

Caroline B. Davis

05/16/97 06:28:47 PM

Record Type: Record

To: Jacob J. Lew/OMB/EOP, Nancy A. Min/OMB/EOP, Christopher C. Jennings/OPD/EOP  
cc: Barry T. Clendenin/OMB/EOP, Mark E. Miller/OMB/EOP  
Subject: HCFA briefing for Hill staff on home health

This afternoon (5/16), I attended a briefing by HCFA staff for Hill staff on Medicare home health. The Hill staff in attendance were from Finance, Ways & Means, and (I think) Commerce, and included Chip Kahn, Julie James, Howard Cohen, and Alison Giles among others. Don Young (ProPAC) and Jen Jenson (CBO's home health/SNF analyst) also attended. Rich Tarplin, Gary Claxton, Sharon Arnold and Ira Burney attended for HHS/HCFA.

This session was essentially a technical briefing by HCFA on the Administration's and the home health industry's proposals. Both proposals have an interim payment system prior to the implementation of an episodic prospective payment system (PPS). Because both proposals eventually implement a somewhat similar PPS, the problem lies in designing an interim system that acceptable to the Hill and which HCFA feels it can implement easily/quickly.

To give you a sense of where things stand, Chip Kahn remarked, towards the end of the meeting, that home health "could be the most controversial piece of the mark-up."

**Administration's Proposals.** Sharon Arnold (HCFA/OLIGA) gave a summary of the Administration's home health payment reform proposals (i.e., tightening the existing cost limits and imposing an agency-specific per beneficiary limit and then prospective payment in FY 2000). The overall consensus among the Hill staff seemed to be two things: (1) they don't believe that HCFA will be ready to implement PPS in FY 2000; and (2) they are not particularly supportive of tightening the existing cost limits structure as an interim step toward PPS.

**Industry Proposal.** Sharon also walked through an overview of the industry's home health proposal (i.e., an interim system with a per visit PPS subject to a dollar limit based on 120 days of care and then an episodic PPS), and provided a critique of the proposal (e.g., asking HCFA to implement an entirely new system immediately and then to implement another new payment methodology only a few years later, the 120-day limit only captures about 60% of home health visits). The industry's proposal also includes a "savings sharing" provision -- an agency that comes in under the 120-day limit would receive up to 50% of the savings, but not more than 10% of its aggregate Medicare payments. Sharon pointed out that this is a very expensive component of the industry's proposal (HCFA has a preliminary estimate that it would cost as much as \$8 billion over the 5-year budget window).

Overall, there did not seem to be either strong support or strong opposition for most of the industry's proposal among the staff who were present. However, several people present (Julie James was one of them) appeared to support the savings sharing idea.

**Other Ideas.** Several alternative ideas were also raised over the course of the meeting. There was strong interest in the fact that Medicare's home health payments have no relationship to the length of the actual home health visit. In other words, Medicare pays for a home health visit, but HCFA

doesn't ask whether the visit lasted for 15 minutes or an hour. Sharon explained that this is not data that HCFA currently collects, but agreed that it would be good information to have.

The possibility of imposing a copay was raised by one staffer (I didn't catch his name), but it didn't get much discussion.

Howard Cohen was interested in looking at proposals to address the wide geographic variation which occurs in home health payments. However, similar to copays, this idea did not get much attention.

Since the Hill staff at the meeting did not particularly like the Administration's interim payment system, HCFA offered to consider any other ideas they might have, but the staffers could not offer any.

**Additional Meetings.** At the end of today's meeting, 2 follow-up sessions were scheduled for next week. On Monday (the 19th) at noon, HCFA staff are supposed to brief Hill staff on other possible changes to home health (I think this means things like paying for visits based on a specified unit of time, e.g., \$5 for each 15 minutes of home health aide care).

Howard and Chip also requested three pieces of information from HCFA: (1) a realistic timeline for the implementation of PPS; (2) a description of where HCFA is in terms of their on-going research in preparation for PPS (both what information they have already gathered and what they still need to collect); and (3) a list of any additional legislative authority that HCFA believes they need to collect data to implement PPS (e.g., regarding the length of a home health visit). They asked for this information by Monday or Tuesday of next week (the 19th or 20th) and plan to reconvene on Tuesday at 5:30 to talk about HCFA's home health research.

{END}

*Home Health File*

DATE: 2-18-97



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OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION  
ROOM 416-G HUMPHREY BUILDING

FROM:

TO : Chris Jennings

[  ] RICHARD J. TARPLIN

OFFICE : \_\_\_\_\_

[  ] HELEN MATHIS

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[  ] KEVIN BURKE

FAX NO : 456 - 7431

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TOTAL PAGES  
(INCLUDING COVER) : 2

[  ] ROSE CLEMENT LUSI

[  ] STEPHANIE WILSON

[  ] HAZEL FARMER

REMARKS:

**HOME HEALTH ERROR RATE**

Q. Madam Secretary, you have been quoted as saying that between 25 to 40 percent of home health agency visits are improperly paid. How confident are you that the error rate is so high?

A. I am very confident. My Inspector General has conducted numerous reviews which show high error rates. Audits of six providers in Florida revealed error rates for claims ranging from 24 percent to 44 percent, except for one which was 75 percent. The corresponding error rates for services contained on these claims was between 20 percent and 40 percent. Tentative results from ongoing audits of home health agencies in other States reveal similar results. The errors include: beneficiaries who were not homebound, unnecessary services, services not rendered, and forging of physician signatures on plans of care.

A Statewide audit in Florida in 1993 revealed a 26 percent claims error rate. However, the actual rate was probably higher since the audit did not include data from the one large abusive provider in the State with a 75% claims error rate.

More recently the Office Inspector General has been reviewing a random sample of home health claims in New York, Illinois, Texas and California. Results to date indicate an error rate similar to the rates shown in our provider-specific audits.

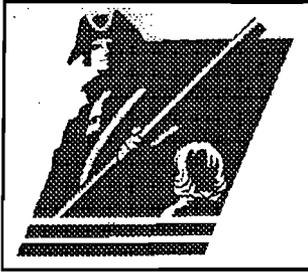
OPTIONAL FORM 99 (7-90)

**FAX TRANSMITTAL**

# of pages **1**

To Carol Taylor From J. Hopchuk  
Dept./Agency Phone #

Fax # 690-8425 Fax # "local"



# FACING FACTS

## The Truth about Entitlements and the Budget

### A Fax Alert from The Concord Coalition

Volume III • Number 2

January 28, 1997

## STILL MORE MEDICARE FOLLIES

In a proposal the Washington Post calls a “gimmick so transparent and crude as to give gimmickry a bad name.” the White House would fend off Medicare’s looming insolvency by shifting more than \$50 billion in home health care outlays from its Hospital Insurance (HI) trust fund, which by law must be in the black to pay benefits, to its Supplementary Medical Insurance (SMI) trust fund, where general revenues will automatically plug any funding shortfall, no matter how large.

This “reform” does nothing to help ensure Medicare’s sustainability or to reduce the federal budget deficit. It simply makes the program look more solvent on paper, thereby allowing the administration to claim that its plan does as much to “save Medicare” as GOP proposals while cutting Medicare spending less.

### Sheer Expediency

According to the latest Trustees’ report, Medicare’s HI trust fund will be exhausted in 2001—meaning that earmarked tax revenues plus accumulated trust-fund assets will no longer provide sufficient budget authority to cover projected benefit outlays. Since HI is by law constituted as a “self-financing” trust fund, this fast-approaching bankruptcy date is forcing Congress and the White House to enact serious cost-saving reforms.

Or rather, it should be. The administration’s proposed benefit swap would instead short-circuit HI’s trust-fund discipline by shifting much of the cost of home health care, Medicare’s fastest growing benefit category, to the SMI trust fund. Under SMI’s trust-fund rules, bankruptcy is not an issue: The program’s general revenue subsidy automatically rises to cover any difference between beneficiary premiums and program costs.

If this is a solution, one wonders why the White House stops there. Why not shift a lot more spending out of HI so that no actual cuts are necessary? While we’re at it, we could, by the same logic, spare ourselves the trouble of reading the Social Security Advisory Council’s report. Instead, we could make Social Security solvent by taking all retirees west of the Mississippi

out of its trust fund and putting them in the general budget.

The administration maintains that its proposal is not as cynical as it sounds since home health benefits are more logically paid out of Medicare’s physician trust fund than its hospital trust fund. But if sheer expediency were not the motive, why does this reform also short-circuit SMI’s (weaker) trust-fund discipline? While beneficiary premiums are supposed to cover 25 percent of total SMI costs, home health benefits shifted into SMI would not be counted in setting premiums.

In truth, the only purpose of the proposal is to allow the White House to say that its Medicare plan would “put ten years on the trust fund.” But as it turns out, the plan doesn’t even do that. It would merely extend HI’s solvency for six years from 2001 until 2007—a decade from today. That this could only be achieved by recourse to gimmickry is a measure of how far we still have to go in facing up to the needed reforms. After all, Medicare is a program that makes benefit promises spanning a lifetime, and whose official definition of solvency is trust-fund balance over seventy-five years.

### Beyond the Trust-Fund Charade

The administration’s home health care proposal could have one positive—if entirely unintended—consequence. Such transparent finagling might one day unmask the whole charade of trust-fund accounting. It makes no difference to taxpayers or the economy whether an individual trust fund is technically solvent or not. The only fiscal bottom line is the net difference between total federal taxing and total federal spending.

For the time being, however, trust-fund accounting at least forces us to acknowledge some link, no matter how tenuous, between benefits paid and revenues raised. Until our political system adopts ironclad budget rules that guarantee a unified budget balance, now and in the future, we would do well not to flout the convention of trust-fund accounting. Yes, it may be artificial. But right now, it’s the only thing we’ve got. ■

Pentice

**MEMORANDUM**

**TO: Interested Parties**

**January 5, 1997**

**FR: Gene S. and Chris J.**

**RE: Pear's *NY Times* Article on Medicare Premiums/Home Health Policy**

Attached are DRAFT talking points and Q&As to help respond to inquiries about Robert Pear's Sunday *NY Times* article on Medicare premiums and our home health care policy. Our position, of course, is to not comment on any specific item in the upcoming budget. However, the enclosed should help respond to general questions about the article and our home health care policy.

We anticipate a number of press and Hill inquiries following-up on this article. Please review and provide any edits to Chris J. by 10:00 am tomorrow morning.

TALKING POINTS ON NY TIMES' MEDICARE PREMIUM STORY

(General: We do not comment on any element of the budget before it is released by the President.)

**PREMIUM INCREASES.** It is no secret that the President reviews every Medicare option with a sensitivity to how proposals will affect beneficiaries. Recent Census Bureau data reveals that fully two-thirds of older Americans have incomes less than \$25,000. Moreover, the Urban Institute has recently estimated that the elderly already spend over one-fifth of their out-of-pocket income on health care.

new data? need to be 3/4

**INTEGRITY OF PRESIDENT'S HOME HEALTH CARE AND BALANCED BUDGET PROPOSALS.** The President's clear and overriding goal is to balance the Federal budget by 2002, extend the life of the Medicare Trust Fund until the middle of the next decade, and to protect our values. His upcoming budget proposal will achieve all of these goals. The home health policy mentioned in the NY Times is also consistent with these goals. It is good policy, has received bipartisan support, and makes it possible to strengthen the Trust Fund without indirectly harming beneficiaries through excessive hospital, doctor and other provider cuts. While the policy reallocates a portion of Trust Fund expenditures into general revenues, it does so in the context of plan that strengthens Medicare and eliminates the deficit.

I don't see how it helps us to say that it is most costly or rapidly increasing. I would drop it.

**GOOD POLICY.** The home health provision is good policy because it focuses on one of the most costly services in Medicare; home health services in excess of 100 visits – the most rapidly increasing part of the benefit – have no place in Part A side (the Hospital Insurance Trust Fund) of the program. In combination with the Administration's proposal to establish a new prospective payment system for home health care, the proposal would constrain the growth and utilization of this benefit.

Explain why

Are we shaping the shift w. it. constrain growth

**BIPARTISAN SUPPORT.** The home health policy mentioned in article has been supported by Republicans and Democrats, and is not new. Reallocating the portion of home health care expenditures that are associated with more chronic care was a proposal included in our last budget. It was also included in the House-passed budget in 1995 -- a proposal that virtually every Republican House Member voted for -- including Ways and Means Chairman Archer and his Health Subcommittee Chairman, Bill Thomas. In fact, a similar allocation of expenditures was the law of the land prior to 1980.

Similar policy? Not idealized w. 11 they call w on it?

**PROTECTS AGAINST EXCESSIVE CUTS.** The absence of the home health policy would necessitate excessive Medicare cuts that would threaten quality health care for millions of beneficiaries. In addition to desire to focus attention on home health care, we advocated the home health proposal last year was because it enabled us to strengthen the Trust Fund without excessive cuts in hospital, physician, nursing home and other important provider payments.

locks us in

AH to "visits in excess of 100" is to say "more than 100 visits after hospitalization" Explain what Part B covers in general vs Part A

## Q&As ON NY TIMES' MEDICARE PREMIUM STORY

**Q. Isn't this home health care transfer just a gimmick that simply shifts dollars around and pushes out the needed tough medicine that Medicare requires?**

✓ **A.** No it is not. The home health policy mentioned in article has been supported by Republicans and Democrats, and is not new. Reallocating the portion of home health care expenditures that are associated with more chronic care was a proposal included in our last budget. <sup>A similar policy</sup> It was also included in the House-passed budget in 1995 -- a proposal that virtually every Republican House Member voted for -- including Ways and Means Chairman Archer and his Health Subcommittee Chairman, Bill Thomas. In fact, a similar allocation of expenditures was the law of the land prior to 1980.

**Q. Regardless of past positions on this issue, Republicans now clearly oppose it on the grounds that it is a gimmick and is flawed policy. How can you defend it?**

**A.** The home health provision is good policy because it focuses on one of the most costly services in Medicare; home health services in excess of 100 visits -- the most rapidly increasing part of the benefit -- have no place in Part A side (the Hospital Insurance Trust Fund) of the program. In combination with the Administration's proposal to establish a new prospective payment system for home health care, the proposal would constrain the growth and utilization of this benefit. Such an intervention is long overdue. *why didn't we do it before then?*

**Q. Even if it is defensible policy, if it is included in this year's budget, shouldn't it be included in the Part B premium -- like every other service in the Part B side of the program?**

**A.** I cannot comment on this year's budget before it is released. However, the President is clearly concerned about any proposal's impact on beneficiaries. Recent Census Bureau data reveals that fully two-thirds of older Americans have incomes less than \$25,000. Moreover, the Urban Institute has recently estimated that the elderly already spend over one-fifth of their out-of-pocket income on health care. ✓

**Q. Doesn't this policy simply add to the deficit, which would require even greater contributions from taxpayers to support the program?**

**A.** While the policy reallocates a portion of Trust Fund expenditures into general revenues, it does so in the context of plan that strengthens Medicare and eliminates the deficit. His last budget did just that and his next budget will do the same.

**ACHIEVING EXPENDITURE AND OTHER CONTROLS  
ON THE MEDICARE HOME HEALTH BENEFIT**

**I. Policies Already Agreed to, or Already Being Undertaken**

**A. Legislative proposals**

1. Eliminate periodic interim payments (PIP);
2. Payment for home health services at location where service furnished;
3. Payment reform (FY 1998-2000): modification of cost limits and imposition of annual per beneficiary payment limit;
4. Payment reform (beginning in FY 2000): implementation of prospective payment system;
5. Codify definitions of "intermittent" and "part-time or intermittent" skilled nursing and home health aide services to conform to current practice.

**B. Regulatory/administrative initiatives**

1. Revised conditions of participation to improve quality of care and protect program integrity by:
  - o mandating agency quality review and performance improvement programs;
  - o strengthening care planning and coordination of services;
  - o safeguarding continuity of care;
  - o criminal background checks as a condition of employment for home health aides;
  - o limit subcontracting of skilled services.
  - o assessment of need for home care (provides a basis for more effectively auditing eligibility factors such as "intermittent" and "homebound");
2. Operation Restore Trust survey initiatives (enhanced surveys on facilities for which allegations of questionable activities have been received or that may have inappropriately billed Medicare; sharing of information between regional home health intermediaries (RHHIs) and surveyors; training surveyors to assess patient eligibility);
3. Targeting survey resources toward poor performing agencies;

4. Imposing civil monetary penalties on physicians for false certification of home health services;
5. New beneficiary pamphlet and video on the home health benefit (qualifying for home health care, what is and is not covered by Medicare, what is a plan of care, how long will services continue, what can a beneficiary be billed for, how to find an approved home health agency, and detecting and reporting aberrancies and fraudulent practices);
6. Introducing a Notice of Utilization for home health patients (due to the significant success of pilot, HCFA will begin sending NOUs to all home health beneficiaries in early 1997);
7. Physician education (public service announcements and other materials to educate physicians and their staffs regarding developing a plan of care, monitoring patient progress, and detecting fraud and abuse).

## **II. Additional Proposals for Consideration**

### ***A. Legislative proposals***

1. Redefine "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are unable to leave the home except with the assistance of another individual or the aid of a supportive device or for whom leaving the home is medically contraindicated (for example, the beneficiary's condition would have to restrict his/her ability to leave the home for more than an average of from 10 to 16 hours per calendar month for reasons other than to receive medical treatment that cannot be provided in the home);
2. Cover therapy visits under Part A only. (No covered visits under Part B);
3. Secretarial authority to make payment denials based on normative service standards based on experience;
4. Tighten definition of "intermittent" and "part-time or intermittent" skilled nursing and home health aide services;
5. Eliminate § 1879 limitation on liability protection for HHAs;

***B. Regulatory/administrative initiatives***

1. Require bonding for Medicare certification;

*DRAFT January 2, 1997*  
*G:\MEDPARTA\JOHN\CONTROL.HH\$*



OCT 29 1996

The Administrator  
Washington, D.C. 20201

NOTE TO: Kevin Thurm  
Nancy Ann-Min

This is a follow-up note to our previous note concerning a correction to the budget neutrality factor used in the computation of the home health agency cost limits effective for cost reporting periods beginning on or after July 1, 1996. We released a Program Memorandum instructing our fiscal intermediaries to correct a technical error that occurred in the calculation of the budget neutrality adjustment.

We have been informed by our actuary that another error has been detected in the calculation of the budget neutrality adjustment. In calculating the budget neutrality factor, we should have deleted from the database those agencies having a wage index that could not be matched with a 1982 hospital wage index. Instead, sixty-six agencies out of 4,987 were treated as having a cost limit of zero rather than being eliminated from the calculation. After making the correction, the budget neutrality factor should be 1.078. The correction does not change the impact on home health outlay projections, since the correct factor is implicit in the home health baseline.

We apologize for the error. We will be instituting additional quality checks to help minimize the chance of error in the future.

We are issuing a corrected Program Memorandum to revise the budget neutrality factor that was previously sent to the fiscal intermediaries. The industry has continued to comment on the revised factor indicating that it still appeared too low. Although this further revision affects the costs of only an estimated 32 % of the providers, a quick correction is needed to assure no unintended damage is done by delayed payments.

We will be happy to handle any inquiries that may arise. Please let me know if you need further information.

Bruce C. Vladeck  
Administrator

cc: Chris Jennings ✓

September 18, 1996

TO: Carol H. Rasco

FROM: Diana Fortuna *DF*

CC: Chris Jennings  
Bill White

Attached is the HHS/HCFA statement on home and community based care and consumer choice that we heard about from the Robert Wood Johnson folks the other day. I recall now that this statement was done after some negotiations between HCFA and ADAPT.

Chris: I thought you might be interested in it.

Bill: I think you have seen this.

**DATE:** May 15, 1996

**FROM:** Administrator

**SUBJECT:** Promotion of Home and Community-Based Services in the Most Integrated Setting

**TO:** Regional Administrator  
Regions I - X

Attached is a copy of a statement issued by Secretary Donna Shalala supporting the principles of home and community care, consumer choice, and self determination. As you know, the Health Care Financing Administration strongly advocates consumer choice in determining utilization of long term services and supports in the most integrated setting possible.

Please share the Secretary's statement with the states in your region. Consistent with this direction, I encourage you to assist the states in the development and implementation of home and community-based services. I am asking Central Office staff to work closely with you to provide any technical assistance you or the states need to stimulate the development and improvement of waivers to maximize customer choice and allow states flexibility to administer such programs.

Over the past year, we have initiated dialogue with consumer advocacy groups across the country, including Americans Disabled for Attendant Programs Today (ADAPT), Family Voices, United Cerebral Palsy, and many others. This initiative has resulted in the identification of many issues concerning individuals with disabilities. Many of these issues have been resolved through discussions between the involved consumers, the Regional Offices and appropriate state agencies. In several states, new waivers have been developed as a result of these discussions. I have requested Paul Mendelsohn of the Office of Beneficiary Relations (410-786-3213) and Mary Clarkson of the Medicaid Bureau (410-786-5918) to coordinate this activity for me. Mr. Mendelsohn and Ms. Clarkson will work closely with staff from Region VIII, which is the regional office focal point for the ADAPT Initiative.

This Agency and Department are committed to providing every opportunity possible to maximize customer choices in the long term care arena. I appreciate your attention, support, and cooperation.

Bruce C. Vladeck

Attachment

**STATEMENT BY HHS SECRETARY DONNA E. SHALALA**  
**SUPPORTING THE PRINCIPLES OF HOME AND COMMUNITY CARE**  
**AND CONSUMER CHOICE AND SELF-DETERMINATION**

I want to take this opportunity to reaffirm our support for the principles of emphasizing home and community based services and offering consumers the maximum amount of choice, control, and flexibility in how those services are organized and delivered. Specifically, we support the principles of:

- promoting greater control for consumers to select, manage, and direct their own personal attendant services;
- expanding community-based, non-institutional supports;
- promoting the use of functional assessments to determine eligibility for home and community based services;
- offering opportunities for states to: (a) provide services in both in-home and out-of-home locations; (b) provide services at any time during the day or night; and (c) offer back-up and emergency services;
- experimenting with alternative ways to finance services (such as vouchers and direct cash payments) in addition to the traditional agency-based model;
- encouraging the use of alternative providers, including informal providers such as friends and relatives;
- developing new ways to help consumers train and manage their attendants;
- demonstrating a commitment to the quality of life of the people who provide attendant care; and
- encouraging the use of agreed-upon individualized plans for attendant care.

The Administration has been steadfast in its support for community care for people of all ages who have disabilities. We know that most people prefer home and community supports and we are pleased that many states are moving aggressively to use their own funds and federal support to improve the quality of life of people who use these supports and those who provide them.

We also recognize that the vast majority of home and community care today is provided by family members and friends. They are there because they choose to be there to support their loved ones. But they need some support and reinforcement. One of the key ways government can help families is to offer some relief, in the form of home and community based services.

Working with the Governors and with consumers and advocacy groups, we have made a number of key regulatory changes over the past two years that demonstrate our strong view about offering incentives for states to expand community based care. Despite grave threats of erosion of the fundamental structure of the Medicare and Medicaid programs, we continue to pursue ways to encourage this movement.

The Department of Health and Human Services is also pursuing an ambitious research and demonstration agenda to find imaginative, new ways to maximize consumer choice and self determination. Many of the elements of this research agenda will have the immediate result of helping many people receive the supports they need. We will, for example, look at new ways to help consumers hire, train and manage their attendants, at alternative providers, and experiment with offering consumers cash instead of services.

I take great pride in being part of an Administration that promotes these basic principles. I am pleased that we have made so much headway in moving toward their realization, although I recognize that we still have much work to do. I continue to appreciate the opportunity to work with the disability community as we work toward our common goals.

## THE TRUTH ABOUT THE HOME HEALTH CARE TRANSFER

Some representatives of the home health industry are attempting to scare Medicare beneficiaries by claiming that the President's proposal would be damaging to those beneficiaries who use home health care services. The industry's claims are false. The home health care transfer makes good policy sense and is a responsible way to help extend the solvency of the Hospital Insurance (HI) trust fund. In fact, the transfer reduces the amount of traditional cuts that would have to be made from Part A to extend the life of the trust fund to the year 2006, thus protecting home health, hospital, and nursing home providers from excessive Medicare cuts. Virtually every Republican Member of the House of Representatives, including Newt Gingrich, Dick Armey, John Kasich, Bill Archer, and Bill Thomas, voted for this concept in the fall of 1995 when they passed their budget reconciliation bill. The following sets the record straight.

*Claim: The policy would rob Americans of \$55 billion in health insurance under Medicare Part A while requiring them to continue to pay the same amount in Medicare payroll taxes.*

**Fact: The policy would not rob any beneficiaries of any health insurance coverage.** Beneficiaries would receive exactly the same home health care coverage that they enjoy today. Part A would pay for some of the services, and, as with current law, Part B would pay for any services that are not financed by Part A.

*Claim: The policy would double bill Medicare patients who have already purchased home health coverage under Medicare Part A through payroll taxes and would have to pay for it again through increased income taxes.*

**Fact: Beneficiaries would in no way be "double-billed" for any home health care services they receive under the Medicare program.** Beneficiaries do not "purchase" a particular Medicare benefit, such as home health care. Payroll taxes, federal income taxes, and Part B premiums paid by participating Medicare beneficiaries all contribute to the current and future operation of Medicare. Beneficiaries are entitled to the full range of Medicare benefits they need by virtue of their eligibility for Medicare, not by virtue of the amount they have paid in payroll taxes. The President's proposals to preserve and improve Medicare do nothing to change this fundamental fact.

*Claim: The policy would increase the cost of health care by discouraging the use of home health services as a substitute for more expensive institutionalization and increase home health agency administrative costs necessary to bill and collect from two different types of insurance plans.*

**Fact: The proposal would not discourage the use of Medicare home health services and would not increase health care costs.** The proposal would establish a mechanism by which some home health visits -- including those that follow a hospital stay -- are financed by Part A, and all other visits are financed by Part B. This would return the home health benefit that is paid for by Part A to its original pre-1980 design as a post-acute care benefit, while home health visits that are not linked to a prior hospital stay would be paid for by Part B.

The proposal would not alter any of the eligibility or coverage rules related to home health care. So, just as under current law, no beneficiaries would be required to have a hospital or other institutional stay prior to receiving the Medicare home health benefit. If a beneficiary happens to be hospitalized before receiving home health care, then the first 100 home health visits would be financed by Part A. If there is no prior hospitalization, Part B financing would step in.

Whether home health care visits are financed under Part A or Part B or both, home health agencies should not have to alter the way in which they bill the Medicare program under the President's proposal.

*Claim: The proposal would reduce access to care by rendering home health vulnerable to the Part B copayment and premium increases.*

**Fact: The President's proposal would not in any way reduce access to the home health benefit and would not change current law with respect to Part B copayments and premiums.** The proposal makes it absolutely clear that the transfer of some home health financing to Part B would not and cannot result in an increase in the Part B premium. Furthermore, the proposal makes it clear that, as under current law, there would be no copayment related to the home health benefit. The President's proposal would help restore the financially vulnerable HI trust fund without imposing any new costs on Medicare beneficiaries.

It is misleading to suggest that a benefit financed under Part B must be accompanied by a copayment. The fact is that some Part B benefits do not have a copayment. Some, but not all, Part A benefits require beneficiary cost-sharing under current law. So, in reality, no benefits are more or less vulnerable to copayments because of their particular placement in the Medicare insurance programs.

*Claim: The proposal is an accounting gimmick that does not reduce the federal deficit, and it obscures the underlying causes for the Part A trust fund's financial problems.*

**Fact: This proposal is not a gimmick -- it is a responsible and desirable reform.** The President's proposal to transfer a portion of home health financing from Part A to Part B makes good sense and, in fact, a similar proposal was approved by the House of Representatives last year when they passed their budget reconciliation bill. Unfortunately, that bill also included unnecessarily deep cuts -- \$270 billion -- in Medicare, and policy changes that could substantially increase beneficiary costs. The President had no choice but to veto this bill.

Medicare Part A was originally designed to finance short-term, recuperative, post-acute care services. When OBRA-1980 eliminated Part A and Part B visit limitations, an unintended consequence was to burden the Part A Trust Fund with approximately 99 percent of the financing for the home health benefit, regardless of whether visits are of an acute care or chronic care nature. The President's proposal recognizes that Part A covers post-acute care services and allows Part B to finance all other home health services, just as was intended and implemented before 1980.

## E X E C U T I V E   O F F I C E   O F   T H E   P R E S I D E N T

28-Jun-1996 06:14pm

TO: Nancy-Ann E. Min

FROM: Anne E. Tumlinson  
Office of Mgmt and Budget, HD

CC: Christopher C. Jennings  
CC: Barry T. Clendenin  
CC: Mark E. Miller  
CC: Caroline B. Davis

SUBJECT: Home Health Shift Talking Points

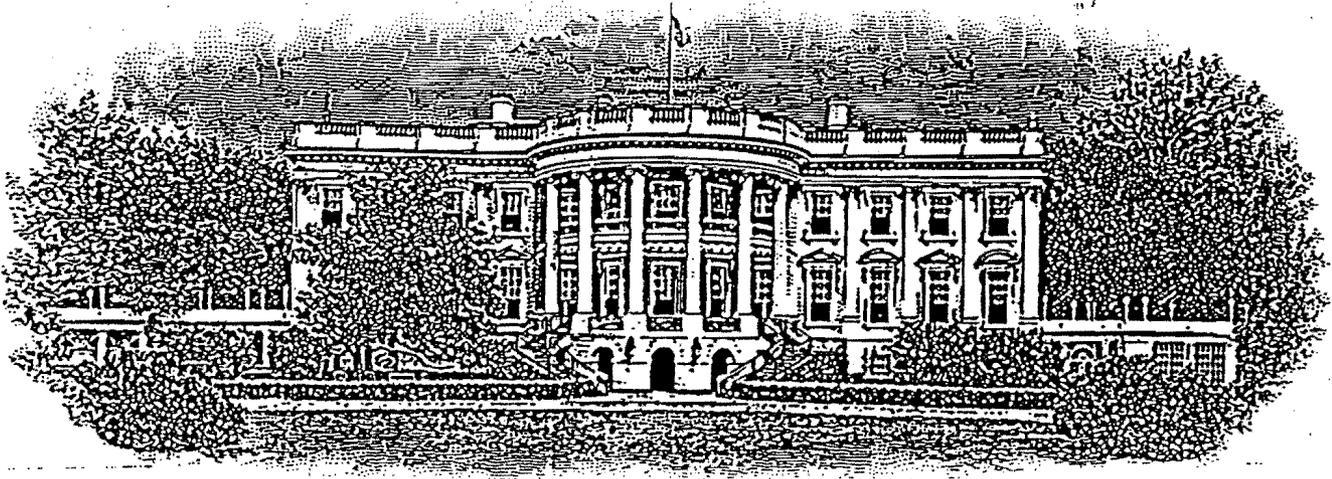
We have transmitted your comments on the home health shift talking points to OLIGA. We would like to raise one issue to your attention.

One change you have made would say, "The President's proposal to transfer a portion of home health financing from Part A to Part B to restore the home health benefit to its original concept not only makes good sense..." OLIGA staff noted that when the Secretary used similar language to discuss this policy, she was criticized because the original policy included Part B home health benefit in the Part B premium whereas the President's plan does not.

OLIGA staff propose using the following, "The President's proposal to transfer a portion of home health financing from Part A to Part B makes good sense..."

Mark and I agree with OLIGA proposed language. Please let us know if you agree.

# The White House



DOMESTIC POLICY

## FACSIMILE TRANSMISSION COVER SHEET

TO: David Burnett

FAX NUMBER: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

FROM: Chris Jennings

TELEPHONE NUMBER: 456-5560

PAGES (INCLUDING COVER): 4

COMMENTS: Following please find a response to an ad in Roll Call (6/27/96) on the President's proposal to shift home health care to Medicare Part B. I hope you find this information helpful. IF you have any questions, please call.

than a little similarity between the challenge Democrats face today and the one Republicans faced two years ago.

In 1994, voters were extremely angry with the Democrat-controlled Congress, and were definitely considering change. Republican leaders felt that simply telling voters to throw

Democratically correct... anxieties that many working voters are concerned about, an

And once the Republicans won, the contract was useful again. It provided a framework for the first three months of the 104th Congress, much like a shopping list. Republican Members knew what they needed to get, and

Democratically correct... anxieties that many working voters are concerned about, an

The proposals may not solve problems, but they do help with those fears. Child care, retirement insurance for kids, portability

## AN OPEN LETTER TO PRESIDENT CLINTON:

### Mr. President:

#### Shifting Home Health To Medicare Part B Hurts Patients

Limiting Medicare Part A home health coverage to "post-hospital" services and shifting the bulk of the coverage to Medicare Part B is **damaging to patients and those who serve them** for the following reasons:

- it quietly robs Americans of \$55 billion in health insurance coverage under Medicare Part A while requiring them to continue to pay the same amount in Medicare payroll taxes;
- it double bills Medicare patients who have already purchased home health coverage under Medicare Part A through their Medicare payroll taxes and would have to pay for it again through increased taxes on fixed incomes;
- it unnecessarily increases the cost of health care by discouraging the use of home health services as a substitute for more expensive institutionalization and increasing the administrative costs necessary to bill and collect from two different types of insurance plans;
- it leads to reduced access to care for the frail elderly by rendering home health vulnerable to the Part B copayment and premium increases; and
- it is an accounting gimmick that does not reduce the federal deficit, and it obscures the underlying causes for the Part A Trust Fund's impending bankruptcy.

The entire home health industry is united in strong opposition to this policy. On behalf of the patients we serve, we urge you to drop this proposal.

### THE PPS WORK GROUP

#### NATIONAL ASSOCIATIONS

American Federation of Home Health Agencies  
Home Health Services and Staffing Association

#### STATE ASSOCIATIONS

Associated Home Health Industries of Florida  
Capital Home Health Association  
California Association for Health Services at Home  
Home Care Association of New York State  
Home and Health Care Association of Massachusetts  
Home Care Alliance of Maine  
Illinois Home Care Council  
Indiana Association of Home Health Agencies  
Maryland Association for Home Care  
Michigan Home Health Association  
New Mexico Association for Home Care  
New York State Association of Health Care Providers  
North Carolina Association for Home Care  
Ohio Council For Home Care  
Pennsylvania Association of Home Health Agencies  
Texas Association for Home Care  
Virginia Association for Home Care

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Rep. Dan

For more information, call ( You may FAX your reservati Conference is sponsored by the Robertson

Roll Call, Thursday, June 27, 1996

## BUYING TIME FOR MEDICARE

Marilyn Moon<sup>1</sup>

In anticipating likely proposals for the Medicare program from the Clinton Administration, it has become fashionable for budget experts and lawmakers to refer to the idea of shifting Medicare's home health care benefit from one part of the program to another as merely a "gimmick" because it does not help to balance the federal budget (news articles, Jan 5 and 10) But that misses the point.

Shifting home health from Part A of Medicare to Part B is needed to help delay the exhaustion of Medicare's Part A trust fund, buying enough time to consider what long term changes make sense for the Medicare program. No combination of reasonable options for slowing the growth in spending on the program will achieve the full amount of short run savings needed to extend the life of the Part A trust fund for more than a year or two. The home health shift -- or some equivalent policy change -- is necessary to supplement other changes.

Medicare's Part A trust fund pays for hospital and related care for persons age 65 and over and those with disabilities. It is financed mainly by payroll taxes. In 1996, spending on Part A grew faster than the revenues coming into the trust fund. Like a family that spends more than it earns, Medicare is dipping into its savings in order to keep paying the hospital and other bills of its beneficiaries.

If left unchecked, the trust fund for Medicare will be exhausted by 2001. And by the end

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<sup>1</sup>Senior Fellow, The Urban Institute. This opinion piece is that of the author and does not necessarily reflect the views of the Urban Institute, its board or its sponsors.

of 2003, the gap is projected to be over \$200 billion.

Efforts to address this gap need to begin immediately, but aggressive attempts to solve the problem *only* through cutting payments to hospitals and other providers of care or reducing benefits would do real harm to the Medicare program. These changes would have to go well beyond slowing the rate of growth of spending. To close the gap in fiscal year 1998, Medicare Part A spending would have to *fall* by about 15 percent -- a feat that none of the usual set of cost savings proposals could achieve.

In addition, subjecting Medicare to major restructuring may not be the answer if it merely shifts the problem onto beneficiaries. Massive changes are underway in the overall delivery of health services and private insurance arrangements for younger families, much to the discomfort of many. Even healthy people are having difficulty in adjusting to the world of managed care, and the rules seem to be constantly changing. More time is needed to assess the impacts of the changing marketplace before locking in changes for Medicare. Further, if incremental reforms begin to slow Medicare growth to more reasonable levels, less restructuring or other changes might be needed over time. Reforms will be needed to preserve the Medicare program, but we need time to consider how to get it right.

What then does make sense? First, efforts should begin immediately to make sensible changes in the Medicare program under both Parts A and B. Examples of changes in the traditional program -- many of which have been proposed by both Republicans and Democrats -- include moving the system used to pay home health benefits away from paying for reported costs to establishing fixed prices, and reducing the level of payments for hospital care to levels in line with the discounts being negotiated by private insurers. Improving the managed care option by

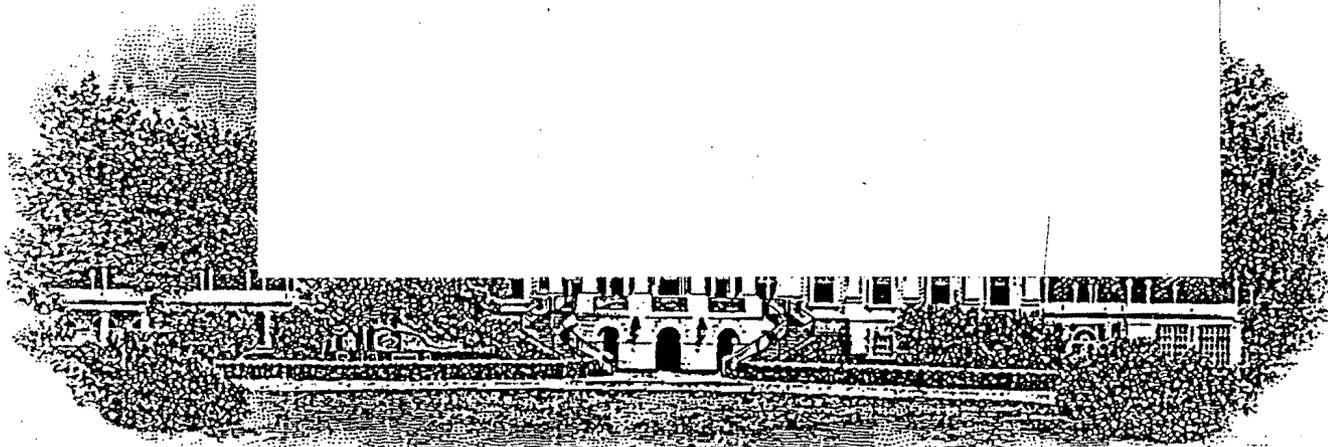
reforming how Medicare establishes premiums while encouraging further enrollment also makes sense. These reforms will help extend the life of the trust fund *and* balance the federal budget. But these changes take time to become fully effective and once implemented, mainly slow the rate of growth of the program over time.

Thus, it is also necessary to look for other adjustments *in addition to* cost savings options to close the gap between spending and revenues and to extend the life of the Part A trust fund. Shifting home health from Part A to Part B would have an immediate impact on narrowing the gap.

In addition, since Part A largely covers institutional care, home health fits in more appropriately with physician and other services provided in the community that are associated with Part B. Originally, home health services were offered under both parts of the Medicare program, so moving some or all of this service to Part B would not be unprecedented.

Why then has such a seemingly minor issue become a sticking point about proposals to change Medicare? It is because such a proposal belies the claim that “saving” Medicare can only be done by cutting spending on the program. Opponents to the shift point out that it does not help balance the federal budget. But that is not why it is being proposed. Indeed, if the only allowable solutions to the trust fund problem that Medicare faces are cuts in spending, then we are in danger of having the cure of “saving” the trust fund kill the patient. Shifting the home health benefit can play a constructive role in buying time for an orderly consideration of longer range solutions to Medicare’s problems.

-will be cleared today  
-should be sent today or  
tomorrow



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Bob

FAX NUMBER: 395-6148

TELEPHONE NUMBER: 5-4871

FROM: Sandy Bublick-Max

TELEPHONE NUMBER: 456-5586

PAGES (INCLUDING COVER): 6

COMMENTS: \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_



OFFICE OF LEGISLATIVE AND INTER-GOVERNMENTAL AFFAIRS



FACSIMILE COVER SHEET

TO: Chris Jennings, 456-5542 DATE: June 26, 1996
Nancy Ann Min, 395-9119
Mark Miller, 395-7840

Telephone: Fax No.

FROM: John T. Hammarlund (for Debbie Chang)
200 Independence Ave SW, Room 341-H
Washington, DC 20201
Telephone: (202) 690-5512; Fax: (202) 690-8168

Number of pages (without cover sheet): 5

Attached, for your review and clearance.

HEALTH CARE FINANCING ADMINISTRATION  
OFFICE OF LEGISLATIVE AND INTER-GOVERNMENTAL AFFAIRS

MEMORANDUM

TO: Chris Jennings  
Nancy Ann Min, OMB  
Mark Miller, OMB

FROM: Debbie Chang

*John Hammarlund, for*

DATE: June 25, 1996

RE: Request Your Review and Clearance of Letter from Bruce Vladeck to NAHC re:  
Clarification of Secretary's Testimony on Home Health Transfer

---

The 6/14/96 *NAHC Report* (from the National Association for Home Care) discusses Secretary Shalala's 6/6/96 testimony before the Ways and Means Committee regarding the transfer of home health financing. We have carefully reviewed the hearing transcript obtained from Ways and Means and determined that the *Report* article (attached) misquotes the Secretary and takes her comments out of context.

We drafted the attached rebuttal letter from Bruce Vladeck to set the record straight. This draft response has received clearance from all HHS components.

We ask that you review this draft and provide any comments to John Hammarlund (690-5512) of my office by Friday noon, June 28, at the latest. We would like to send the letter to NAHC at the end of this week.

Thank you.

cc: Richard Sorian, ASPA  
Peter Garrett, OMA

**DRAFT**

Ms. Dana Sacks  
Managing Editor  
*NAHC Report*  
National Association for Home Care  
228 Seventh St SE  
Washington, DC 20003

Dear Ms. Sacks:

I write to take strong exception to *NAHC Report's* recent characterization of Secretary Donna Shalala's June 6 testimony before the House Ways and Means Committee and, in particular, your suggestion that the Secretary is willing to take the Administration's home health benefit transfer off the negotiating table.

According to the transcript of the Secretary's testimony, the Secretary emphatically stated that the Administration is not prepared to take any proposal off the table before negotiations between the Congress and the Administration resume. The Secretary emphasized that the Administration believes there are areas of common ground between the Republican Medicare reform plan and that of the President. The home health transfer was cited as one of those areas. Indeed, as the Secretary pointed out in her responses to questions from Committee Republicans, a similar policy proposal was included in the House-passed budget reconciliation bill in 1996.

Regarding the Secretary's comment that she was "sorry [she] stepped into it," the transcript makes clear that the Secretary was not apologizing for advancing the home health transfer proposal. Instead, the context of the discussion shows that the Secretary was regretting the rather unseemly discussion led by Committee Republicans that ensued after she cited the home health transfer as an example of common ground.

There are sound policy rationales for the Administration's proposal to transfer financing of a portion of the home health benefit to Part B. Medicare Part A was designed to finance short-term, recuperative, post-acute care services. An unintended consequence of the OBRA-1980 elimination of Part A and Part B visit limitations was to burden the Part A Trust Fund with approximately 99 percent of the financing for the home health benefit, regardless of whether visits are of an acute care or long-term care nature. By capping Part A financing of Medicare's home health benefit, the Administration would be saving the financially vulnerable HI Trust Fund approximately \$56 billion (using CBO's assumptions) over FYs 1996-2002 without imposing any additional costs on Medicare beneficiaries. A transfer of home health financing would also leave open to us the opportunity to build, in the future, a more appropriately designed long-term care home health benefit.

I understand that NAHC has concerns about the home health transfer policy and we are prepared

However, ~~to~~ to have an open debate we must first  
to listen and openly debate the issue. I would be happy to explain in greater detail the rationales  
for this proposal and would appreciate the opportunity to set the record straight. on the Secretary's  
position on this  
issue.

Sincerely,

Bruce C. Vladeck

The Administrator's  
position on this  
issue.

cc Val J. Halamandaris, NAHC President  
Kaye Daniels, Chairman of the Board, NAHC

# NAHC Report

National Association for Home Care's Weekly News Source for the Home Care Industry

Number 665 • June 14, 1996

## Ways and Means Committee Slams Part A To Part B Shift

*Shalala Says "I'm Sorry I Put Forward the Idea"*

House Ways and Means Committee Republicans lambasted the Administration on June 7, for its proposal to shift most of the home care funding from Medicare Part A to Part B. Secretary of Health and Human Services Donna Shalala seemed to back away from that proposal. Secretary Shalala and Secretary of the Treasury Robert Rubin, both Medicare Trustees, were called before the panel to discuss the Trustees annual report that shows that, absent major policy changes, the Medicare Part A (Hospital Insurance) Trust Fund will be insolvent by the year 2001 (see related story, page 7).

After intensely critical questioning, Shalala told the Committee, "I'm sorry I put forward the home health transfer. There is a policy argument to be made for the change, but let's go forward instead with what we agree on."

Representative Bill Thomas (R-CA), chair of the Ways and



Secretary of Health and Human Services Donna Shalala

Continued on page 2

### NR NEWS AT A GLANCE

#### Home Care Industry Briefs Senate Finance Committee On Unified PPS Plan

The National Association for Home Care (NAHC) and the Prospective Payment System (PPS) Workgroup recently held a briefing on the home care industry's Revised Unified PPS for Senate Finance Committee staffers. The Senate briefing on this new proposal for a Medicare PPS for home care was sponsored by the Finance Committee, which has jurisdiction over Medicare. Approximately 25 key Senate staffers attended the Senate briefing, page 4.

#### NAHC Meets with Forum of State Associations Regulatory Advisory Committee on Physician Referral Issue

On June 7, NAHC invited representatives from the newly created Forum of State Association Regulatory Advisory Committee to Washington, DC, to discuss physician certification regulations. This meeting was the second in a series of meetings NAHC is holding on this issue. Last week representatives from freestanding and hospital-based agencies met in Washington, DC, to express their concerns about physician financial relationships with home care agencies, page 4.

#### Medicare Trustees Project Trust Fund Insolvency by FY 2001

In their annual report released June 5 the Medicare Trustees stated that the Medicare hospital insurance trust fund faces bankruptcy early in 2001, a year earlier than formerly projected. The report also stated that the Social Security Trust Fund will become insolvent by 2029, also a year sooner than expected. Secretary of Health and Human Services Donna Shalala, in delivering the report, cited three main reasons for the worsening of the trust fund's fiscal health, page 7.

#### Study Predicts Block Granting Medicaid Would Lower Current Funding Levels by \$250 Billion

A recent study conducted by the Center on Budget and Policy Priorities concludes that the combined effect of block granting federal Medicaid dollars and reducing state matching funds—as proposed in the current Republican Medicaid proposal—would lower current Medicaid funding levels by as much as \$250 billion over six years, page 8.

#### HCFA Publishes Proposed Notice for Changes to Physician Payment

The Health Care Financing Administration is seeking comments on proposed changes to work relative units (RVUs) affecting payment for physician services. The Medicare program establishes payment for physician services through a fee schedule, page 9.

#### HCFA Responds to Request for Policy Interpretation for Skilled Nursing Services Carried Out by a Physician, page 12.

#### Jacobs to Introduce Waiver Legislation

Representative Andy Jacobs (D-IN) has agreed to introduce legislation to retroactively reinstate and make permanent the presumptive status of the waiver of liability for home care, hospices, and skilled nursing facilities.

Jacobs this week sent a letter to the full House of Representatives inviting Members of Congress to join him in introducing the bill.

Call or write your Member of Congress today to urge him or her to cosponsor the Jacobs waiver of liability legislation.

Continued from front page

Means Health Subcommittee, criticized the Administration for offering a plan that would shift 100% of the costs of a benefit—home care—to taxpayers, a move he saw as “unprecedented” in Medicare’s history. While the Administration has been supporting the proposal by suggesting that it is merely returning the home care benefit to its pre-1980 place in the Medicare program, Thomas pointed out that before 1980, the home care Part B benefit also included copays, deductibles, and was financed in part by the Part B premium.

Representative Nancy Johnson (R-CT), who described herself as “a strong advocate of home care,” said that she felt a “public trust to manage Medicare in a way to ensure home health care will be there.” Rep. Johnson used information from the Congressional Budget Office to show that if the home care benefit were moved to Part B and paid for in part through the Part B premium, premiums would jump \$15 per month by the year 2002. Today, the monthly Part B premium is \$42.50. By 2002 the premium is expected to reach \$54.70. However, if \$55 billion of Medicare home care funding is shifted to Part B,

the monthly premium would hit \$69.50 in 2002.

Shalala pointed out that the Part A to Part B shift was approved by the House during last year’s budget fight and that the President’s proposal would shelter the Part B home care benefit from copays, deductibles, or Part B financing.

**Shalala told the Committee, “There is a policy argument to be made for the change, but let’s go forward instead with what we agree on.”**

Upon further questioning by Committee Republicans, Secretary Shalala pressed for bipartisan agreement on moving forward to address the Medicare insolvency problem. She pointed out that, for example, both Congress and the Administration support a prospective payment system (PPS) for home care. The difference between the two

approaches centers on the transition period in reaching a PPS. She urged Congress to set aside provisions in disagreement, pass today what Congress and the Administration agreed on, and leave the longer term, more difficult issues to a bipartisan commission.

Representative Amo Houghton (R-NY), also a Committee member, pointed out that the \$55 billion home care transfer was one of the biggest differences between Congress and the Administration. “But that will be taken off the table,” he asserted. The real question, Houghton pointed out, is what to replace the \$55 billion in cuts with.

Chairman Archer asked Shalala if they could agree to drop the Part A to Part B shift transfer proposal. Secretary Shalala declined to make that commitment, stating that the Administration wanted at least to have the opportunity to make the policy arguments for the Part A to Part B shift while at the negotiating table.

NAHC will continue its high visibility efforts to keep home care in the Part A program and urges its members to keep the pressure up by writing their Members of Congress to voice opposition to the proposed shift from Part A to Part B of Medicare. **NR**

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**NAHC Report**

NAHC Report is published weekly by the National Association for Home Care, a national nonprofit organization representing providers of home care and hospice services throughout the United States.

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**DM** Dani Sarkis  
Managing Editor

Andrew Morrison  
Art Director

Christopher Adams  
Advertising Director

NAHC does not necessarily endorse any of the products or meetings advertised in NAHC Report.

# Bergner, Bockorny, Clough & Brain

Jeffrey T. Bergner  
David A. Bockorny  
Charles M. Brain  
John M. Clough, Jr.

## Fax Transmission

*Resending -  
in case of  
error.*

Date: 6/11/96

From: Chuck Brain

To: *Chris Jennings*

Of: *W-H*

Fax: 456-5542

Number of Pages (including cover):

If there are any problems with this transmission please call (202) 659-9111

*Chris:  
As promised.*

*Chuck*

June 11, 1996

The Honorable William J. Clinton  
President of the United States  
The White House  
1600 Pennsylvania Avenue, N.W.  
Washington, D.C. 20500

Dear Mr. President:

The release of the report by the Trustees on the actuarial soundness of the Medicare (Part A) trust fund will undoubtedly prompt discussions of how to restore solvency to the system while minimizing adverse consequences to beneficiaries.

In these discussions, we urge you not to insist on your proposal to shift a portion of the funding of the current home health care benefit from the Part A to the Part B trust fund. Such a proposal addresses neither the recent increases in Medicare spending for home care nor the basic problems of the Part A trust fund. In addition, the proposal could lead to an increase in costs and a reduction in services to the very elderly who need home care services the most.

The home care industry has joined together to devise a proposal which would provide important budgetary savings by reforming the basic methodology for payments to home care providers. The timely enactment of this "prospective payment system" is far more preferable than simply shifting costs from one trust fund to another.

We, the undersigned state health care associations, look forward to working with your administration to enact needed home care payment reforms and are also united in our opposition to the "Part A/Part B switch."

Sincerely,

Associated Home Health Industries of Florida, Inc.  
California Association for Health Services At Home  
Hawaii Association for Home Care  
Home Care Association of Colorado  
Home Care Association of New York State, Inc.  
Home Health Assembly of New Jersey  
Home Health Care Alliance of Wyoming  
Home and Health Care Association of Massachusetts  
Home Health Care Association of Nevada  
Illinois Home Care Council  
Indiana Association for Home Care, Inc.  
Michigan Home Health Association

Page 2

Minnesota HomeCare Association  
New Mexico Association for Home Care  
North Carolina Association of Home Care  
Ohio Council for Home Care  
Pennsylvania Association of Home Health Agencies  
Texas Association for Home Care  
Virginia Association for Home Care  
Wisconsin Home Care Association

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Home Health Care Association of Nevada  
Illinois Home Care Council  
Indiana Association for Home Care, Inc.  
Michigan Home Health Association

Minnesota HomeCare Association  
New Mexico Association for Home Care  
North Carolina Association of Home Care  
Ohio Council for Home Care  
Pennsylvania Association of Home Health Agencies  
Texas Association for Home Care  
Virginia Association for Home Care  
Wisconsin Home Care Association

### Home Health Shift

**Proposal.** The first 100 home health visits following a three-day hospital stay would be reimbursed under Part A. All other visits, including those not following hospitalization, would be reimbursed under Part B. The visits provided under Part B would not be subject to the Part B coinsurance or deductible nor would this shift impact the Part B premium. For those beneficiaries who are eligible for only Part A or Part B, the benefit would be financed completely by the operative part. CBO estimates that this proposal would shift approximately \$62 billion from Part A to Part B over seven years.

**History.** Medicare home health was originally designed to serve as an acute benefit, but it has increasingly become a long-term care benefit -- in 1992, more than 10 percent of home health users had over 150 visits.

The home health benefit has undergone many changes since the beginning of the Medicare program:

- ▶ The 20 percent Part B coinsurance requirement for home health visits was eliminated by the Social Security Amendments of 1972.
- ▶ From January 1973 to June 30, 1982, there was a \$60 annual deductible on Part B home health care.
- ▶ Prior to July 1, 1981, home health benefits were limited to 100 visits under Part A and 100 more visits under Part B.
- ▶ OBRA 1980 eliminated the following requirements: (1) the 3-day prior hospitalization requirement; (2) the SMI deductible (i.e., beneficiaries no longer have to meet the SMI deductible before Medicare payments for home health services under SMI could begin); and (3) the 100 visits per year limit. OBRA 1980 effectively made the home health benefit unlimited under Part A.
- ▶ OBRA 1980 also permitted proprietary home health agencies (HHAs) to furnish Medicare-covered services in States not having licensure laws. This provision increased the number of proprietary Medicare HHAs.

Currently, the only beneficiaries who qualify for Part B home health benefits are those who are not eligible for Part A.

The House Republicans, in the Medicare Preservation Act of 1995, also proposed a limit on Part A home health coverage. The House bill would have limited Part A home health to 165 days of home health care per episode of illness.

**Rationale.** Home health is one of the fastest growing Medicare benefits, with increases in the number of visits per beneficiary driving this growth. Applying a limit to the Part A home health benefit would recognize that Part A covers only acute care services, and the HI Trust Fund would no longer be forced to support a chronic care benefit. Shifting some home health spending from Part A to Part B also would extend the solvency of the HI Trust Fund. At the same time, moving the remainder of a beneficiary's visits to Part B ensures that no beneficiary would be denied home health care.

### **Proposals to Shift Outlays and Income Between the Medicare Trust Funds**

The two Medicare trust funds are the Hospital Insurance (HI) (Part A) Trust Fund and the Supplemental Medical Insurance (SMI) (Part B) Trust Fund. Since the SMI Trust Fund is predominantly financed from general revenues, it cannot be thought of as a true trust fund. References to the "impending insolvency" of Medicare generally refer to the financial condition of the HI (Part A) Trust Fund. The HI Trust Fund's financial condition is improved either by reducing the amount of HI outlays or by increasing the amount of income to the trust fund. The FY 1997 President's Budget, the House-passed Medicare Preservation Act of 1995 (H.R. 2425), and the final Conference Agreement (H.R. 2491) included proposals to shift flows of financing from one Medicare trust fund to the other.

**Home Health Outlay Shift from HI (Part A) to SMI (Part B).** The President's FY 1997 Budget includes a proposal to shift certain outlays for home health care services from the HI (Part A) Trust Fund to the SMI (Part B) Trust Fund. Specifically, the first 100 home health visits following a three-day hospital stay would be reimbursed under HI. All other visits, including those not following hospitalization, would be reimbursed under SMI. The visits provided under SMI would not be subject to the SMI deductible or a coinsurance charge, nor would this shift affect the SMI (Part B) premium. For those beneficiaries who are eligible for only HI or SMI, the benefit would be financed completely by the operative part.

**History of the Home Health Benefit.** Medicare home health was originally designed to serve as an acute care benefit, but it has increasingly become a long-term care benefit -- in 1992, more than 10 percent of home health users had over 150 visits. Prior to July 1, 1981, home health benefits were limited to 100 visits under HI (Part A) and 100 more visits under SMI (Part B). OBRA 1980 effectively made the home health benefit unlimited under HI (Part A).

**Rationale for Shifting Outlays.** Home health is one of the fastest growing Medicare benefits, with increases in the number of visits per beneficiary driving this growth. Applying a limit to the HI home health benefit would recognize that HI covers only acute care services, and the HI Trust Fund would no longer be forced to support a chronic care benefit. At the same time, moving the remainder of a beneficiary's visits to SMI ensures that no beneficiary would be denied home health care.

**House Medicare Bill Also Included Home Health Outlay Shift from HI (Part A) to SMI (Part B).** The House-passed Medicare Preservation Act of 1995 and the House-passed reconciliation bill (HR 2491) also proposed a limit on HI home health coverage. The House bill would have limited HI home health to 165 days of home health care per episode of illness. Visits beyond 165 days would be paid by SMI.

**Mechanics of Financing the Outlay Shift.** Both of these proposals stipulate that the outlay shift shall have no impact on the SMI (Part B) premium, as a result, all of the outlays shifted to SMI would be subsidized out of general revenue. The annual Federal contribution to the SMI Trust Fund would be increased by an amount exactly equal to the home health outlays shifted from HI to SMI.

CBO's preliminary scoring estimates that the Administration's proposal would shift approximately \$62 billion in outlays from HI (Part A) to SMI (Part B) over seven years. In its October 1995 CBO estimated that the House Medicare bill would shift approximately \$54 billion in outlays from HI (Part A) to SMI (Part B) over the same time period.

### Shifting Income to the HI (Part A) Trust Fund

The Senate Medicare reform bill and the final Conference Agreement included proposals to improve the HI Trust Fund's financial condition by shifting certain types of income from the SMI (Part B) to the HI (Part A) Trust Fund.

**Senate Medicare Bill.** The following amounts would have been transferred to the HI Trust Fund: increases in SMI premium revenue from setting the premium at 31.5 percent of program costs; increases in revenue from an income-related (means testing) SMI premium; decreases in outlays from an increase in the SMI deductible. Mechanically, this would work by creating a permanent appropriation from the general fund to the HI Trust Fund equal to the estimated savings from the three proposals. In effect, the premium increases and outlay savings would be diverted from SMI to HI, with the general fund appropriation serving as a pass-through for the transfer. CBO estimated that these provisions would have increased the income of the HI Trust Fund by \$66.8 billion over FY 1996-2002.

**Conference Agreement.** The Conference Agreement adopted the Senate provisions with modifications. First, it dropped the SMI deductible increase completely. Second, it stipulated that the SMI premium income shifted to the HI Trust Fund would be the amount equal to the difference between the savings from setting the premium at 31.5 percent the savings from setting the SMI premium at 25 percent of program costs. The rest of the savings (i.e., the difference between current law and a 25% premium) would stay in the SMI Trust Fund. As in the Senate bill, all income from an income-related (means testing) SMI premium would be shifted to the HI Trust Fund.

CBO estimated that the income-related SMI premium would increase receipts by \$8.3 billion over 1996-2002. CBO estimated \$45.9 billion in total new receipts from setting the basic SMI premium at 31.5 percent of program costs. CBO did not publish an estimate of how much of this total would go to the HI Trust Fund, but it is likely that most of the new receipts would be shifted to HI because, for most of the years in the budget window, the difference between the current law premium and a 25 percent premium is significantly smaller than the difference between a 25 percent and a 31.5 percent premium.

Shifting the flow of funds between trust funds has no effect on the deficit. The deficit is reduced only by reducing total Medicare outlays (i.e., the outgo from both trust funds combined) or by increasing total income, e.g., through a payroll tax or premium increase. The HI Trust Fund's financial condition is improved either by reducing the amount of HI outlays or by increasing the amount of income to the trust fund.

June 4, 1996

MEMORANDUM FOR THE CHIEF OF STAFF

FROM: Nancy-Ann Min  
Chris Jennings

RE: Medicare Home Health Policy in FY 1997 Budget

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This memorandum provides you with additional background on the Medicare home health policy in our FY 1997 budget, which was highlighted in Monday's New York Times.

Background. The FY 1997 Budget includes a proposal to restructure the way home health care is delivered and financed in the Medicare program. Under current law, home health care is unique in that the service is technically covered under both Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) of the program. However, the payments are made almost exclusively from Part A, and the benefit is not subject to coinsurance or deductibles. Not surprisingly, home health care has become one of the fastest growing parts of the Medicare program, growing at approximately 10.2% per year.

History of the Home Health Benefit. Medicare home health was originally designed to serve as an acute care benefit tied to prior hospitalization, but it has increasingly become a long-term care benefit. Congress has made many changes to the benefit since the beginning of the Medicare program:

- The 20% Part B coinsurance requirement for home health visits was eliminated by the Social Security Amendments of 1972.
- From January 1973 to June 30, 1982, there was a \$60 annual deductible on Part B home health care visits.
- Until July 1, 1981, home health benefits were limited to 100 visits under Part A and 100 more visits under Part B. OBRA 1980 eliminated the following requirements: (1) the 3-day prior hospitalization requirement; (2) the Part B deductible (i.e., the relatively small number of beneficiaries who receive home health services as a Part B benefit no longer have to meet the annual Part B deductible of \$100 before they could receive home health services); and (3) the 100 visits per year limits. OBRA 1980 effectively made the home health benefits unlimited under Part A.

Our Proposal. The FY 1997 budget proposal attempts to restructure the benefit into the acute-care benefit it was initially intended to be. Specifically, the first 100 home health visits following a 3-day hospitalization would be reimbursed under Part A of Medicare. All other visits—including those not following hospitalization—would be reimbursed under Part B. Under our proposal, the visits provided under Part B would not be subject to the Part B deductible or coinsurance, and the Part B premium would not be increased to cover these additional outlays. Moreover, the proposal is deficit neutral; as an accounting matter, it is merely a shift from one Federal budget column to another.

Rationale for the Proposal. There are at least 2 reasons why our proposal makes sense. First, home health is one of the fastest growing areas of Medicare expenditures, with increases in the number of visits per beneficiary driving much of this growth. Applying a reasonable limit to the Part A home health benefit recognizes that Part A is intended to cover only acute care services financed by the HI tax on employees and employers. The Part A trust fund would no longer be forced to support a chronic care benefit that has lost its link to hospitalization. At the same time, moving the remainder of a beneficiary's visits to Part B (and not increasing premiums, deductibles, or co-pays) ensures that no beneficiary will be denied home health care.

Second, we had a policy objective of extending the solvency of the Part A trust fund through at least 2006 (a decade from now), to give us time to address the long-term Medicare financing issues in a bipartisan manner after we had balanced the budget. In order to do this, the actuaries estimated that we needed about \$130 billion in savings from Part A over 1997-2002. In our judgment, it is not possible to achieve savings of this magnitude from Part A without the home health proposal or something like it (see discussion below).

To give you an idea of why this is so, consider that without the home health policy, we have approximately \$74.6 billion in savings in Part A in our \$124 billion, six year Medicare savings package, of which approximately \$50 billion is from hospitals. (The most that had ever been done before from Medicare—including policies in both Part A and Part B—was the \$56 billion, five year package we did in OBRA 1993). Among other things, our hospital proposals reduce the rate of increase in hospital reimbursements from Medicare down to about 1% a year—a reduction in the rate of growth, to be sure, but we believe that the effect of all of our proposals combined (including the Medicaid reforms) will squeeze hospital budgets noticeably.

Because the Republicans have stated that they will not accept our home health policy, and because their most recent proposal (in the House and Senate Budget Resolutions) states that they have dropped their earlier proposal to increase the Part B premium and devote the savings to Part A, they have to come up with approximately \$130 billion totally from Part A to extend the solvency of the Part A trust fund to 2006. There are only 3 places they can go to do this: hospitals, skilled nursing facilities, and home health. If, as appears likely, they go where the money is—to hospitals—they will have to make some \$25 billion in additional hospital cuts on top of the \$73.8 billion they had already proposed. It is not possible to cut hospitals this much without making real reductions in payment rates—i.e., hospitals would be receiving lower reimbursements to care for patients in real terms in 1998 than they did in 1996. This could have severe consequences in terms of access and quality, and we do not believe it is a defensible policy.

House Medicare Bill Also Included Home Health Change. The House-passed Medicare Preservation Act of 1995 proposed a similar change in Part A home health policy. The House bill would have limited Part A home health coverage to 165 days of home health care per episode of illness. Visits beyond 165 days would be reimbursed by Part B.

In addition, the Senate bill and the final Conference Agreement included proposals to shift flows of financing from one Medicare trust fund to another. These proposals directed a portion of the revenues from the increase in the Part B premium to the Part A trust fund, which has virtually the same effect as the home health change (i.e., reducing Part A outlays and thus extending the solvency of the Part A trust fund in a deficit neutral manner), without the policy rationale.

Opinions of the Advocates, Providers, and Health Policy Experts on the Transfer:

Aging advocates (such as AARP), providers (the American Hospital Association), and health policy experts (such as Stuart Altman) believe that the home health transfer may be a viable, defensible option. This is primarily because it focuses attention on the most rapidly rising cost component of Medicare (home health care) and obviously because it reduces the pressure to enact excessive traditional Part A cuts.

The only provider opposed to this approach is, not surprisingly, the National Association of Home Care. Health policy experts who oppose the transfer criticize it on two counts. First, it is a distraction that clouds the need to achieve even greater savings from the Trust Fund. Second, and probably most compelling, they believe that any such transfer should include a requirement that beneficiaries pay their fair share of the increase in Part B expenditures, presumably with higher premiums (their 25% share.)

# THE HOME HEALTH TRANSFER AND THE MEDICARE TRUST FUND: THE FACTS

June 3, 1996

**FALSE CLAIM:** *Without its home health transfer gimmick, the President's budget only extends the life of the Trust Fund by one year.*

**THE FACTS:** Not True.

1. The President's balanced budget guarantees the life of the Medicare Trust Fund for a decade -- the same as the Senate Republican budget. The Congressional Budget Office projects that the President's Medicare reforms would extend the life of the Medicare Trust Fund to 2005. The reforms build on the President's 1993 deficit reduction plan, which extended the life of the Trust Fund by 3 years -- *without a single Republican vote.*
2. The President's budget strengthens the Trust Fund by:
  - a. Reducing provider payments; and
  - b. Restoring the pre-1980 law on Part A home health benefits -- This is NOT a gimmick:
    - Prior to 1980, home health care services unrelated to hospital stays were not financed by the Hospital Insurance (Part A) Program. Only the first 100 home visits after a three-day hospital stay were financed under Part A. All other visits were financed by Part B. This is because Medicare Part A was intended to finance costs related to hospital stays.
    - In 1980, the law was changed and nearly all home health costs were shifted to Part A.
    - The President's proposal simply restores the pre-1980 law because home health care expenditures unrelated to hospital stays should not be financed by the Part A Trust Fund. Shifting home health spending unrelated to hospitalization back to the Part B programs helps extend the life of the Medicare Part A Trust Fund. (This shift will not affect the Part B premiums, coinsurance or deductibles.)
3. **REPUBLICANS ARE BEING HYPOCRITICAL:** The 1995 House Republican budget also shifted some home health costs from Part A to Part B. The House-passed Republican reconciliation bill also transferred certain home health care expenditures from Part A to Part B -- similar to the proposal in the President's balanced budget. *So if Republicans say it's a gimmick, it's a gimmick every Republican in the House voted for.*
4. President Clinton's budget extends the life of the Trust Fund as long as the Senate Republican budget, but without their \$167 billion Medicare cut and without their damaging structural changes. The President's balanced budget proves the Republican \$167 billion Medicare cut and damaging structural changes are not necessary to balance the budget and strengthen the Trust Fund for a decade.

## ADMINISTRATION GIMMICKS

### QUESTION:

The Administration's budget plan relies, in part, on a "gimmick" in extending the trust fund depletion date. The Administration's plan would transfer home health coverage from Part A to Part B. In essence, home health spending goes from a trust fund financed by payroll taxes to a trust fund financed by general revenues and premiums. How can the Administration justify this "gimmick"?

### ANSWER:

- ▶ Let me make clear that not all home health expenditures would be transferred to Part B. Only home care not following an acute event and hospitalization would be transferred. Part A was never to cover this kind of long-term care.
- ▶ We do not believe that the transfer of some of the financing of home care from Part A to Part B is a gimmick. By capping Part A financing of Medicare's home health benefit, one of the most rapidly growing components of Medicare, we would be limiting the HI trust fund expenditures. According to CBO, the home health transfer would save the financially vulnerable HI Trust Fund about \$55 billion over FYs 1997-2002.
- ▶ This idea is not new, nor unique to the Administration. A shift in some home health financing from Part A to Part B has been recognized by Democrats and Republicans alike as a sensible way to help the HI trust fund. Similar proposals were offered by the Republican House in their balanced budget bill (H.R. 2425) and in the so-called "Blue Dog" Coalition bill.
- ▶ The proposal would not in any way adversely impact beneficiary access to home health care, even for those beneficiaries who have only Part A coverage or only Part B coverage. The three-day prior hospitalization requirement only dictates how the benefit is financed and has no bearing on coverage or eligibility. Our plan explicitly states that no co-payments or deductibles would apply regardless of whether the benefit is financed under Part A or Part B.

- Under our proposal there would be no related increase in the Part B premium.

#### BACKGROUND:

There are other good policy rationales for this shift.

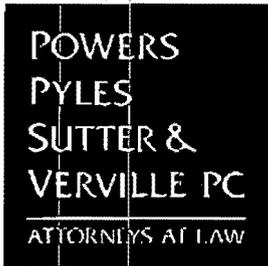
- Utilization and expenditure patterns show that home health has evolved into two distinct benefits: care to persons surrounding an acute event and hospitalization, and care where there is no hospitalization but long-term care services are required.

- This proposal acknowledges this evolution and seeks to bring Medicare financing in line with current utilization patterns. Medicare Part A was not envisioned to accommodate long-term care, and the Part A trust fund can no longer support non-post-acute care home health services.

There is historical precedent for the Medicare home health benefit to be financed under both Part A and Part B. Until the Omnibus Reconciliation Act of 1980, 100 post-hospital visits were financed under Part A for each beneficiary and all remaining visits during a year were financed under Part B. When Congress lifted the 100 visit limit in 1980, the benefit became fully financed by Part A. This shift in financing to Part A was not viewed as a gimmick at the time. The consequence has been to burden the HI Trust Fund with complete financing of home health services whether furnished as acute or long-term care.

- This shift in financing leaves open to us the opportunity to build in the future a long term care home health benefit that is not constrained by considerations of trust fund solvency.

- It is also worth remembering that Republicans also shift money into the Trust Fund to extend its solvency: The Conference Agreement included a proposal that would impose a 6.5 percent surcharge on beneficiary Part B premiums, by raising premiums from 25 percent to 31.5 percent of Part B costs, and transferring this revenue to the HI Trust Fund. Not only did this proposal lack any policy-based justification, it would adversely affect beneficiaries by increasing their premiums.



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October 20, 1995

**By Courier**

Chris Jennings  
 Special Assistant to the President  
 For Health Policy Development  
 White House/Old Executive Office Building, Room 212  
 Washington, D.C. 20500

**Re: Prospective Payment Plan for Home Health Services**

Dear Chris:

We appreciated the invitation to meet with you and HCFA officials on October 18. I believe the meeting was an illuminating experience for all involved. The PPS Work Group would welcome the opportunity to attend a working session with you or your representatives and HCFA to develop a better prospective payment plan than is contained in the Republican Medicare reform proposals, but I believe it is important for you to understand the position of the Work Group in entering into those discussions.

First, although the Work Group is opposed to several changes that were made in the prospective payment plan when it went through the congressional committees, **we will not oppose the prospective payment plan contained in the Republican legislative proposals.** The prevailing view of the Work Group members is to support prospective payment and to work to eliminate or revise the objectionable changes as the Medicare reform bill goes through the legislative process and as we approach the implementation date.

Second, we would be glad to work with you and HCFA to develop an improved version of the PPS plan contained in the congressional proposals, but we are committed to prompt implementation of a plan that contains the basic structure of the plan developed by the Work Group and adopted as the industry's "unified" plan. For example, we believe there would be strong industry support for a version of the congressional proposal that (a) eliminated the 45-day/extended care measure, (b) extended the period for rebasing the per episode limit to 5 years, (c) deleted the limit

# POWERS, PYLES, SUTTER & VERVILLE, PC

Chris Jennings  
October 20, 1995  
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on savings sharing, and (d) permitted the per visit rates and the per episode limits to be updated by the home health market basket index. We would be glad to commit whatever time and effort is necessary to develop an alternative extended care measure and a better case mix adjuster that might be easier to administer. We also believe that the congressional proposal could be improved by incorporating the 14 recommendations approved by the Work Group which I left with Sharon Arnold and John Hammerlund after our meeting.

Third, I do not believe, however, that the Work Group would be interested in a proposal that calls for retention of the current cost reimbursement system and development of an entirely different prospective payment system by the Secretary in the year 2000. Nor do I believe that the Work Group is interested in any interim system that calls for capping visits under Part A and shifting coverage to Part B. We have thoroughly considered and rejected those options because (a) the entire home health industry is suffering because of the incentives under the antiquated cost reimbursement system to increase costs and visits and retain patients on service for as long as possible, (b) the longer the services remain on cost reimbursement and fail to move to prospective payment, the more likely it is that copayments will be imposed (we recognize that, although it is not official Administration policy, there are still some in the Administration who favor copayments), and (c) the Work Group has devoted more than 18 months of intensive work to the development of the plan which forms the basic structure of the congressional proposal, and we believe the proposal (as adopted in the "unified" plan) strikes the best balance that is likely to be achieved between the interests of the government, the beneficiaries, and the providers.

Accordingly, as I stated at our meeting, I do not believe that the Work Group would prefer the proposal set forth in the Democratic substitute Medicare reform bill to the proposal contained in the bills reported out of the congressional committees. Of course, we would prefer a smaller reduction in Medicare expenditures for home health as the Democratic proposal provides and, again, there are many features of the congressional proposals which we believe should be eliminated or revised.

We also believe that the overall reduction in Medicare spending of \$270 billion is too high, as are the reductions in Medicaid spending. But we believe that, at this late date, our time in the type of meeting you suggested would be spent most productively in the development of an improved version of the congressional PPS proposal rather than in an attempt to develop an interim measure and a new PPS plan at some point in the distant future.

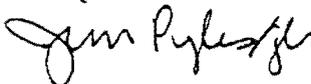
**POWERS, PYLES, SUTTER & VERVILLE, PC**

Chris Jennings  
October 20, 1995  
Page 3

As we mentioned, we brought the Work Group plan to HCFA in February of this year and received strong encouragement to continue developing it. We presented it formally to HCFA Administrator Bruce Vladeck and HCFA staff at a meeting on April 10, and Mr. Vladeck stated to the press and in testimony before the Ways and Means Committee that the proposal held great promise and that a PPS system for home care could be implemented within 18 months of enactment. We have extended a standing invitation to HCFA for months that we will attend a meeting any time and anywhere to work on improvements to the PPS plan. We have visited with many Democratic members of Congress, and they have unanimously supported the PPS proposal developed by the industry. Of course, the Republican support is obvious.

We remain committed to implementation of a prospective payment system as an alternative to copayments and bundling and would be glad to work with the Administration within the foregoing parameters. I look forward to hearing from you regarding the scheduling of the meeting you suggested.

Sincerely,



James C. Pyles

JCP/jlr

2 Copies Please

- One in an envelope

Dr Val Halamantaris

pl