuing to review whether we have any ability administratively to address this issue.

RURAL PROVIDER PAYMENTS

Change the average wage threshold percentages so more rural hospitals can reclassify. We are implementing policies making it easier for rural hospitals, whose payments now are based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are planning to change those average wage threshold percentages in the FY 2001 hospital regulation so more hospitals can be reclassified.

Use same wage index for inpatient and outpatient PPS. In the proposed rule, we expect to help rural hospitals by using the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

Modify Health Professional Shortage Area designations. We are also working to address other concerns of rural providers, where we can, through administrative actions. The Health Care Financing Administration has formed a high-level working group on rural health to work with providers to identify both administrative and legislative issues and resolve those that we have the authority to address under current law. For example, we are working with the Health Services and Resources Administration to modify the Health Professional Shortage Area designations. We are also considering changes to policies related to Critical Access Hospitals, Graduate Medical Education payments for rural providers, and wage indices for rural providers.

AMBULATORY SURGICAL CENTER (ASC) PAYMENTS

Postpone implementation based on 1999 survey. We plan to publish the final rule on payment policy changes for ASCs next spring and implement the new system in July 2000. The current ASC rates have been in place since 1990 and are based on 1986 survey data. We appreciate the desire to incorporate more current data. However, the process of sending out and having the ASCs complete the surveys, auditing the surveys, analyzing the data, writing a proposed rule, commenting on a proposed rule, and issuing a final rule is lengthy. If we were to delay implementing payment changes until the 1999 survey data are incorporated, we would have to delay the payment policy changes planned for July 2000 for an additional three years.

MEDICARE +CHOICE PAYMENTS

Phase in risk adjustment over a 5-year period. In March, we announced a five-year transition to comprehensive risk adjustment for Medicare+Choice plans to minimize the disruption to plans. We plan to begin the transition in 2000 with a 90/10 blend of demographically and risk adjusted rates. This blend will be gradually increased over five years so that in 2004, rates will be fully risk adjusted using a comprehensive adjustment system that takes into account all care settings.

We believe that this five-year transition strikes the appropriate balance between concern for plans and our obligation to be fiscally responsible and ensure that plans are paid fairly and appropriately for the care they provide, especially to the sickest beneficiaries. Our actuaries estimate that this transition schedule will cost the Medicare Trust Funds \$4.5 billion more than full implementation of risk adjustment in 2000. Our current phase-in schedule prevents plans from experiencing more than a five to ten percent shift in rates in the first few years. For example, based on our impact analyses using 1997 and 1998 plan data, no plan would face more than a 1.85 percent reduction in 2000 and plans on average would face only a 0.7 percent reduction in 2000. Significant differences in later years would indicate that a plan's enrollees are substantially healthier than average, in which case it is appropriate to pay more to other plans that are caring for less healthy enrollees. A number of experts, including the Medicare Payment Advisory Commission, support this approach. We would like to work with Congress and other interested parties to further review technical modifications to improve Medicare+Choice risk adjustment.

Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension. For EverCare managed care plans that provide specialized services to the frail elderly, we are extending this demonstration project for an additional year through December 31, 2001. We also will continue the exemption from risk adjustment during this extension. This will provide additional time to complete our evaluation of this project. It also will allow EverCare to submit additional data on the special population it serves, which we can analyze for possible use in refinement of our risk adjustment methodology.

Improve beneficiary protections and access to administration. We also published refinements to Medicare+Choice regulation that improve beneficiary protections and access to information. For example, we clarified that any beneficiary who is enrolled in a Medicare+Choice plan that withdraws from the program is entitled to immediate enrollment in any other remaining Medicare+Choice plan serving the enrollee's area.

Ease provider participation rules. We have taken additional steps to assist plans and encourage their participation in Medicare+Choice. We worked with Congress to give plans two more months to file the information used to approve benefit and premium structures so plans are able to use more current experience when designing benefit packages and setting cost sharing levels. We also eased provider participation rules and increased flexibility for plans in coordinating care for enrollees with serious or complex conditions and in conducting initial health assessments for new enrollees.