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Balanced Budget Act/Givebacks [8]

gf147

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- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MEMORANDUM

October 20, 1999

FROM: Solomon Mussey
Office of the Actuary
Health Care Financing Administration

SUBJECT: Estimated Impact of the Medicare Balanced Budget Refinement Act of 1999 on the Solvency of the Hospital Insurance Trust Fund

This memorandum provides the estimated impact of the Medicare Balanced Budget Refinement Act of 1999 on the solvency of the HI Trust Fund. The financial impacts of the provisions of this bill that affect the HI program were estimated based on legislative language that was provided to OAct on October 15, 1999. The relevant provisions were estimated using the intermediate set of assumptions from the 1999 HI Trustees Report. Estimates of individual provisions of the bill are not provided at this time.

Under current law, the HI trust fund is projected to be exhausted in 2015. We estimate that the subject legislation would advance the exhaustion date of the HI trust fund assets by approximately 1 year, to 2014

The estimates required to determine the solvency impact were completed within a tight timeframe and in some cases reflect less refined methodologies than we would normally employ. Also, the estimates were based on legislative language as of October 15, 1999; if the legislative language changes, then the estimates would be subject to change accordingly. Finally, the estimated operations of the HI trust fund are extremely sensitive to the underlying assumptions. The actual year of exhaustion under this legislation could differ significantly from this estimate.

Solomon Mussey
Solomon Mussey, A.S.A.
Director, Medicare and Medicaid
Cost Estimates Group

Medicare Reform:
Analytical/Budget
stats file

From Greg White -
I don't find it very

The 5.7% vs. 3.8% Reduction in Hospital OPD Revenues

helpful

The original OPD PPS NPRM estimated that hospitals would experience a 3.8% reduction as a result of OPD PPS largely because beneficiaries would pay coinsurance based on 20% of median charges. This original estimate included technical errors.

The reestimate of the impact on hospitals in the subsequent NPRM correction notice indicated that hospitals would receive a 5.7% reduction as a result of OPD PPS NPRM. The change from a 3.8% reduction to a 5.7% reduction is the result of two factors.

First, the 3.8% grew by 0.6% (to 4.4%) as a result of technical reestimates (e.g. recalculation of the rates using better data.)

Second, another error was made in the original notice regarding multiple procedures performed on this same day in an OPD. The general policy in the ASC and physician settings is to reduce Medicare and beneficiary payments for second and subsequent procedures performed on the same day. This discourages unnecessary utilization. Consistent with this policy, the NPRM proposed a 50% reduction in reimbursement for second and subsequent surgical procedures performed on the same day in the OPD.

In establishing the base target amounts for the original NPRM, it was inadvertently assumed in the data analysis for the original NPRM that beneficiaries would pay the full coinsurance amount on multiple procedures performed on the same day. By correcting the notice to reflect the proposed policy to allow beneficiaries to pay half of the coinsurance amount, the estimated reduction to hospitals as a result of OPD PPS grew from 4.4% to 5.7%.

There are two major policy options to address this situation:

(1a) Give back the entire 5.7% by having Medicare finance the full additional amount.
This could be done as follows:

Calculate the **global target amount** (which is used to determine the conversion factor for the OPD reimbursement) as follows:

Medicare payments under the old system plus beneficiary copayments for all procedures (single and multiple) under the old system (which are all based on 20% of mean charges.)

In **actual** hospital payment, the beneficiary pays based on new law (20% of median charges) for all procedures (the full amount for single procedures and half the amount for multiple procedures), and Medicare picks up the balance to hit the target amount. This would result in a 0% reduction to hospitals under the new OPD PPS system, financed entirely by Medicare.

Scoring: We understand the CBO's current 1-year, 5-year and 10-year score of fixing this 5.7%

reduction (assuming the full 5.7% giveback) is \$200 million, \$3.9 billion and \$9.6 billion respectively.

(1b) Give back the entire 5.7% by having Medicare finance 77% (4.4%/5.7%) of this amount and the beneficiary picks up the remaining 23% (1.3%/5.7%).

The global target amount would be calculated in the same manner above in Option 1a.

In actual hospital payment, the beneficiary would be required to pay the full amount under the new system (20% of median charges) for all procedures (both single and multiple), and Medicare would finance the difference to hit the target amount. Note that in this scenario the beneficiaries would pay a higher amount and Medicare would pay less than in Option 1a. This would result in a full 5.7% giveback to the hospitals, with Medicare financing 77% of the giveback (4.4%/5.7%) and the beneficiary picks up the remaining 23% (1.3%/5.7%).

Scoring for this variant is as follows (Program/Beneficiary):

1-year: \$154 million/\$46 million.

5-year: \$3 billion/\$900 million

10-year: \$7.4 billion/\$2.2 billion

(2) The Administration could give back approximately 4.4% of the 5.7% reduction by doing the following:

Calculate the global target amount as follows:

Medicare payments under the old system plus beneficiary copayments under the old system (20% of the mean) for single procedures and for the first of multiple procedure plus new discounted copayments (10% of the median) for second and subsequent surgical procedures.

In actual hospital payment, the beneficiary pays based on new law for all procedures (with discounts for multiple procedures as in Option #1a), and Medicare picks up the balance to hit the target amount. This option would result in a net 1.3% reduction to hospitals under the new OPD PPS system because the target amount would be slightly lower in Option #2 compared to Option#1. Note that we would need to check this option with HHS GC to ascertain whether we have leeway to implement the law in this way based under the current reading of the law where OPD PPS is to be budget neutral for the hospitals.

Scoring: Assuming that CBO's \$9.6 billion 10-year estimate is linear and assumes correction of the entire 5.7% amount, CBO's estimate of this policy whole would be roughly 77% (4.4/5.7) of the original estimate. Thus, the 1-year, 5-year and 10-year score would be roughly \$154 million, \$3 billion and \$7.4 billion respectively.

Summary of Options to Address the 5.7% Reduction in OPD Revenues

Scenario	Target Amount		Actual Payment	
	Program	Beneficiary	Program	Beneficiary
NPRM (#1) (-3.8%)	Old Law	<p>New Law (20% of <u>median</u> charges)</p> <p>Single Procedures: Full (20% of <u>median</u> charges)</p> <p>Multiple Procedures: Full (20% of <u>median</u> charges)</p>	Target amount less actual beneficiary payment	<p>20% of <u>median</u> charges.</p> <p>Single Procedures: Full (20% of <u>median</u> charges)</p> <p>Multiple Procedures: Full (20% of <u>median</u> charges)</p>
NPRM (correction) (-5.7%)	Old Law	<p>New Law (20% of <u>median</u> charges)</p> <p>Single Procedures: Full (20% of <u>median</u> charges)</p> <p>Multiple Procedures: Half (10% of <u>median</u> charges)</p>	Target amount less actual beneficiary payment	<p>20% of median charges.</p> <p>Single Procedures: Full (20% of <u>median</u> charges)</p> <p>Multiple Procedures: Half (10% of <u>median</u> charges)</p>
Option 1a (0% reduction) Medicare finances 100% of the 5.7%	Old Law	<p>Old Law (20% of <u>mean</u> charges)</p> <p>Single Procedures: Full</p> <p>Multiple Procedures: Full</p>	Target amount less actual beneficiary payment	<p>20% of median charges.</p> <p>Single Procedures: Full (20% of <u>median</u> charges)</p> <p>Multiple Procedures: Half (10% of <u>median</u> charges)</p>

<p>Option 1b (0% reduction) Medicare finances 77%. Bene finances 23%</p>	<p>Old Law</p>	<p><u>Old Law (20% of mean charges)</u> Single Procedures: Full Multiple Procedures: Full</p>	<p>Target amount less actual beneficiary payment</p>	<p>20% of <u>median</u> charges. Single Procedures: Full (20% of <u>median</u> charges) Multiple Procedures: Full (20% of <u>median</u> charges)</p>
<p>Option 2 (-1.3%)</p>	<p>Old Law</p>	<p>Combination of Old and New Proposed Law Single Procedures: Full (20% of <u>mean</u> charges) Multiple Procedures: Half (10% of <u>median</u> charges)</p>	<p>Target amount less actual beneficiary payment</p>	<p>20% of <u>median</u> charges. Single Procedures: Full (20% of <u>median</u> charges) Multiple Procedures: Half (10% of <u>median</u> charges)</p>

Illustrative Budgetary Summary of Various OPD Options

		Current Law	PPS Base Year	<i>Change vs. Current Law</i>
HCFA Pending Rule				
	Medicare	50.0	50.0	
	<u>Beneficiary</u>	<u>50.0</u>	<u>44.3</u>	
	Total	100.0	94.3	-5.7
Option 1a				
Hospital Held Harmless	Medicare	50.0	55.7	
Medicare Finances Full	<u>Beneficiary</u>	<u>50.0</u>	<u>44.3</u>	
5.7 Percent	Total	100.0	100.0	0.0
<i>Change vs. Pending Rule</i>	<i>Medicare</i>		+5.7	
	<i>Beneficiary</i>		+0.0	
Option 1b				
Hospital Held Harmless	Medicare	50.0	54.4	
Medicare Finances 77% (4.4%/5.7%)	<u>Beneficiary</u>	<u>50.0</u>	<u>45.6</u>	
Bene Finances 23% (1.3%/5.7%)	Total	100.0	100.0	0.0
<i>Change vs. Pending Rule</i>	<i>Medicare</i>		+4.4	
	<i>Beneficiary</i>		+1.3	
Option 2				
Hospital Have 1.3% Reduction	Medicare	50.0	54.4	
Medicare finances the	<u>Beneficiary</u>	<u>50.0</u>	<u>44.3</u>	
4.4% Giveback	Total	100.0	98.7	-1.3
<i>Change vs. Pending Rule</i>	<i>Medicare</i>		+4.4	
	<i>Beneficiary</i>		+0.0	

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November 1, 1999

Medicare Cuts in Half Rate Of Some Wrong Payments

By LAURIE MCGINLEY

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON -- Medicare reduced by half the rate of improper payments made to home-health agencies, but it remains almost 20% -- "far too high," according to a report by federal investigators.

The report, to be released Monday, is an audit of home-health agencies in four big states -- California, Illinois, Texas and New York -- by Health and Human Service Inspector General June Gibbs Brown. It comes as Congress is working on legislation that would increase Medicare reimbursements to home-health agencies by tens of millions of dollars, primarily for high-cost patients. And it would delay a 15% reduction in home-health rates scheduled to go into effect next October, at a cost of \$1.3 billion during the next five years.

The home-health industry argued the bill is sorely needed to offset major Medicare cuts enacted in 1997.

In the report, Ms. Brown expressed concern about the prospect of boosting home-health payments, given the improper payment rate remains at 19%. "We are aware there are discussions under way to possibly increase current amounts paid to HHAs," she said. "We believe the 19% rate of improper or highly questionable services needs to be one of the factors to consider in determining whether any increase in the current amounts are warranted."

The home-health error rate is far higher than for the Medicare program as a whole; that rate is about 7%. Medicare is the federal health program for the elderly and disabled.

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In a 1997 audit of the same four states, Ms. Brown found 40% of the home-health payments were improper. Auditors consider the payments improper if, among other things, they determine the services provided weren't reasonable and necessary; the beneficiaries weren't homebound; or the services were rendered without a valid doctor's order, or proper documentation.

The new review, conducted at the request of the **Health Care Financing Administration**, which runs Medicare, concluded during nine months in 1998, the program paid "unallowable or highly questionable claims" totaling about \$675.4 million out of a total of \$2.3 billion. "In our opinion, the majority of the unallowable services continued to be provided because of inadequate physician involvement," the report said. In some cases, the physician signed the authorization for home care without knowing the patients' condition. And in several cases, doctors didn't realize that only patients who were homebound qualified for home care.

To increase physician involvement, the Inspector General recommended Medicare require physicians to examine patients before ordering home-health services and to see the patients at least once every 60 days to assess their conditions. In addition, she recommended the Medicare agency consider revising its calculations for a new home-health payment system due to go into effect next year. The high improper payment-rate, she said, means the calculations are "inflated."

The industry took issue with the Inspector General's findings and many of her recommendations.

Theresa Forster, vice president for policy at the National Association for Home Care, a Washington trade group that represents home-health agencies, said the 19% rate "isn't an accurate reflection of the industry or the nation as a whole." She said the auditors, as they did in 1997, focused primarily on states and agencies where there were known to be problems with home-care spending. She rejected Ms. Brown's recommendations that payment rates be curbed further, saying 2,500 home-care agencies have gone out of business because of Medicare belt-tightening in recent years. That has made it difficult for some high-cost beneficiaries to get the home care they need, she said.

HCFA said the reduction in improper payments shows it has made "great progress" in bringing the home-health program under control. But the agency agreed a lack of adequate physician supervision is a problem, and said it is considering options to address it.

In a second report, the Inspector General examined whether the 1997 budget cuts, which resulted in the closure of many home-health agencies, has made it difficult for elderly patients to find home-care services after leaving the hospital. In interviews with investigators, 85% of hospital discharge planners reported patients were able to obtain home care when they need it. But they said some agencies were requiring more information about patients' condition before accepting them as clients.

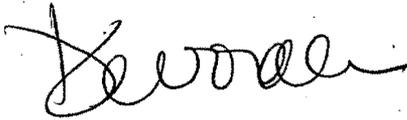
Chris –

Here is the basic background information I found on SGR. OMB is developing a more comprehensive paper for your review tomorrow.

The section on AMA changes includes everything that they requested when they testified in front of Senate Finance on June 10, 1999 – but from Rich Deem's note to you, they are really only concerned about correcting the projections used to develop the physician payment update (so really only the first two bullets under that section).

According to Mark – and he will call you first thing in the morning to discuss this – what the VP could potentially announce this week is the new spending target rate for FY 2000 (an increase of over 2 percent). A positive target rate will mean an increase in the physician payment update. Since this is an increase – and last year's target was a negative number that led to a cut in the update – this news will be welcomed by the AMA, although it's not the systematic reform that Rich is asking for.

Hope this is helpful. OMB's writeup will doubtless be more helpful, accurate, detailed, and interesting to you than this is, but at least this will get you started.

A handwritten signature in cursive script, appearing to read "Howard".

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.

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.

These 2 issues may be part of the same proposal

1 SEC. 2. CONGRESSIONAL POLICIES REGARDING IMPL-
2 MENTATION OF CERTAIN PROVISIONS.

3 (a) INTENTION TO MAKE 1999 BASELINE BUDGET
4 NEUTRAL IN APPLYING THE HOSPITAL OUTPATIENT
5 PROSPECTIVE PAYMENT SYSTEM.—With respect to deter-
6 mining the amount of copayments described in paragraph
7 (3)(a)(ii) of section 1833(t) of the Social Security Act, as
8 added by section 4523(a) of Balanced Budget Act of 1997,
9 Congress finds that such amount should be determined in
10 a budget neutral manner without regard to such section
11 and that the Secretary of Health and Human Services has
12 the authority to determine such amount without regard
13 to such section.

14 (b) INTENTION TO USE CURRENT RISK ADJUST-
15 MENT AND CONTINUOUS OPEN ENROLLMENT UNDER
16 THE FRAIL ELDERLY DEMONSTRATION PROJECT.—Con-
17 gress finds that, in any period in which the demonstration
18 project (known as the “EverCare” project) to demonstrate
19 the application of capitation payment rates for frail elderly
20 medicare beneficiaries under a specialized program that
21 utilizes a specialized interdisciplinary team is in effect,
22 with respect to a nursing facility which is participating
23 in such project as of the date of the enactment of this
24 Act, the Secretary of Health and Human Services has the
25 authority to provide, and the Secretary should provide,
26 that the risk-adjustment described in section 1853(c)(3)

1 of such Act will not apply to a frail elderly
2 Medicare+Choice beneficiary who is receiving services
3 from the facility under the demonstration project.

4 (c) INTENTION TO USE REGULATORY PROCESS FOR
5 IMPLEMENTING INHERENT REASONABLENESS POLICY.—
6 Congress finds that the Secretary of Health and Human
7 Services should not use, or permit fiscal intermediaries or
8 carriers to use, the inherent reasonableness authority
9 under part B of title XVIII of such Act until the Secretary
10 has published proposed and final rules outlining the proc-
11 ess for the exercise of such authority.

12 (d) INTENTION TO DELAY VOLUME CAPS FOR HOS-
13 PITAL OUTPATIENT SERVICES.—Congress finds that the
14 Secretary of Health and Human Services has the author-
15 ity to delay, and should delay for a period of 2 years, im-
16 plementation of a volume cap for hospital outpatient serv-
17 ices under part B of title XVIII of such Act.

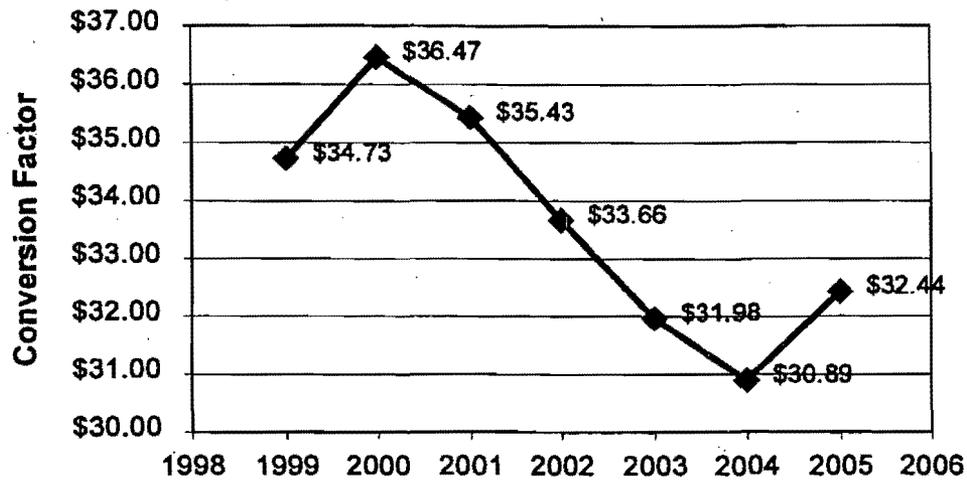
18 (e) INTENTION TO PROTECT HOSPITALS FROM
19 RECOUPMENT RESULTING FROM ERRORS BY FISCAL
20 INTERMEDIARIES IN CERTAIN DSH DETERMINATIONS.—

21 (1) IN GENERAL.—Congress finds that the Sec-
22 retary of Health and Human Services has the au-
23 thority to not seek recoupment of (or otherwise to
24 reduce, disallow, or adjust payments), and should
25 not seek to recoup, payments that result from an

1 error of a fiscal intermediary in providing for the
2 treatment described in paragraph (2) for discharges
3 occurring before October 1, 1998.

4 (2) TREATMENT DESCRIBED.—The treatment
5 described in this paragraph is that, in calculating
6 the disproportionate patient percentage (as defined
7 in section 1886(d)(5)(F)(vi) of such Act) of a hos-
8 pital, patient days for individuals eligible for general
9 assistance under the laws of the State in which the
10 hospital is located, for purposes of subclause (II) of
11 such section, consist of patients who (for such days)
12 were eligible for medical assistance under a State
13 plan approved under title XIX of such Act.

Medicare Physician Payment Rates Under HCFA's SGR Legislative Proposal



OCT. 7. 1999 6:01PM

FAHS

NO. 4466 P. 2



October 7, 1999

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

Post-It® Fax Note	7671	Date	10/5	# of pages	2
To	Richard Woodley	From	Anne Nicoll		
Co./Dept.		Co.	FYI		
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Dear Mr. Chairman:

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

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

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

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

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



OCT 7 1999 6:01PM

FAHS

NO. 4466 P. 3

Page Two

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

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

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

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

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

Sincerely,



Horace B. Deets

NEWS

FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE

October 13, 1999

CONTACT: Trent Duffy or Greg Crist

(202) 225-8933

Statement of Chairman Thomas on Strengthening and Improving Medicare:

WASHINGTON – Rep. Bill Thomas (R-CA), Chairman of the Ways and Means Subcommittee on Health, today issued the following statement on strengthening Medicare that will improve seniors' access to Medicare services through refinements to the Balanced Budget Act (BBA) of 1997:

"Today, we build upon the most significant reform to the Medicare program since its creation in 1965. The Balanced Budget Act fundamentally changed the delivery of quality health care to our nation's seniors and disabled – expanding coverage of preventive benefits, cracking down on fraud and abuse, and extending the life of this vital program for future beneficiaries. The choices this Congress faced two years ago weren't easy, but they were the right thing to do.

That's why I am specifically stating that my colleagues and I will not support any efforts to repeal these landmark changes. We have come too far and enhanced the lives of too many seniors to turn back. The challenges Medicare faces as the nation's 77 million baby boomers prepare to retire are great, but not insurmountable. If we work together, we can continue to meet the ever-changing medical needs of beneficiaries.

The plan we are announcing today is sound and will direct help to those seniors and disabled who need it the most. Our plan dedicates nearly \$15 billion over the next five years to strengthen and improve the Medicare program for every senior – whether they get their care at home, in a nursing facility, or hospital. Further, we give professional caregivers the tools they need to better care for patients – reaching out to that senior in a rural area where the next hospital could be hours away; or giving that grandparent the treatment she needs so she can go home.

In good faith, we have set forth a package that addresses the concerns of providers and how they deliver quality health care to almost 40 million Medicare beneficiaries. But there is still more the Administration must do to help. Coupled with our legislative measures to strengthen Medicare, there are several administrative steps that the Health Care Financing Administration must take to reflect the intent of Congress when it passed the Balanced Budget Act. After all, both Congress and the President worked together to enact this historic legislation. It's only right that we now work together to refine it.

The Administration has danced around this issue long enough. Now is the time for the Administration to act responsibly and help us improve the delivery of health care for beneficiaries. Our nation's seniors deserve no less.

NEWS

FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
October 13, 1999

CONTACT: Trent Duffy or Greg Crist
(202) 225-8933

Chairman Thomas Unveils 15-Point Plan to Strengthen Medicare

**- \$15 Billion Relief for Rural Hospitals, Home Health,
Rehabilitation Therapy, Others -**

Administration Should Do Its Part to Help Beneficiaries, Thomas Says

Subcommittee Markup on Friday, October 15th, 10:00 a.m. in 1100 Longworth.

WASHINGTON – Rep. Bill Thomas (R-CA), Chairman of the Ways and Means Subcommittee on Health, today unveiled a 15-point plan that will strengthen the Medicare program for the 21st Century and guarantee health security for current and future Medicare recipients. The \$15 billion package includes steps the Clinton Administration can take administratively to adjust the Medicare payment structure envisioned by Congress when it passed the Balanced Budget Act of 1997 (BBA).

"Two years ago, Congress fundamentally changed the Medicare program – offering more choices than ever before while extending the financial life of the program. While we have made tremendous progress, we must always work to improve the health care program that so many seniors depend on. This 15-point plan also asks the Clinton Administration to do its share by implementing those Medicare provisions Congress intended when it passed this landmark legislation. America's seniors and disabled deserve no less," said Chairman Thomas.

Chairman Thomas also announced today that the Subcommittee on Health will hold a markup on the Medicare plan this Friday, October 15th, at 10:00 a.m. in 1100 Longworth.

A summary of the plan is attached.

15-Point Plan to Strengthen Medicare

The Medicare Balanced Budget Refinement Act

October 13, 1999

On October 13, 1999, Ways and Means Subcommittee on Health Chairman Bill Thomas announced a plan to strengthen and improve the Medicare program for current and future generations. The plan also calls on the Clinton Administration to fully implement those areas that Congress envisioned when it passed the Balanced Budget Act of 1997.

MAIN FEATURES:

- ✓ **Strengthen Rural Hospitals** – The refinement package increases flexibility in determining payment status and flexibility of rural hospital bed use (swing beds); extends the Medicare Dependent Hospital program for rural areas; provides financial relief to some sole community hospitals, and; modifies the existing Rural Hospital Flexibility Grant Program to permit rural hospitals to obtain computer software and staff training to accommodate changes to new payment systems.
- ✓ **Critical Access Hospitals** – The plan adopts a new average 96 hour length of stay for patients in rural areas; allows hospitals that closed or downsized within the last 10 years to convert to a critical access hospital, which provides intense outpatient medical care; eliminates co-payments by beneficiaries for lab services.
- ✓ **Offer Beneficiaries More Flexibility Through Medicare +Choice** – The plan will offer incentives for health care providers entering counties that do not currently offer managed care plans; allow plans to offer seniors more choices by varying benefit packages; allow Medicare+Choice beneficiaries an open enrollment period when they learn that their plan is ending its contract.
- ✓ **Improve Outpatient Rehabilitation Services** – Provides for separate \$1500 caps for physical and speech therapy services and exempts 1% of high-acuity patients for 2 years.
- ✓ **Maintain the vitality of teaching hospitals** – Permits rural hospitals to increase their Medicare resident numbers to better serve rural beneficiaries.
- ✓ **Preserve Hospitals' Ability to Better Coordinate Care** – The plan requires HCFA to preserve hospitals' ability to coordinate care for patients and improve the accuracy in calculating Medicare payments to hospitals with a disproportionate share of beneficiaries (DSH).
- ✓ **Ensure Smooth Transition for Outpatient Hospitals Switching to New Payment System** – Creates an "outlier" adjustment for high-acuity patients; adjusts payments for innovative medical devices, drugs and biologicals, including orphan and cancer drugs; and provides targeted incentives to increase hospital efficiency.

- ✓ **Ensure Availability of Home Health Care** – Beneficiaries will receive increased access to home health care services through delaying 15 percent payment reductions to home health agencies until one year after implementation of the prospective payment system (PPS). The plan also assists agencies with added paperwork and record-keeping costs. The plan also calls on HCFA to waive interest on repayments to Medicare made by home health agencies.
- ✓ **Increase Care for Medically Complex SNF Patients** – Skilled nursing facilities (SNFs) caring for medically-complex patients will receive adjustments in their payments. In addition, the plan increases the Federal per diem rate for SNF “market baskets.”
- ✓ **Increase Ability to Offer Prostheses, Cancer Fighting Drugs and Ambulance Services** – Allows separate billing by skilled nursing facilities for certain prosthetic devices, chemotherapy drugs, and ambulance and emergency services.
- ✓ **Improving Graduate Medical Education (GME)** – Freezes the Indirect Medical Education (IME) program for one year and adopts a more equitable structure for direct GME payments to teaching hospitals nationwide.
- ✓ **Provide payment updates for renal dialysis, and durable medical equipment** – The plan improves beneficiaries' access to renal dialysis treatments and durable medical equipment such as wheelchairs.
- ✓ **Helping Long-Term and Psychiatric Hospitals** – Adjusts the payment system for existing long-term and psychiatric hospitals through increased continuous improvement and bonus payments through FY 2002. The plan also requires the Secretary to develop and implement a payment system based on discharge of patients.
- ✓ **Maintain Risk Adjuster Payment Demonstration Project for Frail Elderly** – The plan calls on the Administration and HCFA to continue a demonstration project that will help those special needs seniors.
- ✓ **Update Payments for Physicians Caring for Beneficiaries (Sustainable Growth Rate)** – The plan modifies the way doctors are paid for treating patients, based on a sustainable growth rate (SGR) that stabilizes Medicare payments to physicians.

**SUMMARY OF PROPOSED MEDICARE PROGRAM REFINEMENTS
AND BUDGETARY IMPACTS**

<u>Type of Activity or Provider</u>	<u>Legislative Five-Year Estimate</u>	<u>Administrative Five-Year Estimate</u>
Medicare+Choice	\$ 1.3 billion	\$ 0.2 billion
Hospitals	\$ 3.0 billion	\$ 5.2 billion
Skilled Nursing Facilities	\$ 1.8 billion	
Out-of-Hospital Rehabilitation Services	\$ 0.6 billion	
Home Health Agencies	\$ 1.3 billion	\$ 0.2 billion
Renal Dialysis, Durable Medical Equipment	\$ 0.4 billion	
Subtotal, Before Interactions	\$ 8.4 billion	\$ 5.6 billion
Interactions with Medicare+Choice payments, Part B premium, and Medicaid	\$ 1.0 billion	
Total, Direct Spending	\$ 9.4 billion	\$ 5.6 billion

Total, Combined Legislative and Administrative Spending = \$ 15.0 billion

Note: Share of spending after accounting for interactions is 63 percent legislative and 37 percent Administrative.

Committee on Ways and Means Subcommittee on Health

Summary of Medicare Payment System Refinements With Budgetary Impacts

ITEMS	DESCRIPTION
Hospital: Classification of Urban and Rural Hospitals	<p>A) Establish a process to allow urban hospitals to re-classify to rural status</p> <p>B) Update reclassification criteria for hospitals located between two Metropolitan Statistical Areas (MSAs) to 1990 census data, permit hospitals to choose between 1980 and 1990 criteria. Apply and current census data thereafter</p>
Rural Hospitals: Swing Bed Program	<p>A) Eliminate certain restrictions to swing beds for hospitals with 51 to 100 beds. This policy becomes effective when swing beds become subject to the SNF PPS, beginning July 1, 2001.</p>
Rural Hospitals: Grant Program for Small Rural Hospitals	<p>A) Modify the existing Rural Hospital Flexibility Grant Program to permit rural hospitals to obtain computer software and staff training to accommodate changes due to new payment systems mandated by the 1997 Balanced Budget Act.</p>
Rural Hospitals: Graduate Medical Education	<p>A) Permit rural hospitals to adjust their resident limits upward 30 percent if they expand existing training programs</p> <p>B) Permit hospitals that are not located in underserved rural areas to increase their resident limits if the increase is due to separately accredited rural training programs</p>
Part A Hospital: Sole Community Hospitals	<p>A) Allow those hospitals now paid on the Federal rate to receive a blend of 1982 or 1987 costs and 1996 costs. Starting in FY 2001, these hospitals would receive payments based on 25% 1996 costs and 75% 1982 or 1987 costs. In FY 2002, a 50/50 blend; in FY 2003, 75% 1996 costs and 25% 1982 or 1987 costs. In FY 2004, rate would be 100% 1996 costs.</p>
Part A Hospital: Medicare Dependent Hospitals (MDHs)	<p>A) Extend MDH program for five years</p>

ITEMS	DESCRIPTION
<p>Part A Hospital Rural Critical Access Hospitals</p>	<p>A) Adopt 96 hour length of stay, on average, per patient</p> <p>B) Allow hospitals that closed or downsized within last 10 years to convert to CAH status</p> <p>C) Allow CAHs an option to bill for outpatient services based on an all-inclusive rate.</p> <p>D) Eliminate coinsurance for clinical laboratory services furnished on an outpatient basis by CAHs.</p> <p>E) Clarify statutory references concerning the ability of CAHs to participate in the swing bed program</p> <p>F) Extend CAH eligibility to for-profit hospitals that meet current criteria (mileage, etc)</p>
<p>Part A Hospital: Long Term and Psychiatric Hospitals</p>	<p>A) Provide Temporary Enhanced Continuous Improvement Bonus (TECIB) payments to existing LT and psychiatric hospitals for FY 2000 through FY 2002. (No rehabilitation hospitals are eligible.) Increase current law amount by 0% in FY 2000; 0.5 percentage point in FY 2001; and 1 percentage point in FY 2002. LT and psychiatric hospitals opening on or after date of enactment are not eligible to receive TECIB payments.</p> <p>B) Secretary reports to Congress by July 1, 2000 on a per discharge PPS for LT hospitals. Total payments shall be budget neutral for FY 2003-2007.</p> <p>C) Secretary reports to Congress by July 1, 2000 on a per diem PPS for psychiatric hospitals. PPS implemented in FY 2003. Total payments shall be budget neutral for FY 2003-2007.</p>
<p>Part A Hospital: PPS-Exempt Hospitals</p>	<p>A) Wage adjust the 75th percentile cap</p>

ITEMS	DESCRIPTION
<p>Part A Skilled Nursing Facilities</p>	<p>A) Increase payments by 10 percent for 12 RUGs (categories are Extensive Service, Special Care and Clinically Complex) to adjust for high cost medically complex patients. Effective date: April 1, 2000 through September 30, 2000.</p> <p>B) For FY 2001, increase the Federal per diem rate by the skilled nursing facility market basket percentage change plus 0.8 percentage point.</p> <p>C) Allow SNFs to choose between the higher of current law or 100% of the Federal rate for payments</p> <p>D) Allow separate billing of specific prostheses and chemotherapy drugs. Allow separate billing for ambulance for ESRD services.</p> <p>E) Allow Part B add-on payment for SNFs participating in case mix demonstration project in 6 states</p>
<p>Medicare Part B Physicians: Changes to the Sustainable Growth Rate (SGR)</p>	<p>A) Change the update adjustment factor to reduce update oscillation</p> <p>B) Require the Secretary to correct estimates in SGR system calculations. Make corrections for 1998 and 1999 using 1997 baseline.</p> <p>C) Require the Secretary to publish an estimate of conversion factor updates by March 31 of the year before their implementation</p>
<p>Part B Hospital: Outpatient Prospective Payment</p>	<p>A) Create an outlier adjustment for high cost cases.</p> <p>B) To allow outpatient PPS to adjust to case mix over time, provide a 2-3 year temporary transitional pass-through for additional costs of innovative medical devices, drugs and biologicals, including orphan and cancer drugs. Drugs to be paid at 95 percent of AWP. New devices to be paid by a method to be devised by the Secretary.</p> <p>C) Create a non-budget neutral payment floor with "corridors" to provide targeted incentives for hospitals to increase their efficiency as quickly as possible while protecting them from large losses.</p>
<p>Part B: Therapy Caps</p>	<p>A) Separate \$1,500 caps per beneficiary/per facility for physical and speech therapy services</p> <p>AND</p> <p>B) Exempt 1 percent of high-cost patients for 2 years</p>

ITEMS	DESCRIPTION
Part B Durable Medical Equipment & Oxygen	A) Continue freeze for FY 2000. Update by CPI-2 percentage points in FY 2001 and FY 2002
Part B: Dialysis	Composite rate increase of 2.4% FY 2001 update = 1.2% FY 2002 update = 1.2%
Parts A and B: Home Health	A) Pay for completion of OASIS paperwork by allowing the home health agency to bill \$10 per beneficiary for FY 2000 ONLY. [\$15=\$100M/5. \$20=\$100/5. \$50=\$300M/5] B) Delay 15% reduction until one-year after implementation of PPS. Secretary to report to Congress within 6 months after PPS implementation on the need to further reduce payments, if any.
Parts A and B Graduate Medical Education	A) Freeze IME adjustment at 6.0% for one year only in FY 2001. Reduce to 5.5 percent in FY 2002 and thereafter. B) Adopt national average direct GME payment method in FY 2001: Increases in FY2001; reductions over 4 years
Part C Medicare+Choice Risk Adjustment	A) Implement risk adjuster as follows: for CY 2000, 90% old method and 10% new method; for CY 2001, 90%/10%; for CY 2002, 80%/20%; for CY 2003, 70% old method and 30% new method; CY 2004 and beyond, all-setting risk adjuster
Part C Medicare+Choice New Entry Bonus	A) For any county that does not have an M+C plan since 1997, increase final M+C payment rate by 5% for the first year that any plan enters the market. Increase 3% for that plan's second year. This increase is after all other calculations. Effective for plans beginning in CY 2000-CY 2002.
Part C Medicare+Choice Five-Year Rule	A) Allow a plan to re-enter a market within the five-year period if two conditions are met: 1) a legislative change was enacted within 6 months of a plan's announcement to withdraw and that change would result in higher M+C payments and 2) either no other or one other plan has entered the county.
Part C Medicare+Choice Comparison Data	A) Require HCFA's Office of the Actuary to calculate county-level per capita fee-for-service data and to publish those data annually in the M+C regulation.
Part C Medicare+Choice Plan Termination	A) Allow M+C beneficiaries an open enrollment period as soon as they receive notice that their plan is terminating its Medicare contract.
Part C Medicare+Choice Flexibility in Benefits	A) Allow plans to vary benefit packages within a service area as long as the Medicare+Choice rates vary within a service area.
Part C Medicare+Choice ACR Filing Deadline	A) Move the adjusted community rate (ACR) proposal submission date from May 1 to July 1 of the same year

ITEMS	DESCRIPTION
<p>Part C Cost Contracts</p>	<p>Extend cost contracts an additional two years</p>
<p>Part C Social HMOs</p>	<p>A) Extend the program until 18 months after the Secretary reports to Congress on March 31, 2001. (This would extend the demo through September 30, 2002). No costs in FY 2003. MedPAC to make recommendations within 6 months of Secretary's report.</p> <p>B) Change the limit on enrollment until permanent to an <u>aggregate</u> limit (for all sites total) of 324,000. (SHMO was scored based on 9 sites of 36,000 per member limit)</p>

WILLIAM V. ROTH, JR., DELAWARE, CHAIRMAN

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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-8200

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

*Copy
of Roth
Letter*

September 24, 1999

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

Dear Mr. President:

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

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

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

The Honorable William Jefferson Clinton
September 24, 1999
Page 2

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

Sincerely,



William V. Roth, Jr.
Chairman

Enclosure

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

Hospitals

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

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

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

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

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

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

Skilled Nursing Facilities

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

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

Physician Payments

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

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

Home Health Agencies

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

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

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

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

Ambulatory Surgical Centers (ASCs)

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

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

Medicare+Choice

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

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

From OMB Staff.

too high

BBA Legislative Givebacks - SFC Mark Preliminary Scoring
 (\$ in billions, by fiscal year, some scoring from CBO and some from OMB)

	2000	2000-04	2000-09	Comments
Inpatient Hospitals				
IME freeze @ 6.5% for 2000-2003	0.4	3.5	3.5	OACT scoring using MSR baseline; prelim. CBO = \$2b over 5 & 10
Fix certain DSH overpayments			2.0	Costs may decrease; CBO #
SNFs				
Increase certain RUGs by 7.5%			1.5	CBO estimate; OACT will be higher
Fix rates for demo. SNFs	0.0	0.0	0.0	Too small to score; technical fix
Allow SNFs to skip transition to PPS	0.3	0.8	0.8	OACT estimate (off of Trustees)
Home Health				
Phase-in 15% cut over 3 years (5%/10%/15%)	0.0	2.2	2.2	OACT estimates off MSR; preliminary CBO scoring - \$1.3b over 10
Delay 15% until PPS implemented	0.0	0.1	0.1	Linking 15% cut with PPS will increase pressure to delay PPS; CBO #s
Increase per-visit limits from 106% to 108%	0.0	0.0	0.0	
Eliminate 15 min. reporting requirement	0.0	0.0	0.0	
Remove DME from consolidated billing	0.0	0.0	0.0	
Reduce interest payments on overpayments	0.0	0.2	0.2	Scoring - no interest payments for 3 yrs; SFC policy unclear; CBO #s
Hospice				
Eliminate BBA market basket cut	0.1	0.5	1.0	Disable scoring
Physicians				
SGR fix	0.0	0.0	0.0	IFPB proposal, budget neutral. Otherwise, large costs.
Outpatient Departments				
Stop-loss: 90, 85, 80%; Rurals and cancer 100%	0.1	1.2	1.2	Assumes rural and cancer protections are temporary; CBO #s
Other Part B				
Combine therapy caps and increase to \$3500	0.3	2.0	3.3	Staff estimates; OACT and CBO will score very differently
Increase ESRD rate by 2.4%	0.1	0.4	0.9	Staff estimate
Rural Initiatives				
Full market basket for SCHs and MDHs		0.3	0.8	Yr x Yr not available; CBO #s
Crit. Access Hospitals - 96 hr. ALOS	0.0	0.0	0.0	Will have very small costs
Allow certain urban hospo to reclassify as rural				Scoring not available
Medicare+Choice				
Extend phase-in for risk adjustment	0.0	6.1	8.3	OACT scoring; CBO could be as low as \$2b over 10
Base transition for plan withdrawals	0.0	0.0	0.0	
Extend waivers for SHMOs	0.0	0.0	0.0	
Specify provision of inpatient coverage notices	0.0	0.0	0.0	
Other provisions				No details available.
Subtotal, Medicare (does not include Medicaid effect)	1.2	17.3	27.8	
MEDICAID				
DSH: MN, WY, NM, DC	0.0	0.2	0.3	OMB #s
Lift sunset & 12 quarter limit on transition fund	0.1	0.2	0.2	OMB #s
CHIP: Puerto Rico and the Territories	0.0	0.1	0.3	OMB #s
Stabilize CHIP allocation formula	0.0	0.0	0.0	OMB #s
Improve CHIP data collection	0.0	0.1	0.2	OMB #s
Subtotal, Medicaid	0.2	0.6	1.1	
TOTAL, MEDICARE + MEDICAID 1/ (does not include impact of Medicare proposals on Medicaid)	1.4	17.9	28.9	

1/ With CBO estimates for IME freeze, phasing-in the 15% HH out, and M+C risk adjustment, 10-year total would equal approx. \$15b.

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

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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

Medicare Hospital Outpatient (OPD) Prospective Payment System

The 1997 BBA instituted a Prospective Payment System (PPS) for hospital services in outpatient departments (OPD). The PPS will limit beneficiary copayments. The issue is to whether limiting copayments will be associated with (1) an offsetting increase in payments to hospitals from the Medicare Trust Fund, or (2) a reduction in amounts that hospitals receive for OPD services.

The statute is subsection 1833(t) of the Social Security Act, in particular the "Calculation of base amounts" required by paragraph (3). Under subsection 1833(t)(9), there is "no administrative or judicial review" of the HHS "calculation of base amounts under paragraph (3)."

Paragraph (3)(A) directs HHS to "estimate the sum of – "(i) the total amounts that would be payable from the Trust Fund *under this part* for covered OPD services in 1999, *determined without regard to this subsection . . .* and (ii) the total amounts of copayments estimated to be paid *under this subsection* by beneficiaries to hospitals for covered OPD services in 1999"

The estimate of beneficiary copayments in (3)(A)(ii) does not have a plain meaning. That is because a literal reading of "under this subsection" would result in a "circular" set of calculations. The calculation in (3)(A) is among the first in a series of calculations required by paragraphs (3), (4), and (5). The copayment amounts determined in (5), which are the end product of this series of calculations, are also the amounts that would be needed to calculate the copayment amount in (3)(A)(ii), which is where the agency begins the calculations. But this assumes that the agency knows the answer before it does all the calculations. A circular set of calculations cannot work.

Because the statute cannot work if "under this subsection" is given literal effect, and since there is no way to construe those words to have a different meaning, those words should be disregarded, and the copayment estimate in (3)(A) should instead be based on pre-existing law. Copayments can be calculated based on pre-existing law, and this would allow the entire series of calculations.

Disregarding "under this subsection" is consistent with traditional principles of statutory construction, which "permit the elimination or disregarding of words in a statute in order to carry out the legislative intent or meaning." (*Sutherland on Statutory Construction.*) This is the preferred reading, because it avoids rendering the entire subsection unworkable, and thus a nullity.

This reading is consistent with congressional intent. The "circular" text appeared at Conference. The prior Senate and House bills had identical text for (3)(A) (as well as similar text for the rest of 1833(t)), which would have required an estimate based on pre-existing law. Prior to Conference, the relevant parties understood that, with the bill's reduction in copayments, there would be an offsetting increase in Trust Fund payments. While Conference revisions were made, the Conference Report's explanatory statement does not indicate that these were intended to yield a dramatically different result -- in terms of OPD payments to hospitals -- than would have been the case under the House and Senate bills.

It has been suggested that, to avoid the circularity of the literal reading, the HHS proposed rule relied on the "unadjusted copayment amount" in paragraph (3)(B) in order to make the estimate under (3)(A)(ii). Although such reliance might avoid circularity, it is not a plausible reading of (3)(A)(ii), because the "unadjusted copayment amount" does not represent "the total amounts of copayments estimated to be paid under this subsection."

Medicare Hospital Outpatient (OPD) Prospective Payment System

In the Balanced Budget Act of 1997, Congress instituted a Prospective Payment System (PPS) for services that hospitals provide in their outpatient departments (OPD). One of the system's features is that it is intended to limit the copayments that beneficiaries must pay for OPD services. The issue has been raised as to whether reductions in beneficiary copayments under the PPS will be associated with (1) an offsetting increase in payments to hospitals from the Medicare Trust Fund, or (2) a reduction in amounts that hospitals receive for OPD services.

The statutory provisions governing the PPS are found at subsection 1833(t) of the Social Security Act (42 U.S.C. 1395l). In resolving the issue above, it appears that the operative provision is paragraph (3) of this subsection, on "Calculation of base amounts." In particular, paragraph (3)(A) directs HHS to "estimate the sum of –

"(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under 1833(b) did not apply, and

"(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999, as though the deductible under 1833(b) did not apply."

At the end of subsection 1833(t), in paragraph (9), Congress provided that "[t]here shall be no administrative or judicial review under [two specified provisions in the Social Security Act], or otherwise of . . . (B) the calculation of base amounts under paragraph (3)." In its proposed rule, HHS stated that "Section 1833(t)(9) prohibits administrative or judicial review of the . . . calculation of base amounts . . ." 63 FR 47552, 47555 (Sept. 8, 1998); *id.* at 47587 (same).

The Statute Does Not Have A "Plain Meaning"

The argument has been made that paragraph (3)(A) has a plain meaning, under which the reduction in beneficiary copayments under PPS results in a reduction in the amounts that hospitals receive for OPD services, rather than in an offsetting increase in Trust Fund payments. This argument is based on the difference in the two subparagraphs: namely, that subparagraph (i) requires an estimate of "the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection," whereas subparagraph (ii) requires an estimate of "the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999." The argument appears to be that, as a result of these highlighted language differences, the reduction in beneficiary copayments under PPS will result in a reduction in the amounts that hospitals receive for OPD services, rather than in an offsetting increase in Trust Fund payments.

On a closer inspection, however, it becomes evident that paragraph (3)(A) does not have a plain meaning. That is because the suggested reading of paragraph (3)(A) is fundamentally “circular” in nature, as follows. The calculation of the Trust Fund and copayment amounts in paragraph (3)(A) is among the first in a series of statutory calculations required by paragraphs (3), (4), and (5). Having calculated the sum of the Trust Fund and copayment amounts in paragraph (3)(A), the agency then enters this number into the calculation of the “conversion factor” for each OPD service in paragraph (3)(C). The “conversion factor,” in turn, enters into the calculation of the “medicare OPD fee schedule amount” for each OPD service in paragraph (3)(D). The “medicare OPD fee schedule amount,” in turn, enters into the calculation of “[t]he amount of payment made from the Trust Fund under this part” for each OPD service in paragraph (4). Finally, the Trust Fund payment enters into the calculation of “the copayment amount under this subsection” in paragraph (5).

It is at this point that we have come full circle. The copayment amounts in paragraph (5), which are the end product of this series of calculations, are also the amounts that (under the suggested “plain meaning” reading) are needed by the agency to calculate the copayment amount in paragraph (3)(A), which is where the agency begins this series of calculations. But this assumes that the agency already knows the ultimate answer (i.e., what will the copayment amounts be under the PPS) before the agency has made the calculations that, under the statute, are supposed to yield the answer. Simply put, such a circular calculation cannot work.

It is a traditional principle of statutory construction that laws should be interpreted, to the extent possible, to avoid unreasonable consequences.¹ A reading of a statute that makes it circular, and thereby unworkable, is an example of the type of interpretation that should be avoided.² At the very least, such a reading cannot be the “plain meaning” of the statute, absent overwhelming evidence that Congress actually intended to require an agency (as would be the case here) to undertake a series of circular calculations.³ In this case, there is no such evidence. There is no other statutory language that supports this contention that Congress intended a circular set of calculations, and there is no legislative history that supports such a reading.

¹ See *Sutherland Statutory Construction*, § 45.12, at 61 (5th ed. 1992) (“It has been called a golden rule of statutory interpretation that unreasonableness of the result produced by one among alternative possible interpretations of a statute is reason for rejecting that interpretation in favor of another which would produce a reasonable result.”).

² See *O’Connell v. Shalala*, 79 F.3d 170, 176 (1st Cir. 1996) (upholding HHS reading of statute because plaintiffs’ contrary reading would render the statute “virtually unworkable”); *Sutherland Statutory Construction*, § 45.12, at 61 (“an interpretation which emasculates a provision of a statute is not preferred”).

³ See *Sutherland Statutory Construction*, § 45.12, at 61 (“it must be assumed that [the legislative] process achieves an effective and operative result. It cannot be presumed that the legislature would do a futile thing.”).

**The Better Reading is to Interpret the Statute as Requiring
The Agency to Estimate the Copayment Amount Based on Prior Law**

As indicated above, a literal reading of paragraph (3)(A) renders circular, and thus unworkable, the entire series of calculations in paragraphs (3), (4), and (5). This circularity arises from three words in subparagraph (ii) --- “under this subsection.” Since the entire statute is made unworkable by a literal reading of these three words, the question of how to interpret paragraph (3)(A) -- and thus of how to interpret subsection 1833(t) generally -- boils down to whether these three words should be interpreted in literal manner that renders the entire subsection unworkable or whether they should be interpreted in a manner that allows the entire subsection to work.

Based on traditional principles of statutory construction, the clear answer is that, since subsection 1833(t) becomes unworkable if subparagraph (3)(A)(ii) is applied literally, that provision should be read in a manner that “achieves an effective and operative result.”⁴ This result is achieved, not by placing undue weight on a literal reading of the three words “under this subsection” (which would render the entire subsection unworkable), but instead by looking to the entire statute.⁵ Because the statute cannot work if these three words are given literal effect, and since there is no way to construe these three words to have a different meaning,⁶ they should simply be disregarded. As *Sutherland* explains,

⁴ *Sutherland Statutory Construction*, § 45.12, at 61; see *id.* (“It is important that a statute not be read in an atmosphere of sterility, but in the context of what actually happens when human beings go about the fulfillment of its purposes.”).

⁵ See *United States Nat. Bank of Ore. v. Indep. Ins. Agents of America, Inc.*, 508 U.S. 439, 455 (1993) (“Over and over we have stressed that, in expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its objects and policy.” (internal quotations omitted)); *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 242 (1989) (“the intention of the drafters, rather than the strict language, controls” in cases where “the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters”); *O’Connell v. Shalala*, 79 F.3d at 176 (“While one can focus with Cyclopean intensity on the words singled out by the petitioners and perhaps construct a coherent argument . . . , courts are bound to afford statutes a practical, common-sense reading. Instead of culling selected words from a statute’s text and inspecting them in an antiseptic laboratory setting, a court engaged in the task of statutory interpretation must examine the statute as a whole, giving due weight to design, structure, and purpose as well as to aggregate language.” (citation omitted)).

⁶ It has been suggested that, to avoid the circularity of the literal reading, the proposed rule relied on the “unadjusted copayment amount” in paragraph (3)(B) in order to make the estimate under subparagraph (3)(A)(ii). Although such reliance might avoid circularity, it is not a plausible reading of subparagraph (3)(A)(ii), because the “unadjusted copayment amount” does not represent “the total amounts of copayments estimated to be paid under this subsection.”

“A majority of the cases permit the elimination or disregarding of words in a statute in order to carry out the legislative intent or meaning. . . . Courts permit the elimination of words for one or more of the following reasons: . . . where it is necessary to give the act meaning, effect, or intelligibility, . . . where the use of the word would lead to an absurdity or irrationality, where the inclusion of the word was a mere inaccuracy, or clearly apparent mishap, or it was obviously erroneously inserted, . . . where it is necessary to avoid inconsistencies and to make the provisions of the act harmonize . . .”

Sutherland Statutory Construction, § 47.37, at 283-84. While this entails the sacrifice of three words, this is the preferred reading of the statute because it involves far less loss than the alternative of rendering the entire subsection unworkable, and thus a nullity.

While subsection 1833(t) cannot work if “under this subsection” is given its literal effect, it is the case that the estimate of beneficiary copayments in subparagraph (3)(A)(ii) can be calculated based on pre-existing law, and that this calculation would enable the entire subsequent series of calculations to be performed. Accordingly, in order to give the maximum effect to subsection 1833(t), the estimates required by paragraph (3)(A) should be based on pre-existing law -- both with respect to the Trust Fund payments and with respect to the beneficiary copayments.

There is no evidence that this corrective reading of paragraph (3)(A) is contrary to congressional intent. The problematic, circular language in paragraph (3)(A)(ii) was not found in either the Senate or the House versions of subsection 1833(t). Instead, the language appeared only at the final stage of the legislative process, during the Conference. Prior to Conference, the Senate and House versions of the bill had contained identical text for paragraph (3)(A) (as well as largely similar provisions for the remainder of subsection 1833(t)), and this prior version of paragraph (3)(A) would have required an estimate based on pre-existing law. Moreover, it appears that, prior to Conference, the relevant parties understood that, with the bill’s reduction in beneficiary copayments, there would be an offsetting increase in Trust Fund payments. While it is the case that revisions were made at Conference to subsection 1833(t), including to the language in paragraph (3)(A), the Conference Report’s explanatory statement does not indicate that these revisions were intended to yield a dramatically different result -- in terms of the payments that hospitals would receive for OPD services -- than would have been the case under the House and Senate bills.⁷ See H. Conf. Rep. No. 217, 105th Cong. 1st Sess., 783-85 (1997).

⁷ See *Sutherland Statutory Construction*, § 45.12, at 63 (“Where the court must choose between equally plausible interpretations of ambiguous statutory language, the court will consider the effect on the parties involved and choose the interpretation that avoids a patently unjust result.”); see *id.* at 11 (1993 Cumulative Supplement) (“Where literal enforcement of a statute will result in a great injustice which was not contemplated, a court will construe a statute to give effect to what must have been reasonably intended by the legislature.”).

Conclusion

Congress recognized that HHS would have to carry out a series of complex calculations in order to transition from the previous system to the newly established PPS. This recognition is evidenced by the fact that, in subsection 1833(t)(9), Congress expressly stated that “[t]here shall be no administrative or judicial review” of, among other things, the agency’s “calculation of base amounts under paragraph (3).”

A literal reading of subparagraph (3)(A)(ii) – placing great stress on the three words “under this subsection” – renders circular the entire series of calculations in paragraphs (3), (4), and (5). Since those three words cannot be construed in manner that would make the statute workable, they should be disregarded, and the agency should rely on pre-existing law to make both of the estimates in paragraph (3)(A). This results in a statutory reading that is not only workable, but also consistent with congressional intent.